The Role of the Mother's Own Experience of Being Born in Giving Birth

Author: Mehl, Lewis E, USAFMC, PhD

Publication info: Pre- and Peri-natal Psychology Journal 7. 3 (Spring 1993): 243-259.

Abstract: None available.

Full Text: Headnote ABSTRACT: This paper presents the hypothesis that the woman's own experience of being born has an impact on how she will give birth. This impact is proposed to occur primarily through the birth story as symbol for a socialization process, in which the woman learns how to view her body and Nature and how to react to the sensations of labor. The more anxiously she reacts, the more likely that her body will hold "physiological expectations" of fear that will work against the process of birth. Statistical analysis of a non-randomly selected population provided confirmation in the expected direction with significance. Clinical material is presented which emphasizes the complexity of psychophysiological learning in a cultural context. Psychotherapy can help women to undo the effects of socialization through providing them with symbols upon which to draw, to remember (while in labor) a view that their bodies are quite capable of giving birth effectively. INTRODUCTION Through my clinical work with pregnant women, I have come to suspect that the mother's own experience of being born has an association with her own process of giving birth. Through previous research (Mehl, 1990b; Mehl and Manchanda, 1991; Mehl, et al., 1991), I suspected that this association unfolded through a socialization process for which the birth experience is a guiding symbol, one that teaches a woman how to view her own body, how to interpret the sensations of labor and how to feel about Nature and natural processes. In exploring the literature for this paper, I found no studies in the scientific literature on this topic, but, to my surprise, I did come across popularized versions of my hypothesis. The popularized versions state, in essence, that "you have a tendency to give birth exactly like your mother did." It states a causal relationship rather than an associational one and proposes to explain the means of causality. Consider one quote from a popular pregnancy workbook: "As young children, we love our family and want to be a part of it. If that's the way the world is or that's the way things are for the women in our family, we unconsciously assume that they will be that way for us as well. Difficulties blamed on bone structure for a hereditarily small pelvis more often stem from unconscious agreement with what birth is like in one's family. Diagnosis of lack of progress or a disproportion between the baby's head and the mother's pelvis have very little to do with bone size, as is attested to by mothers who have had vaginal births after cesareans (VBACs) and have often given birth naturally to babies who were much larger than their first cesarean babies. By bringing to light some of the birth experiences of your family and making conscious some of the conclusions you may have come to, it is possible to take steps toward realizing your freedom and creating other options for this birth. At present just be aware of the assumptions about yourself and the world; in the next chapter we'll look at how to let go of unproductive ones and replace them with positive affirmations." (Baldwin and Palamarini, 1986: 50). An implicit hypothesis is stated here: women unconsciously strive to be like other women in their families. Making conscious the birth experiences of the family is thought sufficient to change this learning. Here is another presentation of this implicit, popular hypothesis: "If your mother told you that birth is difficult, and you feel best when you are being loyal, you may have supported her thoughts about birth when you labored. Many cesarean women were born by cesarean. We believe the reason for this is psychological, not anatomical. Women who have a strong need to bond with their mothers may create situations that will put them on common ground with their mothers, to help them relate, rebond, reconnect. These women need to know that they don't have to please their mother or do the birth her way in order to show their love for her." (Cohen and Estner, 1983: 274) These authors separate psychological and anatomical problems, presuming to be able to designate problems to one category or the other. Similarly, they present loyalty (a personal psychological process) as an explanation for socialization, a process that

