JOPPPAH 24(2) 67–128 (2009)
ISSN 1097-8003

JOURNAL of PRENATAL & PERINATAL PSYCHOLOGY & HEALTH

Published by the Association for Pre- and Perinatal Psychology and Health (APPPAH)
Editor: Bobbi Jo Lyman PhD

Volume 24, Number 2
Winter 2009

Journal of Prenatal and Perinatal Psychology and Health

Official Journal of the Association for Pre- and Perinatal Psychology and Health (APPPAH)

Published by
APPPAH
PO Box 1398, Forestville, CA 95436
apppah@aol.com www.birthpsychology.com

Journal of Prenatal and Perinatal Psychology and Health

Volume 24, Number 2, Winter 2009

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JOURNAL OF PRENATAL AND PERINATAL PSYCHOLOGY AND HEALTH publishes findings from the cutting edge of the rapidly growing science of prenatal and perinatal psychology and health. The journal, published quarterly since 1986, is dedicated to the in-depth exploration of the psychological dimension of human reproduction and pregnancy and the mental and emotional development of the unborn and newborn child. It is intended to provide a forum for the many disciplines involved such as psychology, psychiatry, midwifery, nursing, obstetrics, prenatal education, perinatology, pediatrics, law and ethology. The journal also deals with the numerous ethical and legal dilemmas which are emerging as society re-evaluates its attitudes toward adoption and abortion or strives to establish moral positions on hightech obstetrics and third-party conception. The opinions expressed in articles and claims made in advertisements are those of the authors and advertisers, respectively, and do not imply endorsements by APPPAH or the printer, Allen Press, Inc.

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INDEXED IN: American Psychological Association Abstracts, PsychInfo, and Health Instrument File.

 Journal of Prenatal and Perinatal Psychology and Health (ISSN 1097-8003) is published quarterly in the Fall, Winter, Spring and Summer by APPPAH, 8152 Grape Avenue, PO Box 1398, Forestville, California 95436-1398. Periodicals Postage Paid at Forestville, CA., and at additional mailing offices.

POSTMASTER: Send address changes to: PO Box 1398, Forestville, CA 95436-1938 USA.

Journal of Prenatal and Perinatal Psychology and Health 24(2), Winter 2009

Editorial

This issue of the journal presents three thought-provoking articles, each with unique and individual perspectives. A focus on the mother in each sensitizes us to what the effects of the external environment is for the mother, affecting the environment of the mother for the prenate. To know one, is to know the other.

The first article discusses the importance of the pregnancy period as much more than a biological one, namely, a major life transition. Thus, the authors, Drs. Côté-Arsenault, Brody, and Dombeck from the University of Rochester, School of Nursing, Rochester, New York, examine this pivotal event as an important rite of passage. Case studies are offered to illustrate the points presented.

Submitted by authors from the University of New England, Armidale, Australia is an article entitled, *Differentiating Subtypes of Postnatal Depression Based on a Cluster Analysis of Maternal Depressive Cognition.* Drs. Church, Dunstan, Hine, and Marks performed a quantitative study examining 406 postnatal women that had either a cognitive vulnerability to depression and those for whom depression was related to motherhood. Finding maladaptive cognitions in both populations that impact their symptoms the researchers suggest improvements in treatments that are easily assimilated into current evidence-based clinical guidelines.

Readers will find that the third article is an important contribution to those who yearn for a more detailed historical context for our field. Otto Rank may have written the foundation text in 1929, but the importance of motherhood and the influence of the womb on the developing child have been existing since the beginning of human kind. In his carefully prepared paper, Fr. Walter R. Taylor traces ancient symbols around fertility and the sacredness of birth from pre-history to the early Christian era and uses an ample amount of illustrations. This is a must-read for anyone developing university lectures on the influence that the goddess has had on our field.

It is with the current issue that I end my work as the Editor-in-Chief of the APPPAH Journal. For more than eight years I have treasured this responsibility, mostly because of how each article has

helped to define our small, but vitally important, field. I was "birthed" (mentored) into the job by David Chamberlain with the fall 2002 issue, and eagerly took the reins for the winter issue. I would not have been as successful, nor felt the deep personal rewards, without the support of my Associate Editor for most of my tenure, Dr. Jeane Rhodes. I will remain devoted to the Association of Prenatal and Perinatal Psychology and Health by serving on the Board of Directors and no matter what I do I will always be a voice for the unborn. And one last time, let me express my great appreciation to the researchers and creative/scholarly writers who must work tirelessly to polish their manuscripts before submission.

Bobbi Jo Lyman, Ph.D., Editor-in-Chief
Santa Barbara Graduate Institute of
The Chicago School of Professional Psychology

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Pregnancy as a Rite of Passage: Liminality, Rituals & Communitas

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Abstract: Pregnancy, a major life transition, significantly impacts aspects of a woman's physical, psychological and social self. Theoretical perspectives of pregnancy are compared in terms of their utility. Using the theoretical frameworks of anthropologists van Gennep and Turner pregnancy is viewed as liminal, a space between social structures. Passage through pregnancy to parenthood is explored in its social context as a rite of passage. Viewing pregnancy and birth as a liminal phase provides a valuable framework for understanding normative and non-normative pregnancy experiences. Case studies are presented, with application and analysis illustrating the experience of liminality, and its inherent rituals and communitas.

Key Words: Pregnancy, rite of passage, liminality, rituals, communitas, personhood, case studies

While searching for theories of pregnancy that could help guide and explain "being pregnant" the notion of rites of passage and its inherent liminal phase were explored. Anthropologists, van Gennep and Turner, wrote seminal works during the twentieth century identifying contexts and ceremonies surrounding major life events, such as pregnancy. Ceremonies or rites of passage have assisted pregnant women through all variations of the childbearing process in every culture. These were not new thoughts but we discovered that they invoked paradigm-shifting insights. Viewing pregnancy and birth through the lens of liminality, with its inherent rituals, provides a valuable framework for understanding normative and non-normative pregnancy experiences. Most particularly, the idea of

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liminality opens many doors into understanding pregnancy as it exists within a societal context. The purpose of this paper is to introduce the perspective of pregnancy as a rite of passage with a transformative liminal experience. Through case applications, we explore the usefulness of this theoretical framework for clinicians and scholars.

Broadening the View of Pregnancy

Pregnancy, commonly defined as the state, condition, or quality of having a fetus growing within a female body (Thomas, 1993) limits the concept of pregnancy to a physiological state. However, pregnancy is often underrated as to its broader, psychological, social and human significance. Pregnancy is a condition that transforms a woman into a mother. Pregnancy is experienced as a life-changing event. There are few well-defined societal, medical or emotional constructs in place that acknowledge all the aspects of this important life event. Medical professionals focus primarily on the biological and physiological aspects of pregnancy with a specific focus on standards of normal adaptation, growth and development at each stage of gestation (Cunningham, Leveno, Bloom, Hauth, Gilstrap & Wenstrom, 2005). Pregnancy in western cultures is often viewed through this medical lens (Davis-Floyd, 1992). Viewing pregnancy as simply a physiological state is inadequate when trying to understand the woman's *experience* of pregnancy. This narrow view ignores the enormous impact pregnancy has on a woman's self concept, her relationships with spouse and family, the way the pregnancy and subsequent birth changes her role in society and all of the accommodations she must make to be pregnant and prepare for motherhood. Responses to her that only focus on her pregnant body and growing fetus diminish her personhood. A broader view of pregnancy acknowledging pregnancy as a major life event that encompasses significant physical, psychological, and social accommodations during gestation, birth and post partum is needed. Theories of pregnancy will be summarized and critically analyzed for their utility in guiding the care of pregnant women with this in mind.

Pregnancy Theorists

Pregnancy as a psychological state has been examined by a number of theorists. Deutsch (1945), a student of Freud, was the first to describe the psychology of women and pregnancy. She concluded that only a portion of the difficulties surrounding the transition to

motherhood could by explained physiologically. She was also the first to describe 'motherliness' as a series of mental processes that begins long before delivery. Deutsch's theories of motherhood and motherliness were strongly influenced by psychoanalytic theory and described pregnancy as an intra-psychic experience with emotional connections to a physical process (Deutsch, 1945). This theory provides a broader and more relevant framework for viewing pregnancy compared to the strictly physiological viewpoint primarily adopted by health care providers. Bibring (1959) later focused on the psychobiological disequilibrium that occurs as a result of the physiological and psychological changes during pregnancy. Bibring theorized that the self-involvement of early pregnancy alters once the baby begins exhibiting signs of life (quickening) and that this evolves into the concept of the fetus as a separate person. Bibring viewed the psychological changes accompanying pregnancy as essentially normal and part of a woman's maturational process. Benedek (1970) further described the psychobiology of pregnancy based on Deutsch's earlier work. Benedek described pregnancy as a symbiotic biological and psychological process that occurs between mother and fetus. She theorized that pregnancy is a biological process where the needs of both the mother and fetus are met through complementary actions and reactions. The description of pregnancy as a change in a woman's state of consciousness was introduced by Colman and Colman (1971; 1973/1974). They attributed this change in consciousness to both physiological changes (chemical, hormonal) as well as changes in personal independence and social relationships.

All of these perspectives add to one's understanding of pregnancy but the greatest contribution to a holistic view of pregnancy came from Rubin (1984), a nurse scientist, who saw pregnancy as affecting every area of a woman's life. Rubin examined pregnancy empirically through the lenses of psychoanalysis, development, social psychology and cognitive mapping. Rubin (1984) examined pregnancy primarily in terms of the development of a maternal identity and the completion of tasks of pregnancy with particular emphasis on safe passage through pregnancy and delivery, social acceptance and integration of motherhood into one's self-identity. A student of Rubin, Mercer (2004) went on to further examine the psychological processes a woman goes through during pregnancy in terms of assimilation of the role of motherhood. According to Mercer "An ideal image of self as mother is constructed from her extensive psychosocial work during pregnancy and postpartum, and through this image the maternal identity is incorporated into her self-system" (2004, p. 226).

The psychological views of pregnancy examined by these theorists expand the concept of pregnancy beyond being a biological or physiological process by focusing on psychological aspects of pregnancy in terms of its societal and personal impact. Of particular note is the major social transition a woman undertakes during pregnancy in terms of relationships, social milieu, family and friends. All of human existence occurs within a cultural context, and it is within this context that much can be understood regarding the critical nature of pregnancy in a woman's life.

Culture and Status Change

Rites of Passage

From a social perspective, pregnancy holds powerful meaning for a society and a woman. Pregnancy is a temporary condition that triggers major changes in a woman's personal and societal status. Van Gennep's work on the analysis of life-crisis ceremonies, which he called "rites of passage," provides a framework for understanding the activities that accompany these major life events (1908/1960). He proposed that rites of passage fall into three major phases: separation, transition, and incorporation. Van Gennep viewed those rites as "enabl(ing) the individual to pass from one defined position to another which is equally well defined" (p. 3). Van Gannep argued that social structure includes rules, roles, and relationships within which persons are defined. Therefore, the associated rites of passage address how roles and relationships change within the social structure. At times such as puberty and marriage all societies have rites of passage to acknowledge initiation to a changed social status and to cushion the transition for the person involved. Van Gennep stated that pregnancy was definitely a transitional period, divided into whatever months are deemed important in that society. In societies where pregnancy is regarded primarily as a physiological fact, points of particular importance include: the first trimester (highest risk of miscarriage), quickening (fetal movement felt 17-20 weeks), viability (generally agreed as 24 weeks gestation), and term (greater than 36 weeks). When viewed as a rite of passage, pregnancy itself can be seen as a transitional state between "woman-not-mother" and "woman-mother." Pregnancy is often announced not only as a "biological fact" but as a statement of personal change (i.e. "I am pregnant." "I am expecting." "I am in the family way.") The announcement itself is a rite of separation which, viewed through a van Gennep lens, indicates the movement of

the woman from her former situational position toward, but not yet in, a new status (van Gennep, 1908/1960). The transition phase, also known as a liminal phase, is the period of time between two social statuses. In the case of pregnancy, the liminal period between "non-parent" and "parent" it is often marked by regularly scheduled prenatal visits to assess the health of the mother and the growth of the fetus. The woman is no longer who she was, and not yet who she will be. She is "situated on the border between two worlds" (van der Hart, 1983, p. 38). Her role as a pregnant woman is acknowledged by society as leading toward motherhood, although she is not yet there. For example, an obviously pregnant woman might be referred to as "mother" by persons other than her children. The birth itself is a significant rite of passage in which the psychological readiness of the woman to become a mother may be reinforced or challenged. The phase of incorporation at the end of a usual pregnancy is referred to as social parenthood by van Gennep; this is distinct from the physical birth. Social parenthood refers to being seen as the parent to a child and typically occurs when the mother returns home after birth, with the new child in her arms, anticipating the inclusion of the new baby and family unit into the community and family. Social parenthood is clearly distinct from physical parenthood as illustrated by the instance of adoption or surrogacy, or when a seriously ill neonate remains in intensive care for months. In the cases where there is dissonance between physical and social parenthood, the period without clarity in rules, roles or relationships introduces, extends, or leaves unresolved a liminal phase. This is because the rite of incorporation into parenthood is unclear.

Liminality

Turner (1967/1987), a social anthropologist, also studied rituals of passage and emphasized the critical importance of transitions with a focus on the precarious state of liminality. Like van Gennep, Turner viewed liminality as the state of being between varying points in a social structure. Turner elaborated on this theme, arguing that a person must successfully traverse a state of being 'betwixt and between' two different social states in order to achieve a new societal status. Turner (1967/1987) stated that changing status in society involves three phases: 1.) separation, or the process of moving out of or away from the position once held in society (boy, girl, unmarried, child) 2.) marginality or liminality, in which a person is no longer who they once were but has not yet assumed a new role in society (teenagers,

engaged but not yet married, pregnancy) and 3.) aggregation wherein a person assumes a new societal role following a separation and liminal process (woman, man, adult, married, mother). Turner emphasized that this societal role transition is typically accompanied by societally reinforced rituals or rites of passage. (Turner, 1967/1987). Liminality takes place at the societal level, about one's place in society. It is, according to Turner, "a becoming, and, in the case of rites de passage, even a transformation – here an apt analogy would be water in process of being heated to boiling point or a pupa changing from grub to moth." (Turner, p. 4). Turner pointed out that an important element of liminality, is fear and uncertainty. Being defined by what is not-yet-there feels threatening. "The subject of passage ritual is, in the liminal period, structurally, if not physically, invisible" (Turner, p. 6).
Communitas, an aspect of liminality described in depth by Turner as an experience shared by a group of persons in similar transitional situations. Support for the person in liminality is obtained via communitas and surrounds issues involving the loss of the old structural status and evolves in a place where the structure is unclear or absent. Turner (1977) calls communitas "anti-structure". The state of liminality and the communitas-related structures around, in support of, and involved in this transitional process comprise this societal anti-structure. Turner notes that communitas reflects the needs of those in the liminal state and therefore, like those in liminality, often represents that which is not made obvious or is invisible in societies (Turner, 1977):

> Communitas breaks in through the interstices of structure, in liminality; at the edges of structure, in marginality; and from beneath structure, in inferiority. It is almost everywhere held to be sacred or "holy," possibly because it transgresses or dissolves the norms that govern structured and institutionalized relationships and is accompanied by experiences of unprecedented potency. (Turner, 1977, p. 128)

Through this transitional experience, support is obtained for those who are experiencing liminality. This support can help acknowledge and reflect the process as well as offer skills and enhance personal and societal bonds. Communitas offers those in liminality recognition, support and the skills necessary to transition into their new roles. However, communitas is often seen as powerful, threatening or dangerous (Turner, 1977).