Pearsons said involves the family helping the individual to internalize a culture. Perhaps it is better to avoid postulating unconscious mental processes for as long as possible. Later the authors say: "If your own birth was difficult or traumatic, that memory may be activated as you are birthing your own child. If you experienced birth as difficult, you wanted to save your child from that experience. A cesarean seemed the best alternative." (Cohen and Estner, 1983: 275) One might call this a psychological-genetic hypothesis in that it proposes psychological factors as explanatory from early childhood, but also invokes unconscious mental processes. Given several popular versions of the proposal that a woman's personal birth affects the way that she will give birth, it seemed important to begin more scientific investigations of this idea along with a more rigorous delineation of how and when this can happen. One biological-genetic hypothesis is rampant in medicine and spills over into psychology and the popular press. This hypothesis states that you may behave like your parents (get the same diseases they got, have the same type of labor, etc.). With the exception of a few specific conditions, this hypothesis too is largely unconfirmed. PRELIMINARY HYPOTHESIS My preliminary hypothesis is that a pregnant woman's own personal birth experience is a powerful symbol for a socialization/acculturation process within the family that offers a particular view about Nature and about women. The retelling of the family stories (sometimes to mythic proportions) about birth reinforces a point of view about the performance of women's bodies and of how much one can or cannot trust in Nature. The pregnant woman who was born by cesarean and hears frequently through the years about how "she and her mother almost died during the birth process if not for the doctor who cut her out in the nick of time" is bound to feel a bit uneasy about the birthing process. Similarly, the woman who hears frequently about how easily she was born and how pleasurable it was for her mother will have a different view of the physiological functions of women's bodies. So what, we might ask? So what if two women have different views? The point here is that faith or lack of faith in the birthing process is associated with a physiological expectancy. Here lies an interesting concept crucial to this hypothesis which has emerged over and over in the psychobiosocial literature. When the woman demonstrates negative faith (doubt) in her body's ability to give birth, this can be manifest as if the body will not give birth. How does this happen? What we expect or fear colors our perception. When the sensations of labor begin, the doubt and lack of trust in Nature engenders fear and anxiety. A threat is perceived. Perceived anxiety activates brain benzodiazepine receptors which in turn activate and arouse the hypothalamo-pituitary-adrenal axis and the sympathetic nervous system. Increased catecholamines and glucocorticoids are produced. The production of oxytocin is relatively inhibited through lateral inhibition processes within the hypothalamus, in turn affecting production in the pituitary gland. The quality of uterine contractility decreases along with uterine blood flow and fetal oxygenation. The labor and the baby can suffer. The body behaves as if fear or anxiety were true. This can be called a physiological expectancy. I want to contrast this sharply with a belief, which I take to be a rationally developed view on a particular issue. Bodies do not have beliefs, rather, they respond to the perception of danger. Perceived danger relates to "knee-jerk" perceptual responses, often outside ordinary conscious awareness. Thus, the hypothesis states that the mother-to-be's own personal birth experience affects her labor through the physiological effects of these expectancies. Similarly the more anxious she feels, the more highly aroused and activated her sympathetic nervous system and hypothalamo-pituitary-adrenal axis. I want to contrast this sharply with a more blame-oriented, psychoanalytic point of view which is implicit within the popular quotes I presented. In that point of view "belief systems" and conflicts and tensions mysteriously affect physiology. Unconscious mental contents are inferred based upon a psychoanalytic process. This is far from my thinking which is focused upon learning and not unconscious contents. Inferences of unconscious contents inevitably lead toward blame and are dangerous and demeaning for that reason. I would dispense with the term "belief systems" and limit ourselves to talking about learning. The woman at any moment in time is a syncretic totalization (to use Sartre's term) of all that she has learned. Part of that learning is her socialization. Socialization has physiological consequences when that socialization is about how to view and interpret our personal body functions. When the woman has learned to interpret the early signs of labor as signs of

impending danger or even doom, the body will respond as if it expects danger. We can however, understand all these concepts in terms of learning and behavior and do not need complicated constructs such as "belief systems" or the various conflicts and tensions associated with the negotiation of those belief systems. We can blame ourselves for these inner struggles, but how can a woman blame herself for reacting based upon what she has been taught. Learning is out of our grasp. It is environment-driven. We cannot decline or control the learning process. Sometimes this learning occurs even through one trial, as for the woman who has a traumatic, humiliating, and painful experience during a pelvic examination and "learns" to tighten her pelvis in anticipation of pain whenever she is examined. She may involuntarily tighten her pelvis during labor based upon this earlier learning and this may interfere with her labor. This is not due to inferred psychological conflicts, but the result of learning. The resolution of any associated problems rests in the provision of alternative learning. One more area deserves consideration. Elsewhere [Mehl, 1990b] I have written about the existence of prenatal memories in adults. David Chamberlain (1989) and David Cheek (1989) have also addressed the existence of such memories. In my paper, I argue that, if we accept the existence of these memories, we must expand our view of memory toward the holographic concept of Karl Pribram or Sheldrake's concept of a morphogenetic field, since adults are remembering events (confirmed by others) for which their nervous systems should be physiologically inadequate to record. Nevertheless, memories of the pregnant woman's own birth experience are unnecessary for the hypothesis here. Learning can occur quite adequately without conscious memory of the experience promoting the learning. Presumably the human organism learns something from the experience of being born. This learning becomes part of a larger process of learning. If the birth is traumatic and becomes an initial event in a string of traumas, the child learns to distrust the world and her body. If the birth is traumatic, but love and comfort are provided in adequate quantity afterwards, the child may learn that painful events can occur, but we can trust in others to comfort us and in our bodies to rebound in resiliency. These are two quite different lessons. To fully state the hypothesis, the pregnant woman's experience of being born is part of a socialization process toward her view of Nature and the functions of her body that affect her sense of faith and trust in her body to give birth. The actual experience of being born can produce one-trial learning effects, more or less offset by later learning experiences. To the extent that this learning results in birth and the sensations of birth being perceived as threatening, the activation of the hypothalamo-pituitary axis and the sympathetic nervous system will occur, and will increase risk. METHODS Population Data was collected from 194 pregnant women. The data was collected prior to delivery and was obtained from a varied population, in Tucson, Arizona; Portland, Oregon; the San Francisco Bay Area and Burlington, Vermont. Women from all socioeconomic classes were represented in the sample, ranging from the medically indigent to the independently wealthy. They were recruited from health practitioners who were interested in my other studies on systems-dynamics computer models for pregnancy risk assessment (Mehl and Manchanda, 1991 and Mehl, et al., 1991). All shared a willingness to be interviewed at length (2 hours or more over two sessions) and to complete some questionnaires on their own between interview sessions. Most patients were interviewed in only one trimester. Several were interviewed in each trimester. All of the larger racial groupings were represented including Native Americans, Orientals, blacks, Caucasians and Hispanics. Data-collection Instruments As part of the data-collection packet used (available from the author), questions were asked regarding the pregnant woman's own personal birth, her mother's birth of other siblings and the birth stories of women friends and relatives (including her sisters). Specific queries were made about length of labor, length of gestation, operative delivery, anesthesia, other complications (including oxytocin administration, forceps or hemorrhage) and length of breastfeeding (if it occurred). We asked for a simple statement regarding how the woman's mother viewed pregnancy and birth (as well as how it was viewed by her sisters and women friends). The NIMH Pregnancy Research Inventory was administered. Scales had been previously developed for fear of labor and birth, fear for the safety of the baby and negative/positive statements made about birth. A prenatal thematic apperception test was administered in which a series of 10 pictures were given showing women in various situations related to