Pregnancy as a Liminal Phase

Pregnancy changes how women view themselves and are viewed by others. Treating pregnant women with extra care, opening doors for them or giving up a seat to them on the bus, serve as both reminders and social constructs that acknowledge and reinforce the pregnant woman's social status. As they become more visibly pregnant, the pregnancy itself becomes who they are in their social environment. Women recognize changes in both their inner self and their social self. It is clear that their world is changing, the future with a baby will not be the same as life before that child. However, the new self and the person they are becoming remains structurally invisible, defined by a state that is between personal definitions.

Entering into liminality requires moving away from a previous definition into the unknown. This invisible state gives rise to communitas, a state of communal connection in support of those occupying the liminal space. Pregnancy is an unfamiliar state for most women, leaving them not knowing how 'to be' in society. For example, pregnant women may find it disconcerting when strangers enter their personal space to touch their belly or when they are subjected to scrutiny regarding eating and health behaviors. Liminality may lead women to seek communitas via pregnancy support groups, prenatal yoga class, and childbirth classes. The structures in support of the birth process that have evolved outside of societal norms, such as the Bradley method or the modern midwifery movement in the United States, are often considered out of the mainstream. This is consistent with Turner's definition of communitas as being an "anti-structure", and it is valuable to note that many pregnant women looking for guidance find these communities supportive and instructive.

In the case of pregnancy, much of the feedback about one's status comes from the pregnant woman's social surroundings. "The structural 'invisibility' of liminal persons has a twofold character. They are at once no longer classified, and not yet classified." (Turner, 1967/1987, p. 6). This invisibility leads to ambiguity. Transitional beings in a state of liminality often lack clear status, rank and personhood. For this reason, liminality is, by definition (Turner, 1967/1968), an ambiguous state that can be dangerous and frightening. The idea of what one once was and how one previously defined oneself has changed, the woman who once existed becomes hidden for a time and the act of creation is defined by what has not yet happened. Acknowledging pregnancy as a liminal state is critical to a full understanding of what it means to be pregnant and its inherent personal risks. It is similar to being in a negative space.

Liminality as Creation

When one views liminality as a 'becoming', one can see that it is, inherently, a creative process. Creating within a social space is the transformation from possibility to definition. In the case of pregnancy, this creative process is literally the act of creation.

An analogy between creating a work of art and a creating a child can illustrate the emotional state a pregnant woman finds herself in. A drawing starts with a line or an idea. In pregnancy it begins with a cell. The process of becoming, or assuming the form it is intended for is difficult to define because, for a time, the creation is defined only by what is in the creator's mind (an idea, a vision) and the space around it (the paper, a changing belly). In a drawing this would be called negative space, in the case of pregnancy it is defined by the image of what you will become (mother), and what you will create (child) but ultimately what is not-yet-there (negative space). According to the *Encyclopædia Britannica* (negative space, 2008), negative space is the empty space around an object. Often, it is a carefully considered and important part of composition. It is the pause in music, the space around or within an object that defines its edges. Often the negative space is a construct intended to enhance the understanding, or character of the positive portion of a piece (negative space, 2008). Liminality, when understood from this perspective, becomes the social space a woman enters in the process of redefining her character as well as her role in society. While pregnant, she is neither 'mother' nor 'not-mother,' she is in the act of creation, between the idea and the finished product. The pregnancy itself becomes the lens through which she sees herself and redefines herself. In art, negative space provides a framework for viewing the edges of and defining the object itself in the same way that pregnancy defines the change from what one once was as well as provides the framework for defining what one will become.

Contemporary Views on Liminality

Viewing an important life transition as a liminal phase is not new. Turner's conceptualization of transformation as a rite of passage with a liminal phase has been used to analyze other life transitions. Recently it has been used to explain the education and learning process (Meyer & Land, 2005), to understand the concept of transition as it applies to nursing (Meleis, Sawyer, Im, Hilfinger & Schumacher, 2000; Schumacher & Meleis, 1994) and to explain the process of life

changes in lay terminology (Bridges, 1980). Of particular interest, however, is contemporary examination of liminality as it applies to pregnancy, birth and fetal loss. In this realm, Turner's ideas are used to investigate and explain the major changes in how women are treated, acknowledged or separated from mainstream society and made invisible during pregnancy, birth and the postpartum period (Côté-Arsenault, 1995; Davis-Floyd, 1992; Layne, 2003).

In her book, *Birth as an American Rite of Passage* (1992), Davis-Floyd, a contemporary anthropologist and feminist speaks to the birth process in the United States. "The rituals of initiatory rites of passage convey messages that speak of a culture's most deeply held values and beliefs" (Davis-Floyd, 1992, p. 44). In a country built on the values of capitalism and the industrial revolution, those values are reflected in the technology and financial industries surrounding medicine and birth. According to Davis-Floyd (1992), the rite of passage accompanying birth reflects these values. She maintains that the technocratic model for birth is based on the values of our society, and because these values are reflected in society, they become entrenched in the ritualization of the birth process. Davis-Floyd (1992) argues that this technocratic model for pregnancy and birth reflects a social paradigm in which technology yields high authority, and this is reflected in the process of birth as well as in the institutions, hierarchies and bureaucracies that surround it. Inherent in this model is the notion that the woman takes a passive role in her pregnancy with technology in the lead. This notion accentuates the uncertainty the woman feels about the social role during pregnancy.

Examples of the role of technology in pregnancy and birth can be seen throughout pregnancy where obstetrical visits are demarcated by increasingly advanced machines, techniques and technologies. Pregnancy is no longer confirmed by missing a menstrual cycle. Although the woman knows she is pregnant, this is called 'inaccurate.' Instead, confirmation of the pregnancy requires a blood test at the obstetrician's office, followed up by a sonogram to verify gestational age. The 'high tech' obstetrical environment is considered more reliable than a woman's self-knowledge. Advances in technology such as three-dimensional ultrasonography are prime examples of high cost-high technology rites of passage that have become standard practice in this country (Davis-Floyd, 1992). It is important to note that for a woman in a socially ambiguous state (liminality), the use of and dependency on technology can make the woman feel further diminished. Because a machine is looking inside her uterus, her personhood is by-passed.

The danger inherent to the liminal status during pregnancy is

evident when employers are hesitant to hire someone who is or might become pregnant, or when planning is being done for trips or holidays—a woman's physical condition is subject to change. Hesitancy to commit to things yet to come is an indicator of a woman's sense that she does not know how she will feel about those commitments in the future. Inner thoughts, fantasies, and self reflection are a woman's way of pondering her self now and in the future. As a rite of passage, pregnancy is accompanied by rituals such as going to prenatal exams, childbirth classes, and baby showers (Côté-Arsenault, 1995; Côté-Arsenault & Donato, 2007). An important factor to acknowledge in this transition is the personal investment a woman must make in assuming a new role. This investment must be present in order to engage in these rituals. Without the personal investment of the pregnant woman and those around her, these rituals cannot take place. These rituals are necessary for successful role transition and are intended to cushion the transition from woman to mother. The final rite of passage is the birth itself, and successful preparation for this event facilitates the process. The liminal state of pregnancy typically ends with the rite of incorporation, bringing the new baby home from the hospital, a few days after birth where neighbors and family greet the 'new family' (Côté-Arsenault, 1995).

Layne (2003) refers to liminality in her feminist account of pregnancy loss in America. She points out that pregnancy also involves the liminality of the fetus, that is, often unrecognized fetal personhood (its status in society). This point is vitally important to understanding the psychological mind frame of the parents. These parents are committed to this embryonic child of theirs, but its status in society is uncertain. Combining the liminality of the pregnant woman with that of her fetus, there are two "liminal entities." (Layne, p.59). The taboo status of pregnancy loss, Layne continues, signals the importance of these events. "[T]he silence that surrounds this topic does not result from its lack of consequence; on the contrary, taboo status signals the importance of these events." (p. 64). When a loss occurs in pregnancy there are two uncompleted rites of passage, that of the mother and that of the fetus; society generally acknowledges neither one. Being between two fixed points of classification causes confusion and anxiety. Pregnancy loss runs contrary to the desired perception that physicians are infallible, and that nothing can go wrong if we follow the science. Pregnancy loss causes anxiety because it brings to the forefront our human frailties in this time of great authoritative knowledge and our dependence on that fallible knowledge.