pregnancy and birth. Responses were elicited regarding the story occurring in the picture, what participants were thinking and feeling, and how the scene would resolve. An expert system knowledge base was developed for the consistent interpretation of subjects' responses to the pictures. Its validity was established through comparisons with the interpretations of experts. Perceived anxiety and self-esteem were rated over the two-year period preceding the interview. Instructions were read to subjects about how to make these ratings so that they remained consistent among subjects. We were searching for perception of anxiety and self-esteem and not a more objective measure of these qualities. Women were asked about their feelings about pain during labor and how they would cope with it. They were asked their reasons for having a baby at this time in their life. They were asked questions about the circumstances of their own deliveries. A "faith in birth as a natural process" rating from 0 to 10 was developed from their scores on the NIMH Pregnancy Research Inventory scales and the rating of their stories on the prenatal thematic apperception tests. The higher the rating, the more the woman mirrored Kierkegaard's genuine faith applied to the birthing process. Outcome data was collected for the women regarding what happened at their birth. This included length of labor, type of delivery, medications used, condition of the baby and length of recuperation/hospitalization. Data Analysis Data was analyzed using the simple descriptive-statistics routines of the SYSTAT statistical-analysis package for the Macintosh computer. In view of the exploratory nature of the research, an assumption of normal distributions was made which has not yet been confirmed. RESULTS Seventy-eight (40.2%) of the women experienced complicated deliveries (defined as oxytocin augmentation, Cesarean delivery, premature delivery, or delivery of an infant requiring resuscitation and intensive care). This large percentage was not surprising considering that many of women had experienced a prior complication that motivated their participation in the study. Of the seventy-eight women, nineteen (24.4%) of them had themselves been born without complications. Of the remainder of the sample who had uncomplicated deliveries (116 women), forty women (34.5%) had been themselves born in complicated deliveries. Use of the student's t-test for testing significance gave a significance of $p = 0.005$ for these results. Thus, women who gave birth to their own children in a complicated manner were more likely to have been born in a complicated manner than women who gave birth to their own children in an uncomplicated manner. Individual complications were not present in sufficiently great numbers to permit reliable statistical testing. Thus, we did not have sufficient numbers to test if women born by Cesarean were more likely to have Cesarean deliveries with their own children. A significant association was found between having been born in a complicated manner and being rated as having low levels of faith in birth as a natural process. The correlational coefficient was .69. Women manifesting complicated deliveries were much more likely to have a low rating on the level of faith in birth as a natural process (48 of the 78 were less than 4 on a ten-point scale; 22 were rated as less than 6). Women manifesting normal deliveries, on the contrary, were more likely to be perceived as having high levels of faith in birth as a natural process. Seventy-six of the 116 women were rated as having a score of 6 or more. Only 8 were rated as having a score of less than 4. When 5 was used as a cut-off point for simple statistical testing, the difference between the two groups was highly significant at less than the 0.001 level. A high correlation existed between low levels of faith in birth as a natural process and anxiety (.82) and low self-esteem (.53). Thus, it seemed logical to continue to believe the hypothesis that the mother's experience of being born is part of a larger process associated with later birth complications, and correlated also with increased anxiety and lowered self-esteem during pregnancy. The results of qualitative analysis will be presented next, and these point toward this process as a socialization process. Further statistical analysis could be done, but it is important not to push the statistical analysis further than the sampling methodology and the type of data presented here would indicate. This is more of a qualitative study that seeks to present an interesting hypothesis than a statement of the final word regarding this hypothesis. This was not a random sample since it recruited women who were interested in understanding more about their risk status and who had at least 2-3 hours of time to give to the researchers. Following Popper (1988), we can never prove a hypothesis, but we can set the stage for refutation. No statistically significant differences would have constituted a refutation