Women pregnant after perinatal loss have lived the reality that

things can go wrong in pregnancy; medicine is limited in its abilities (Côté-Arsenault & Marshall, 2000). These women have lived the liminal experience of pregnancy and now are choosing to return to it in the hopes of a better outcome. They want and need to move through the rites of separation and transition to the rite of incorporation—they need to bring home a healthy baby so that they will successfully enter the social status of parenthood. The drive to be out of the dangerous and anxiety provoking state of liminality is very strong; the desire to have full social status is primary.

Moving from the theoretical to the practical, through case study application, will clarify some of the points made previously about liminality, rituals, and communitas.

Case Studies

Three contrasting case studies are presented below, with a discussion to follow. The instances described are a typical pregnancy with expected responses, a pregnancy complicated by a perinatal loss, and an atypical pregnancy and birth. These cases are a synthesis of clinical observations sculpted to more effectively illustrate our point and maintain individual anonymity. Actual cases were encountered through our clinical experiences, and women's personal descriptions of their pregnancies after perinatal loss collected in multiple descriptive studies (Côté-Arsenault & Donato, 2007; Côté-Arsenault, Donato & Earl, 2006; Côté-Arsenault & Marshall, 2000; 1995).

Typical Pregnancy

Jackie was a 28 year old, pregnant for the first time. She and her husband were very excited to be starting their family. After the "official" pregnancy test at the obstetric office, the news of the pregnancy was spread through family and friends. In spite of the inherent excitement, Jackie often felt ambivalent about being pregnant; she thought, "Oh my, what have we done?" Nausea and vomiting were experienced as a rite of passage. Jackie was very excited when her pants no longer fit around her and clothing styles had to be altered. She noticed what other pregnant women were wearing and how they were acting. Plans were being made for the time surrounding the expected birth. Baby names were offered by everyone; Jackie and her husband discussed and eliminated names until they decided on one for a girl, another for a boy.

Prenatal visits every four weeks marked off the months of the

pregnancy; fetal movement was very exciting at 20 weeks but then kept Jackie awake at 32 weeks. The middle trimester was fun and she was feeling good, then she began to feel very large and uncomfortable—anxious for the end to be near. The couple began childbirth classes where they fit right in with other large bellied couples, they learned breathing techniques, methods for breastfeeding and parenting and Jackie's husband learned how to support Jackie during and after the birth. They talked about nursery decorations with other expecting parents and got some good ideas for putting the finishing touches on the nursery. Baby showers were given by friends at work and family members; parenting advice was now given freely. Preparation for birth included practicing breathing techniques, obtaining a car seat and having it installed and the packing of a bag in anticipation of labor and the ensuing trip to the hospital. Jackie and her husband fantasized about what labor and birth would be like, and she discussed options and expectations with her husband. Three days after her due date Jackie went into labor; after 12 hours of labor and 1 hour of pushing, a healthy baby girl was born. Jackie and her husband were amazed at the process, themselves, and their child.

Jackie crossed the threshold into liminality when she discovered her pregnancy. The rituals that marked this transition were her initial positive pregnancy test followed by the confirmation from her obstetrician and her subsequent announcement to others. These small, increasingly more important rituals were key events that marked the progress of the pregnancy as well as her personal investment in the process. Prenatal care was sought to ensure a healthy mother and baby during pregnancy, but from a cultural perspective, it also provided a ritual that marked off the weeks of pregnancy. Visiting a care provider such as an obstetrician or midwife helped the couple feel that the pregnancy was "real". This happened when there was confirmation of pregnancy, hearing the fetal heartbeat, and updates on fetal growth. Jackie's pregnancy was experienced not only by her and her husband, but also by the extended family in looking forward to the birth, naming the baby, and setting up the nursery. Jackie found communitas through birth classes, where she obtained support and advice from other pregnant woman. Through communitas, Jackie gained advice about parenting, incorporating the child into their home and navigating the birth process. In addition, "elders" often teach the pregnant mother and support persons about what to expect in labor and birth, and try to provide anticipatory guidance for bringing a newborn home. These social support structures cushioned the many adjustments and

discomforts that Jackie experienced as she got used to the idea of being pregnant, and tried to picture herself as a mother.

Complicated Pregnancy

Ella was 34 years old, married to Stephan, and was surprised to see a positive pregnancy test result. Ella and her husband immediately told family and friends their news because everyone had been urging them to start their family, and they wanted to share their excitement. In doing so, she quickly crossed into a state of liminality. Conversations were prefaced with inquiries about how Ella was feeling and if they had had a sonogram. Was it a boy or a girl? A close friend of Ella's was also pregnant at the same time; they enjoyed comparing notes and sharing what they were each experiencing. Everything in the pregnancy had gone well thus far, so the in-laws gave Ella and Stephan a baby shower at 21 weeks gestation for the parents and expected baby boy. It was fun and reaffirming. Each of these rituals required increasing personal investment and provided tangible reinforcement of impending role change.

One week later, the situation changed when Ella noticed troubling wetness; at the hospital it was confirmed that her membranes had ruptured prematurely. Bed rest at the hospital, fetal monitoring, vital signs and blood values were carefully watched. Uterine contractions started to occur, and Ella showed signs of infection. Labor progressed quickly; there was no time to make plans or to call family to come. At 23 weeks tiny baby Joseph was born; he lived for 2 hours. Ella and Stephan spent time with their son, they held him, agreed to have photos taken, watched as the nurses took hand and footprints. There was nothing that could be done. One week later a small memorial service was held. Friends and family were unable to offer comfort or know what to say, the new baby things were whisked out of sight. Little Joseph quickly became a subject no one wanted to bring up. Ella slipped into a depression, crying daily, feeling very alone and empty. Stephan tried to stay strong, hating to see Ella so sad. Both would-be parents felt helpless. Ella's mother told them to "try again" in a few months.

In the case of perinatal loss, a mother enters liminality with the realization that she is pregnant and is going to be a mother. She is separated from the non-mothers and begins to see herself and her husband in new ways; family and friends are with them, and they will be there to welcome the new baby and new parents into their new roles. However, a healthy baby was not brought home in this case, so

the rite of incorporation did not occur. The baby had a name but no place in their community. Although little Joseph was much-loved by Ella and Stephan as parents and spouses they do not know what to say or how to act. Emotionally Ella was a mother, but socially she was not. She could not bear to talk with her friend who delivered a healthy baby; their connection was broken. The suggestion of forgetting about Joseph, moving on, and getting pregnant again seemed unconscionable to Ella. They still felt like they were in transition, but without a happy ending. How could all of the positive feelings and dreams be wiped out so quickly and completely by others? A sense of bewilderment and betrayal, grief and loss, and some precious memories were all that was left. In the case of a complicated pregnancy such as this, the mother entered liminality but is left in this frightening place of being between roles. She *feels* like a mother, yet has no baby to hold or bring home to complete the rituals of incorporation. Ella stands on the sideline, in the margins, without guidance on how to act or who she is.