in this sample. Thus we can say that the hypothesis is plausible and worthy of further investigation and delineation. Qualitative Research Twenty-nine women were interviewed in depth (with the help of hypnosis and guided imagery) to elicit a further sense of the role of their own complicated birth in the later birth of their children. For nineteen of these women, the idea that a complicated personal birth should affect them in the present was illogical. During hypnosis, however, several themes emerged relevant to this question for all twentynine women: a) For 5 of the women, the theme of their mothers almost dying in childbirth had been constantly repeated throughout their childhood and adolescence. Their emotional reaction was one of fear and guilt. The fear was activated by thoughts of birth. The guilt pertained to their acceptance of the idea that their birth had almost killed their mothers. b) For 6 of the women, the theme of shame and disgust with birth had been developed throughout their childhood and adolescence, with constant repetition. These women reacted with the same emotions to stimulus triggers for birth. c) Nine women had grown up amidst constant reminders that the body could not be trusted and did not function on its own. Physician intervention was expected. Fear was elicited by being far from physician availability. One might say that anxiety was heightened until the complication occurred. At this point anxiety was reduced, for the expected negative event had finally occurred. d) One woman seemed to genuinely report under hypnosis a onetrial learning effect in which her birth memory (and its recall) was sufficient to engender a fear of birth. The physiological reactions to the activation of this fear had been sufficient to stop effective contractions. e) Eight other women were interviewed with no particular theme emerging with sufficient clarity of explanatory power. This could have related to a mismatch between the hypnotist and the woman or to the lack of sufficient rapport, or to a complexity which this simple study could not tap. All of these women reported high anxiety and low selfesteem and all expressed doubt in the birth process. The linkage to early experience and/or parental and family socialization could not be made. CLINICAL CASE EXAMPLES Evelyn was pregnant for the fourth time, but had never had a baby. She had experienced two therapeutic abortions and one spontaneous abortion. Her boyfriend had been arrested impersonating a woman while robbing a grocery store just before her first miscarriage. He had returned long enough for her to conceive again and had left again. Evelyn had been an i.v. drug user as had her boyfriend, but was not currently on drugs. Evelyn's mother had told her incessantly about her birth. She had heard repeatedly from her alcoholic mother how she had almost killed her mother during a long three-day labor in which her mother got every drug in the book and was in "horrible pain for days and days and days." Evelyn was finally delivered by forceps. Evelyn changed midwives at 30 weeks of gestation because she didn't feel that she was getting enough support from her first midwife. Evelyn described a horribly traumatic miscarriage where she screamed in pain. On a history questionnaire given by the second midwife she said "I don't want the baby to have brain damage from lack of oxygen. I wouldn't want it to get stuck. I'm afraid because I read mother and daughter can have similar experiences. I don't want to have the same experience as my mother." When questioned about people's opposition to her birth plans, she replied that "People say you don't know how much pain I'll be in." A friend had convinced her that she would be begging for drugs. In response to why she wanted to deliver at home she said, "I thought I would be in more control and not freak out as much. I feel nest-bound. I don't even like to leave my cats for long periods or overnight. My house is comfortable and familiar. I need more contact with someone personally to help me be comfortable. She saw the benefits of home as "Less interference. Hopefully less fear." Evelyn said, "I get scared of the pain from the miscarriage. I lost control totally. I couldn't take the pain and freaked out. I was out of control, crawling around screaming. I had a few anxiety attacks the first few months of pregnancy. Evelyn was afraid she would suffer severe postpartum depression and kill her baby, having read about that, too. She spent many hours with her midwife talking about how terrified she was of labor and of pain. When Evelyn entered labor, she called her midwife around 11am. By 1 pm she was 4 cm dilated, but the baby was high in the pelvis. The midwife reported that Evelyn seemed to be doing well and not very anxious. The midwife went to get her equipment and do an errand. She received an urgent page and returned to Evelyn's house where she was 7-8 cm dilated with the baby low and doing very well. An hour later her labor picked up

and into heavy transition and Evelyn began screaming. She was 8-9 cm dilated. The midwife called her assistant to come over and told Evelyn she was doing great and was going to have the baby soon. At that point, Evelyn began screaming "I can't do this anymore. She completely lost control as did her boyfriend. Her boyfriend freaked out. Fifteen minutes later, at 6 pm, her cervix had returned to 6 cm and was 60% effaced. It was swelling and shutting down with contractions. She remained at this level of dilation with the baby actually ascending in the birth canal. She was transported to the hospital begging for an epidural. She completely refused vaginal examinations saying it hurt too much. In retrospect, the midwife believes that Evelyn had convinced herself that she would have a birth like her mother's. Throughout the pregnancy, she had wrung her hands over and over about how she would have a birth just like her mother's. This case could be used to illustrate many points. Applying my hypothesis to the case, we could say that Evelyn had participated in a socialization process in which she came to expect with certainty that she would not give birth. She actually had negative faith in birth as a natural process. Her reading material reinforced this view. I doubt that the birth itself was as important as her mother's iterative litany about Evelyn's damage to her and the horrible, horrible pain that Evelyn caused her. The birth itself is probably overshadowed by far by the socializing effects of popular theories that Evelyn would give birth as did her mother. It would be hard to say what exactly Evelyn had learned from her life experiences. We could speculate that the entire totalization, in response to the knowledge that birth was relatively immanent, elicited a fear response that caused her body to tighten the cervix and effective contractions to cease. Animal studies have shown that the cervix closes and contractions stop in response to fear (catecholamines are thought to be part of the mediators of this process). Another case will illustrate the therapeutic use of our hypothesis. If the actual birth event is a symbol for a socialization process, then reliving it in an altered manner can cast light on other socialization processes that need reinforcement. We can learn through experience, whether it is actual or imagined. Lynn was a 30-year-old woman who had experienced a cesarean with her past delivery. Her mother had also had her babies by cesarean. Lynn was rebelling against the idea promoted in her family that the women all had small pelvises. Unfortunately, during her first labor, she had received this diagnosis, not progressing past 4 cm. At this point the socialization was rather complete. Her actual experience was of a cesarean birth and this experience had been reinforced throughout her childhood and young adult life, teaching her that the women in her family needed cesareans. Yet she also rebelled against that view. She had partially glimpsed an alternate view, one in which she could give birth without a cesarean. She came to me for a consultation regarding her second pregnancy. Immediately I sensed that another explanation was needed which held the possibility of change pregnant within. I essentially repeated what I have said here, emphasizing that labor is a psychobiosocial process, that she may have learned ways of coping and physiological responses that were not to her advantage, that she was swimming in a sea of culture which controlled her more than she controlled it, and that we might work together to explore other possibilities. I used guided imagery to take her through her past cesarean and, with the use of hypnosis, created an experience of another Lynn who had grown up differently. This other Lynn had complete faith in her ability to give birth. Surely she had other problems, but giving birth was not one of them. We playfully went through several births with this other Lynn. In another session, we relived an alternate birth with Lynn in which her mother gave birth to her vaginally and with natural childbirth. This, of course, created a substantially different image of her mother than the actual image. Throughout the process, the tone was playful, that of constructing alternate pasts for our learning and enjoyment. I was not interpretive. In hypnosis I gave suggestions for learning to give birth from the experiences of these constructed alternate selves and pasts. Lynn did have a relatively short vaginal birth of a larger child than her first birth. I think the therapy was conducive to that birth experience, not because of helping her to recall buried memories, nor because I changed the past, but because I played with these concepts to help her learn a different view of her body. She learned faith. I held the faith that she could give birth and communicated it to her through a teaching process in which we played with concepts of self, past and reality. I supported her view of herself as capable and competent and gave her ways to access symbols which