Atypical Pregnancy

Theresa discovered she was pregnant at 19 years old. At approximately 10 weeks, after a positive home pregnancy test, she went to see her midwife where her pregnancy was confirmed via blood test. Theresa's initial investment in the pregnancy consisted of picking up pamphlets about fetal growth in the office. This was her first and only tentative step toward liminality. Her personal investment in role transformation was minimal. At approximately 16 weeks the father of the baby was incarcerated for parole violation. Afterward, Theresa became ambivalent about the pregnancy and resistant to prenatal care including skipping prenatal appointments and refusing her glucola test. She withdrew from school and avoided friends during her pregnancy. She was disinterested in communitas; she had no baby shower and did not acquire baby clothes or furniture on her own. She informed her mother about the pregnancy after she began to show at approximately 30 weeks. Approximately nine weeks later, Theresa arrived at the hospital contracting regularly every 3-5 minutes. Theresa's mother accompanied her, but insisted that she could not remain at Theresa's side due to lack of childcare for her children at home, thus leaving Theresa alone and without support. Theresa was admitted to the hospital and assisted into a gown but appeared very agitated and panicked: wide-eyed, thrashing through her contractions, breathing quickly and shallowly and refusing to accept help from her nurses. Theresa was mostly non-verbal, but managed to demand pain

medication, which was administered quickly. Theresa responded within minutes by relaxing and sleeping between contractions. When she awoke, approximately 2 hours later, she was screaming and thrashing, with uncontrolled rapid breathing. She appeared to be traumatized: rolling her eyes back and struggling violently during her midwife's attempt to perform a vaginal exam. During the vaginal exam Theresa crawled on her elbows off the head of the bed, defecating on the bed in the process. Theresa had to be physically lifted back onto the bed by several nurses. During this process, Theresa closed her eyes moaning, thrashing and pushing. After her healthy 7 pound 4 oz baby boy was born, Theresa refused to look at or hold her baby. She passively allowed her midwife to perform a vaginal repair without complaint and asked politely for a new, unsoiled gown before falling into deep sleep. The baby was subsequently given up for adoption.

This case is in sharp contrast to the two previous cases. This pregnancy is hallmarked by the absence of common rituals for assimilating the role of pregnancy and ensuing motherhood. Rituals, personal and medical reassurance in the form of social support (communitas), and acknowledgement of the pregnancy were clearly avoided. Theresa avoided personal investment in role change including acts to protect and acknowledge her unborn child. She avoided prenatal care, had no baby shower, did not seek out other pregnant women and withdrew from friends during her pregnancy. Family, partner and societal support both for Theresa and the unborn child were conspicuously absent. In addition, Theresa could not prepare for the child on her own. She did not attend childbirth classes or prepare a new home for her unborn child. As a result of avoiding communitas, she was both uneducated about what to expect and unprepared to deal with labor or her unborn child. Left without support during the labor, Theresa was alone, scared and appeared traumatized. Her labor was hallmarked by the significance of her psychological un-preparedness for the process. Her behavior was suggestive of both dissociation and regression. Ultimately, the baby was given up for adoption without much thought or consideration regarding the role of motherhood. It is clear, from this example that Theresa was unable to acknowledge the state of pregnancy, much less incorporate the role of motherhood.

Discussion

The cultural framework of liminality provides a lens through which to view pregnancy as 'betwixt and between' the status of not-mother and mother. Pregnancy, within a society, is a social state that

affects more than a single woman; it changes the family and community as well as the mother-to-be's status within those groups. Pregnancy is a major upheaval for a woman. The use of rituals helps her to transition into a new role and assists her in adjusting to the many changes she is experiencing. The normal pregnancy case study demonstrates how these rituals assist to demarcate the progress of pregnancy, bringing some predictability and excitement about the upcoming birth of a mother and a baby. The rituals around doctor visits, baby showers and birth ceremonies are integral to successful passage through the liminal state. They also serve as acts of personal investment in role change, reaffirm the reality of her pregnancy and demonstrate the possibility of societal and familial recognition and acceptance of who she is becoming.

The supporting social experience of communitas provides a unique lens through which to view pregnancy support groups like childbirth, breastfeeding and Bradley method type classes. The inherent liminal state of pregnancy is frightening and anxiety provoking. Communitas is a necessary and psychologically healthy approach to dealing with the uncertainty and fears surrounding this societal transition. Through communitas, a woman gains validation of her hopes and fears, finds others like her to reflect the intensity of the transition process and gains advice about labor, birth, incorporating a new child into a family and parenting.

The case studies illustrate how viewing pregnancy from the perspective of liminality helps in understanding maternal integration of pregnancy and motherhood as a personal and social transformation. In the first case study, there is obvious confluence between maternal investment and role transformation. She engages in the rituals that indicate the safe passage of time, herself and her baby, and the communitas activities that aid in successful reintegration into society. Jackie has support from family and also engages in communitas with other pregnant women during the planning for baby and preparation for birth in childbirth classes.

In the second case study, the loss of a child leaves the woman feeling like a mother, but socially and medically she is not given that role. She engaged in the rituals and communitas that she needed, but the death of the child prevented reintegration either as a mother or a woman. This case study illustrates a key component of liminality, in that once one leaves a former societal status, they cannot return. In this case she left being simply a woman, but having birthed a child that died, she is unable to become a mother in a way that society would recognize and unable to return to thinking of herself as being only a woman.

Finally, the third case study illustrates the rejection of the maternal role. While she was medically and physiologically pregnant, emotionally she refused personal investment in role transformation. She avoided engaging in ritual or communitas. Due to her own rejection of the pregnancy psychologically and socially, and lacking support to this end, she was ill-prepared for motherhood and did not respond positively to impending birth. She could not connect with the experience of other pregnant women. Therefore communitas that might have provided safe passage through liminality was not available to her and she found herself in labor without the support or skills that these resources might have provided.

When things do not go as planned, as in the case of perinatal loss, women are left in a state of liminality where resolution does not occur. In subsequent pregnancies these women return to liminality but often avoid social rituals because, while they are intended to be comforting, the rituals are painful reminders of their losses (Côté-Arsenault & Donato, 2007). When women avoid communitas they often fail to find the support, reassurance and investment necessary to fully incorporate role transition. They are avoiding hurt and disappointment by eschewing traditional rituals, but in doing so they lose the comfort the ritual was intended to provide. Rituals such as announcing the pregnancy and having a baby shower shed too much light on the vulnerabilities inherent in the woman's view of pregnancy. These women are reluctant to engage in these cultural rituals until they know that things will turn out well, given their negative past experience.

Rituals in pregnancy currently exist but perhaps more could be developed. Similar to attempts in times of perinatal loss to create rituals surrounding birth and death, additional avenues of support could be devised for all pregnant women. This is most important when rituals are not available or are unacceptable, as in Case 3.

The goals of new programs could include making women equal and active partners in their prenatal care and focus on providing communitas via support groups, mentoring opportunities, pregnancy education, role playing, and story-telling to facilitate their transition to motherhood and prepare them for parenting. One existing program that does much of this is the Centering Pregnancy program (Rising, 1998). In the Centering Pregnancy program, prenatal care is provided through groups of women at similar gestational ages. These groups have 10 sessions across pregnancy in which they perform physical assessments and examinations, as well as provide education, and support. This format facilitates the communitas needed in liminal

phases, empowers women, and equalizes their role in caring for self. Women learn from the care provider and each other; they check their own urine, weight, blood pressure, etc. Education also addresses self care and care of their new baby, thus preparing the women for the role of motherhood.

The physiological, psychological and nursing theorists' work on pregnancy and the development of motherhood were examined as potential pregnancy perspectives but they have limited usefulness. Viewing pregnancy as a rite of passage with a liminal phase provides a valuable framework for understanding women's responses to pregnancy as well as serving as a guide for areas of focus needed for pregnancy support. Care of pregnant women must address emotional and social needs. Restricting pregnancy care to physical assessments and needs is insufficient. Care providers must use all available means to broaden their scope of care; society, women, and their children will benefit from these efforts.

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Journal of Prenatal and Perinatal Psychology and Health 24(2), Winter 2009

Differentiating Subtypes of Postnatal Depression Based on a Cluster Analysis of Maternal Depressive Cognitions

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ABSTRACT: Based on the analysis of cognitive style, this study demonstrated that women experiencing postnatal depression (PND) fall into two categories: (a) those with a general cognitive vulnerability to depression and for whom childbirth is a non-specific stressor; and, (b) those whose depression is directly related to the stressful demands of motherhood. Studying an Australian sample of 406 postnatal women who completed the Edinburgh Postnatal Depression Scale (EPDS), the Dysfunctional Attitudes Scale (DAS-24), and the Maternal Attitudes Questionnaire (MAQ), hierarchical cluster analysis identified three groups distinguished on the basis of depressive symptomatology and/or the nature and strength of maladaptive cognitions.

KEY WORDS: Postnatal depression; dysfunctional maternal cognitions; dysfunctional general cognitions; sub-groups of PND

Postnatal depression (PND) is a common but serious condition affecting 10-20% of mothers in the first year postpartum (O'Hara, Neunaber, & Zekoski, 1984). The symptoms of PND include low mood, anhedonia, forgetfulness, irritability, anxiety, sleep disturbance, low self-esteem and guilt (Stuchbery, Matthey, & Barnett, 1998). In severe cases, PND can affect not only the mother's functioning, but also her partner's mood, and the cognitive, behavioral and emotional outcomes of her infant (Hendrick, 2003; Lovestone & Kumar, 1993).

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition text revision, (DSM-IV-TR) classifies PND as a Major

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Author Note: Author order is alphabetical. The first three authors all contributed equally to the preparation of this manuscript. We would like to thank Dr. Claire Lamplugh, Dr. Margaret Brechman-Toussaint, and the Perinatal Department at Nepean Hospital for their assistance with this project.

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Depressive Disorder (MDD) that has an onset within four weeks of delivery (American Psychiatric Association, 2000). This classification reflects the observed similarity between the symptoms and presentation of PND and MDD, and suggests that the key distinguishing feature of PND is its temporal relationship with childbirth. However, evidence has emerged to suggest that differences can also be found in the cognitions of sufferers (Cooper & Murray, 1995; Olioff, 1991; Warner, Appleby, Whitton, & Faragher, 1997).

Cognitive theories of depression posit that dysfunctional attitudes and negatively-focused cognitive schemata form a relatively stable risk factor for the onset of depressive symptoms (Abramson, Seligman, & Teasdale, 1978; Alloy et al., 1999; Beck, 1967). Such schemata, which involve themes of failure, inadequacy and hopelessness, are typically represented within global dysfunctional attitudes about the self, the world and the future (Beck, 1967). High levels of dysfunctional attitudes, often assessed by the Dysfunctional Attitude Scale (Weissman & Beck, 1978), have been shown to be a trait-like feature (Zuroff, Blatt, Sanislow, Bondi, & Pilkonis, 1999) associated with vulnerability to depression (Otto et al, 2007) and the severity of depressive symptomatology (Dent & Teasdale, 1988; Norman, Miller, & Keitner, 1987). Within the wider literature, a body of evidence consistently demonstrates a positive relationship between global negative thinking patterns and MDD (Alloy et al., 1999; Reilly-Harrington, Alloy, Fresco, & Whitehouse, 1999; Woody, Taylor, McLean, & Koch, 1998).

As would be expected, dysfunctional negative cognitions are also evident in women with PND (Grazioli & Terry, 2000; Olioff, 1991; Warner et al., 1997). In line with the diathesis-stress components of Beck's cognitive theory of depression (Beck, 1967), and as implied by the DSM-IV-TR diagnostic criteria, high scores on the DAS-24 have been found to be predictive of PND in women who also report high levels of parental stress (Beck, 1967; Grazioli & Terry, 2000). However, it seems that not all women with PND experience negative cognitions relating to the experience of childbirth (Warner et al., 1997). Using the Maternal Attitudes Questionnaire (MAQ) to measure maladaptive attitudes to motherhood, Warner et al. (1997) found that a sub-group of women who become depressed in the postnatal period do not engage in such thoughts. This finding supported Cooper and Murray's (1995) earlier proposal that women with PND fall into two categories: (a) those with a general cognitive vulnerability to depression and for whom the birth of their child functions as a non-specific stressor; and, (b) those whose depression is directly related to the stressful demands

of motherhood.

The possibility that two sets of negative cognitions can serve as risk factors for PND is perhaps reflected in the evidence-based treatments for this disorder. Cognitive behavioral therapy (CBT; Beck, Rush, Shaw, & Emery, 1979), which aims to alter negatively-focused cognitions, is a standard empirically-validated treatment for MDD (Elkin, 1994) and PND (National Institute for Health and Clinical Excellence, 2006, 2007). However, other treatments for PND that address adjustment and role-transition issues have also been shown to be effective [e.g., mothercraft skills training (Perth Clinic, 2006), non-directive supportive counseling (National Institute for Health and Clinical Excellence, 2007) and Interpersonal Therapy (IPT) (National Institute for Health and Clinical Excellence, 2007; O'Hara, Stuart, Gorman, & Wenzel, 2000)]. If empirical support was found for Cooper and Murray's proposition that PND sufferers are a cognitively heterogeneous group, then perhaps recommended treatments could be targeted to more specifically address the underlying mechanisms of pathology.

The purpose of this study, therefore, was to examine the negative cognitions of women suffering from PND. By measuring both general depressogenic and maternal-specific negative attitudes, we predicted that subgroups, based on cognitive style, would be found. In the light of previous studies, we hypothesized that depression in some participants would be associated with elevated levels of both general and maternal-specific dysfunctional attitudes, but in others, dysfunctional maternal attitudes alone would be the main cognitive correlate of their depression.

METHOD

Participants

The names of 1100 women who had given birth in the previous 5 to 14 weeks (identified on six different occasions across a 12-month period) were randomly selected from the birth register of a large metropolitan health district in Sydney, Australia. The women were mailed an explanatory letter, a consent form, questionnaires and a reply paid envelope. Women were excluded if they were suffering from severe puerperal psychosis or if their infant had significant health problems and/or required neonatal intensive care. Of those contacted, 37% (N = 406) returned completed questionnaires. The modal time for questionnaire completion was 12 weeks postpartum.

Twenty-two percent of respondents (n = 89) exhibited depressive symptoms potentially within the clinical range (EPDS scores ≥ 10). This subgroup was the primary focus of this investigation. These respondents were aged between 20 and 41 years (M = 29.64, SD = 5.08) with diverse educational backgrounds (30% 10 years or less of formal education, 26% 12 years, 37% technical trade or graduate level, 7% post-graduate level). Forty-nine percent of women were primiparous, 26% had two children, 18% had three and the remaining 6% had four or five children. The majority of most recent births (62%) were by normal delivery, 9% were assisted (forceps or vacuum extraction), and 28% were by Caesarean Section. Sixty-one percent of respondents indicated that their pregnancy was planned, and 36% reported a previous diagnosis of depression.

Measures

Postnatal depression. The Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987), a 10-item, well-validated screening tool, was used to assess PND. The scale has sound psychometric properties including high internal consistency in past research (Cronbach's α=.87, Cox et al., 1987), and in the current sample (α = .87), and good construct validity. A cut-off score of 10 has been shown to have 89% sensitivity for identifying symptoms in the clinical range (Murray & Carothers, 1990). Scores above 12.5 have demonstrated a 93% specificity and 95% sensitivity for predicting symptoms equivalent to MDD using DSM-III criteria (American Psychiatric Association, 1987; Harris, Huckle, Thomas, Johns, & Fung, 1989).

Dysfunctional maternal cognitions. Dysfunctional maternal-specific cognitions were assessed using the Maternal Attitudes Questionnaire (MAQ; Warner et al., 1997). The MAQ consists of 14 items related to motherhood (e.g., to be a good mother I should be able to cope well all the time) and associated role changes (e.g., I have resented not having enough time to myself since having my baby). Items are rated 0-3 such that high scores reflect more negative perceptions of the experience of motherhood. The MAQ has shown good construct validity and reliability in past research (Cronbach's α = .84, Warner et al., 1997) and the current sample (α = .72).

Dysfunctional general cognitions. The 24-item Dysfunctional Attitude Scale (DAS-24), which assesses fixed negative values and perfectionist attitudes associated with depression (e.g., my happiness depends more on other people than it does on me; I should always have

complete control over my feelings), was used to measure general dysfunctional cognitions. Items are rated on a 7-point scale, higher scores indicating greater endorsement of dysfunctional beliefs. The DAS-24 has exhibited good construct validity, test-retest reliability and internal consistency (Power, Duggan, Lee, & Murray, 1995). Cronbach's α for the current sample was .90).