represented her own strength and ability to give birth. IMPLICATIONS FOR PSYCHOTHERAPY This paper suggests that the duty of the psychotherapist during pregnancy is to discover socialization and learned responses that would produce a negative outcome if activated during labor. Our role is to provide an alternative to that socialization in which the woman can learn faith in birth and confidence in herself. We may need to be the carriers of her faith and to provide her with symbols upon which she can draw to access the power and strength of faith in self and nature. We need to be alert to the possibility of self-blame and to reverse that tendency when possible. I would argue that we do not need to postulate unconscious mental processes; rather, the least blame-oriented point of view is to speak of socialization as a learning process in which physiological expectancies develop. When actual experience activates these "expectancies," threat is perceived and biochemical and neurological reactions occur that turn these perceived threats into physiological responses. Unfortunately these physiological responses may not be compatible with normal labor and delivery or the objective reality of the woman's situation. DISCUSSION The thrust of this paper has been to present the argument that the woman's own experience of being born has an impact on how she will give birth. A hypothesis was proposed: that this impact arose primarily through the birth story as a symbol for a socialization process in which the woman learns how to view her body and Nature and how to react to the sensations of labor. The more anxiously she reacts, the more likely that her body will hold "physiological expectations" of fear that will work against the process of birth. Statistical analysis of a non-random population provided confirmation in the expected direction with significance and did not refute the theory. Clinical material was presented that emphasizes the complexity of psychophysiological learning in a cultural context. Psychotherapy can help women to undo the effects of socialization through providing them with symbols upon which to draw to remember (while in labor) a view that their bodies are quite capable of giving birth effectively. Additionally, the therapist transfers a faith in the woman and her body to her through the teaching interactions of the psychotherapeutic environment. We need to create an understanding for how an event 20 to 40 years removed can have an impact in the present. In other research (Mehl, 1990a) I have been developing a mathematical computer-simulation model for the birth process. Through this model, increased ability to predict the course of labor and birth, including complications, gestational age and birthweight has been achieved. Several variables have emerged as useful in that model which may be relevant to this question and allow the generation of a testable hypothesis. These factors include "faith in birth as a natural process," perceived anxiety, and self-esteem. FAITH IN BIRTH AS A NATURAL PROCESS Since this construct seemed highly useful for understanding the outcome of the labor process, we should undertake a more detailed study of the word "faith." Faith is different from "belief." In believing something, we consider an issue, hear the arguments on its various aspects, and make a decision to support one or another position. Scientists tend to believe hypotheses with more or less certainty. Faith, however, is something different. Faith implies an inner certainty in the absence of proof. Faith is qualitatively different from belief. A person who believes can be dissuaded by a sufficiently strong argument to the contrary. The person of faith cannot succumb to argument, for faith is not based upon rational thought. Of all writers on the issue of faith, Kierkegaard is perhaps the most elegant. He distinguished faith from belief or "attempted faith" through what he called the "Knight of Faith" and the "Knight of Infinite Resignation." For Kierkegaard, the greater the uncertainty, the greater the faith. Faith is entirely non-rational. It is an inner knowingness or certainty which appears entirely absurd on the surface, to the rational observer. Kierkegaard observed that the person of faith did not need to preach or demonstrate his or her faith, but could appear quite ordinary, even bourgeoisie. When doubt does not exist, neither does struggle. Faith need not proclaim itself or clamor for followers so as to establish its certainty. The person of faith quietly follows his or her path without need for confirmation, since this is the essence of faith. On the other hand, the "Knight of Infinite Resignation," or the person attempting faith, is frequently seen and observed. The louder his or her clamoring, the more likely he or she is to believe him or herself. The more publicly demonstrable, the more convinced he or she will become. This "almost faith" has an anxious quality to it, unlike genuine faith. It appears driven toward achieving