RESULTS

Cluster Analysis

A hierarchical cluster analysis, using Ward's method on squared Euclidean distances, was performed with total MAQ and DAS-24 scores as the clustering variables for the 89 respondents with scores >10 on the EPSD. Examination of the dendrogram and agglomeration schedule indicated that the optimum number of clusters was three. Three univariate analyses of variance, with cluster membership as the independent variable and the MAQ, DAS-24 and EPDS as dependent variables, were then conducted to explore whether the clusters varied significantly with respect to these variables. Results indicate that all three groups scored between one and two standard deviations above the mean on depressive symptoms: Table 1 (p. 94) displays the descriptive statistics for participants scoring 10 or above on the EPDS, and the number of women in each group.

Two clusters (Cluster 1 and Cluster 2) had EPDS scores that were not significantly different and which suggested that the participants were suffering from depressive illness (i.e., >13; Cox et al., 1987). Participants in Cluster 1 (n=35) had moderately elevated scores on the DAS-24 (>2SDs) and mildly elevated scores on the MAQ (>1-2 SDs); Cluster 2 (n=32) had average range scores on the DAS-24 (i.e., +/- 1 SD) and mildly elevated scores on the MAQ. The mean EPDS score (M = 11.77) for women in Cluster 3 (n=22) suggests that while depressive symptoms were present, these were likely to be sub-syndromal. This cluster's mean scores for the DAS-24 and the MAQ were in the average range.

Tukey's post hoc tests, also reported in Table 1, show that the members of Cluster 1 had significantly higher DAS-24 scores than those of the other two groups (almost 2 SD above the mean for this sample), similar MAQ scores to Cluster 2, but significantly higher MAQ scores than Cluster 3. The DAS-24 scores for Cluster 2 were significantly lower than those of Cluster 1, but significantly higher than those of Cluster 3. The MAQ scores for Cluster 2 were not

Table 1

Descriptive Statistics for Variables Used in the Study Showing Means for Groups in Homogeneous Subsets Based on Hierarchical Cluster Analysis.

Measure	Theoretical		Total sample		Cluster 1	Cluster 2	Cluster 3
	Min	Max	*M*	*SD*	*M*	*M*	*M*
Edinburgh Postnatal Depression Scale	0	30	6.18	4.62	14.23^{a}	13.16^{ab}	11.77^{b}
Maternal Attitude Questionnaire	0	28	3.46	3.08	7.23^{a}	6.91^{a}	3.82^{b}
Dysfunctional Attitude Scale	24	168	71.21	21.57	113.60^{a}	82.28^{b}	56.91^{c}

Note: Total sample: $N = 406$; Cluster 1: $n = 35$; Cluster 2: n = 32; Cluster 3: n = 22. Means that do not share the same subscript are significantly different using Tukey's post hoc tests, $p < .05$.

significantly different to those of Cluster 1, but were significantly higher than those of Cluster 3. Cluster 3 scores on both the DAS-24 and MAQ were significantly lower than those of Clusters 1 and 2.

Discussion

This study examined the cognitions of women experiencing PND. Cluster analysis revealed that within this study's sample, three subgroups could be identified and distinguished on the basis of severity of depressive symptoms (as measured by the EPDS) and/or the nature and strength of maladaptive cognitions. Two groups had EPDS scores suggesting the presence of significant depressive illness. In one group, participants were experiencing high-range general dysfunctional cognitions and moderately high range dysfunctional maternal attitudes. This suggests that for this group depression was the result of a trait-like vulnerability, combined with a maladaptive response to childbirth and new parenting. In the other group, the participants' depressive symptoms were associated with average range general dysfunctional cognitions, but moderately high range dysfunctional maternal-specific cognitions. For this group, it appeared that their depression was substantially a function of maladaptive responses to recent maternal experiences. The third group, whose EPDS scores indicated sub-syndromal symptoms of depression, was found to have average range general dysfunctional and maternal specific cognitions. Thus, there appeared to be no specific type of negative cognitions functioning as a risk factor for depression. Overall, the results of this study support and extend the findings of previous research (Grazioli & Terry, 2000; Warner et al., 1997) by demonstrating that within a sample of women with PND, distinct cognitive correlates of depression can be identified. Such findings have implications for treatment.

Evidence-based clinical guidelines (National Institute for Health and Clinical Excellence, 2006, 2007) suggest a range of psychological interventions for PND which are graded in intensity to parallel the severity of the presenting symptoms. For mild to moderate depression, the recommended management includes self-help strategies such as computerized CBT, non-directive counseling delivered at home, and brief CBT or IPT. For moderate to severe depression, structured psychological treatment (CBT or IPT), supplemented with antidepressant medication if preferred by the patient, is the recommendation. While the literature provides evidence of the effectiveness of each of these treatments (Chabrol et al., 2002; O'Hara

et al., 2000), the persistence of symptoms in some women could be the result of poorly-matched intervention.

Based on the findings of this study, it seems that treatment matching might be improved by assessing both general cognitive style and attitudes towards motherhood. Women who display significantly high levels of general depressive cognitions might benefit most from therapies that focus on the treatment of depression in general (e.g., structured CBT or IPT), whereas women experiencing primarily maladaptive maternal-specific cognitions might be more appropriately treated with IPT, home-based counseling, or a mother-craft program (National Institute for Health and Clinical Excellence, 2007; Perth Clinic, 2006)

Some limitations of this study should be considered. First, while EPDS scores above the chosen cut-off levels suggest the presence of clinically significant PND, without the use of diagnostic criteria (e.g., SCID, First, et al., 2002) it is not possible to firmly assert that these were at the level of an MDD or not. Further, with a response rate of only 37%, it cannot be assumed that the sample was representative of the population of postnatal women. However, comparisons with other community-based samples from Australia (Boyce, Hickey, Gilchrist, & Talley, 2001; Horan-Smith & Gullone, 1998) and the United Kingdom (Cox, Murray, & Chapman, 1993) suggest comparability.

These limitations aside, this study has highlighted the potential value of assessing the cognitions of women presenting with PND, in order to inform a tailored intervention. A useful goal of future research would be to evaluate the effectiveness of cognitive treatments designed to fit subgroups of women who present with predominantly general or maternal-specific maladaptive cognitions.

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Journal of Prenatal and Perinatal Psychology and Health 24(2), Winter 2009

Mary the Dawn: Ancient European Symbols of Fertility and Pregnancy for Pedagogical Purposes

Fr. Walter R. Taylor

ABSTRACT: In this paper, I will trace Ancient European Symbols of Pregnancy and Fertility from pre-history to early Christian times. Whether ancient female images represented goddesses or not, is not under discussion here. I will explore the possibility that symbols of pregnancy and fertility take on a purpose beyond self-expression, art, or worship and suggest the plausibility of pedagogical purposes in a pre-literate world. By including symbols, I also hope to show how some the roots of our modern alphabet go back to pre-history, and speak of the sacred sciences of birth.

KEY WORDS: Pregnancy, fertility, goddess, female, symbols, pedagogy

The art historian Thomas F. Matthews (1993) notes that to some nominally literate people, "… images were their way of thinking out loud ...Indeed, the images are the thinking process itself" (p. 141).

The oldest handmade images we have are figurines, the Venus of Tan Tan (see Figure 1) and the Venus of Berekhat Ram, which are dated at about 300,000 BC[1] (Bednark, 2003). The earliest man-made temple we know of, built in 11,000 BC, is in Turkey and replete with mother goddess symbols (Curry, 2008). The temple shows that some early cultures surrounded themselves with symbols of life—life that is fertile and pregnant.

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[1]The Venus of Berekhat Ram, made from "a basaltic tuff pebble containing scoria clasts" was found in the northern Golan Heights of Israel and appears to be the oldest image thus far identified. Another ancient image, the Venus of Tan-Tan, about 58 mm or 2.3 inches tall, made of Quartzite, was found in Morocco. Dating these ancient artifacts is difficult. But the best clues we have now date the images "…between 300,000 and 500,000 years. The Early Acheulian industry of Morocco and the Maghreb generally is older than 500,000 years." (Bednark, 2003).