an impossible certainty. It defies the rationality of belief but is ever shadowed, even haunted by doubt. True faith is a house built upon a solid foundation. "Almost faith" can appear as a magnificent structure but ever resting upon a shaky foundation. True faith weathers any storm that would send "almost faith" crashing. How does this pertain to birth? The woman of genuine faith does not concern herself with worry about complications. This is not, however, a form of denial. Despite all the modern clamor to the contrary, it simply does not occur to her to worry. It is intuitively obvious to her without proof that her baby will be born the way babies have always been born. She is not the woman stridently bearing copies of research studies to her doctor to argue for a particular birth plan. She takes the process matter-of-factly. Perhaps she will even have certain interventions common to her doctor, not because she wants them or believes them necessary or important, but simply to humor her doctor. The woman of "almost faith," however is striving to push the doubt from her mind. She struggles against the thought in the back of her mind that a certain percent of women do have problems and she could be in that percent. Perhaps she speaks up at meetings, organizes or attends lectures, reads widely about natural childbirth and has many opinions. The woman of genuine faith may never read a book about birth for its essence is already understood by her. She knows birth and is certain that it will happen for her. This is not to say that she does not have fear, for she may be afraid of pain or of the changes that having a child will bring in her life. But her fear is more like the fear of performing, a first date, or of a move to another city. Coupled with the fear is a certainty that she will pass through it and all will be fine. In contrast, the fear of those who lack faith or manifest the "almost faith" condition can be more terrifying, even petrifying. There is not that certainty of passage through the fear, but rather a large uncertainty as to the outcome, more like the fear of a soldier who faces his first battle knowing he may die. How does this construct relate to the mother's own experience of being born? From looking at the clinical data, the hypothesis emerged that the mother's own personal birth experience could contribute to her sense of faith in birth as a natural process, and not just as one event, but as an event which stands out within a larger process. When the mother-to-be's mother had major complications, this was not a single, one-time event, but rather part of a larger process. Women who have complications in one delivery tend to have complications in other deliveries. The birth can become an often-discussed event, the discussion of which is a kind of socialization to how that family views the process of birth. The discussion and presentation of the memory of the mother-to-be's birth becomes a socialization or acculturation process perhaps more powerful than the actual experience itself. The tenor of these family (or women-in-the-family) discussions sets a tone and teaches whether or not one can trust Nature and the birthing process. Additionally, during pregnancy, the less trust (faith) the woman has in the birthing process, the more likely she may experience anxiety. The more anxiety she feels, the more her self-esteem can suffer. In conclusion, I hope this paper will stimulate further consideration of the role of socialization to a perspective on the body and body sensations and of faith or the lack thereof in the birth process. Further studies should consider the psychophysiology of learned expectations and could be laboratory-based. In psychotherapy with pregnant women, we need to remember that our role as therapists is to hold the faith that they may have lacked and to provide this to them through whatever modality we use. I am most comfortable with guided imagery and hypnosis to teach faith and confidence quickly. Other therapists with different personalities will do this differently. Nevertheless our aim should be the same. References REFERENCES Baldwin, R. and Palmarini, T. (1986). Pregnant feelings. Berkeley: CA: Celestial Arts. Chamberlain, D. (1989). Memory before and during birth. Los Angeles: J.P. Tarcher. Cheek, D. and Rossi, E. (1989). Mind-body hypnosis. New York: Norton. Cohen, N.W. and Estner, L. (1983). Silent knife: Cesarean prevention and vaginal birth after cesarean. South Hadley, MA: Bergin and Garvey. Mehl, L.E. (1990a). A systems dynamics computer simulation model for predicting risk in the medically low-risk woman. Intl. J. Perinatal Studies 1: 40-55. Mehl, L.E. (1990b). Prenatal memory. Intl. J. Perinatal Studies 2: 101-110. Mehl, L.E. and Manchanda, S. (1991). Use of a systems dynamics model to study the role of alcohol in pregnancy. Technical paper. Prevention Research Center, Berkeley, California. Mehl, L.E., Madrona, S., and Manchanda, S. (1991). Use of a systems dynamics computer

simulation model to predict birth risk. Technical paper. Prevention Research Center, Berkeley, California. Popper, K.R. (1988). Realism and the aims of science. London: Hutchinson. AuthorAffiliation Lewis E. Mehl, Mjyor, USAFMC, Ph.D. AuthorAffiliation Lewis Mehl received his medical degree from Stanford University School of Medicine. His Ph.D. is in clinical psychology. He has been a Clinical Assistant Professor in the Department of Family Practice at Stanford University and at the University of Arizona as Research Assistant Professor. He is board-certified in Behavioral Medicine and is currently completing family practice training at the University of Vermont. He is a Major in the United States Air Force Medical Corps. The opinions expressed herein are those of the author and do not necessarily represent those of the United States Air Force or the Department of Defense. Address correspondence and reprint requests to the author at the Department of Family Practice, University of Vermont College of Medicine, Given A-111, Burlington, VT 05405.

Publication title: Pre- and Peri-natal Psychology Journal

Volume: 7

Issue: 3

Pages: 243-259

Number of pages: 17

Publication year: 1993

Publication date: Spring 1993

Year: 1993

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: New York

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 08833095

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198678511

Document URL: http://search.proquest.com/docview/198678511?accountid=36557

Last updated: 2010-06-06

Database: ProQuest Public Health