Figure 1 – Venus of Tan Tan

Figure 2 – Enthroned Goddess of Çatal Hüyük

Figure 3 – Etruscan Chariot facing

Figure 4 – Medieval Limburg

The Kahun Gynecology Papyrus, from around 1825 BC, is the oldest, intact written document we have. It is interesting to note the purpose of this most ancient document:

> The Kahun Gynecology Papyrus] describes methods of diagnosing pregnancy and the sex of the fetus, toothache during pregnancy, diseases of women, as well as feminine drugs, pastes and vaginal applications (Arab, 2008).

At various archeological sites in Ancient Europe, we find female images covered with symbols. Considering how crucial successful childbirth was to survival, the speculation that the ancient feminine images may have been used for teaching purposes in a pre-literate world seems reasonable. Today, we speak of teachings *Set in Stone* to lend a venerable and authoritative quality to lessons. In pre-history stone, clay, bone, wood, and plant juices were the only available teaching and recording mediums. Many of the artifacts described in this paper were found in what seems to have been common areas or kitchens (Gimbutas, 1989). Not only would this indicate their prevalent, widespread, and everyday use, but their importance as well.

These were not sacred, as in set apart, holy objects. Neither were they insignificant rare objects. In considering the fundamentals of a society, passing knowledge from one generation to another is an important task in even the most primitive cultures. When these images and symbols are viewed in this light, their meaning, purpose, and prevalence become clear.

In discussing ancient female images, the names goddess or Venus are often used. The goddess enthroned, between two animals, as in Çatal Hüyük, 6,000 BC (see Figure 2), is seen in Etruscan Chariot facings (see Figure 3), and medieval churches such as in Limburg Netherlands (see Figure 4), or in Bully, France, (see Figure 5). The most popular and sophisticated version survives in Christian art as the Virgin Enthroned (see Figure 6). The theme of the divine birth/child between two beasts, also re-emerges in Christian settings thousands of years later (see Figure 7). Therefore, the very language I am using may influence readers to assume that the ancient images I refer to are of goddesses. Though I will use that term for the purpose of this paper, I leave others to debate the religious overtones the name implies.

The crude and amorphous shapes found in some ancient images may have resulted from wear over time, or may be due to primitive skill levels in pre-historic eras. The triangular figurine of possibly

Figure 9 – the Venus of Brassempouy

Figure 10 – Goddess from Vršac, Yugoslavia c 4,500 BC

Figure 5 – Medieval Church Bully, France

Figure 6 –Virgin Enthroned

Figure 11 – Dishes from
a&b- Alba, Transylvania 4,500 to 4,000 BC
c&f- Cucuteni, Romania 3,800 to 3,600 BC
d- Sipenitsi, Galicia 3.700 to 3,500 BC
e- Ruse, Bulgaria4,500 to 4,300 BC

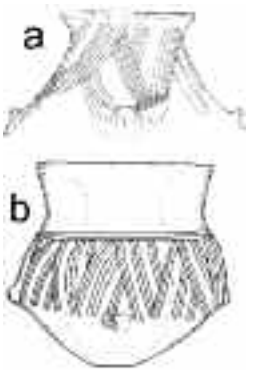

Figure 12 – Vases
a is from Vinča, Romania 5,200- 5,000 BC
b is from Lengyel, Hungary c 5,000 BC ng

Figure 7 – Christ Between Animals

Figure 8 – 500,000 Year Old Carving

500,000 BC from Heidelberg Germany is one such example (see Figure 8). Yet, one of the oldest images we have, a 1.5 inch female head carved from a mammoth's tusk from around 30,000 to 22,000 BC, found in Brassempouy, France, is appropriately proportional and, appears to have an art nouveau quality about it (see Figure 9). Therefore, I look upon other examples of ancient art not simply as reproducing physical realities, but, in some cases, as purposely made abstract symbols as well.

One reason for claiming that certain symbols were used in teaching about birth is that they were typically found on female images or in places that are thought to have been birthing centers. Marija Gimbutas (1989) has studied more than 30,000 sculptures and artifacts from over 3,000 sites, and has found consistent themes, patterns and symbols supporting the position that the symbols written about here are related to birth, and obstetrical teachings in ancient Europe.

In medieval times, towns often grew up around sacred learning sites, such as temples, or churches (Haverfield, 1913). The size and configuration of a central structure would identify it as a special purpose building, capable of sheltering many people. The universality, similarity and consistency of the foot print of this type of town planning with the ruins of older settlements, leads one to assume that the roots of this European practice go back to antiquity. More to the point, all the great cathedrals of medieval Europe are dedicated to the Mother of God, Notre Dame. In classical times, the great cities of Ephesus and Athens sprung up from goddess temples. So not only was the central structure a sacred building, the finding of female images and goddess symbols carved into pre-historic temples show that the practice of dedicating the most important temples to a female deity was prevalent in pre-historic times as well.

To understand the pedagogical meanings these ancient symbols, I will explore some of the basic ones: lines, spirals, sets of three, anthropomorphic and anatomical shapes, other animals and follow them into the Christian Era[2].

Lines

The earliest cave wall markings and clay objects were marked, or chiseled, with straight lines. Curved lines came soon after. Early

[2] This is only a partial list of Goddess related symbols. See the bibliography for more exhaustive texts.

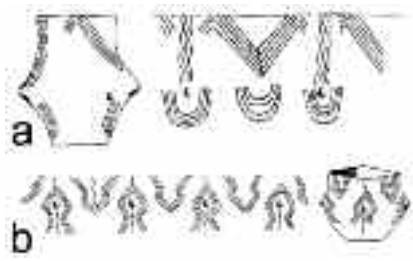

Figure 13
a is from Tisvavasvari-Josefháza, Hungary c 8,000 BC
b is from Sarazsadany-Templomdom, Hungary c 6,000 BC.

Figure 14 – Cucuteni, Romania 4,400-4,300 BC

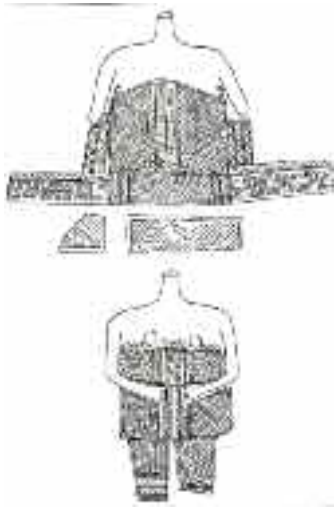

Figure 15 – Enthroned Goddess with Early Greek Keys. Szegvár-Tüzköves, Hungary 5,000 BC or Earlier

Figure 16 – Mammoth Ivory Figurine from Lespugue, France c 21,000 BC. (Note-damaged areas have been reconstructed.)

goddesses were marked with parallel lines, *raining* lines, and zigzags, often in sets of three (see Figures in 10). One may observe dishes (see Figure 11) and vases (see Figure 12) having three lines inside a swirl or seed implying power, especially as in the power of fertility and life generation. As a goddess, or mother, brings life by water (that is, rain, oceans, rivers, amniotic fluid, and/or breast milk), these lines may have a primary meaning[3]. When a man or woman is full of erotic life, he or she produces moisture. One may observe that after Mother Nature pours out rain, the womb of earth will spontaneously produce life, as in frogs. A child is born after a woman *pours out* water. Wavy lines represents breasts and flowing milk on figurines and pottery (see Figure 13). As artistic skill and technique improved, more stylized waves appeared, as in Cucuteni, Romania, around 4,400 BC (see Figure 14) or in combination with other symbols, such as elements of the Greek key pattern in Szegvár-Tüzköves Hungary at least as early as 5,000 BC, if not earlier (see Figure 15). Later, in Greece and Celtic Europe, we find strong goddess/water connections when the goddesses are depicted as connected to rivers, wells, and other forms of water.

Mother and child, during pregnancy, are one. Yet the one becomes two after delivery. One of the most basic symbols of the two that is one and one that is two in ancient female figurines is the often seen symbol of a double line, double egg, and double bulge (see Figure 16). We may see a lack of understanding about the mechanics of conception but, to be fair, Ashley Montagu notes that European scientists did not have a real grasp of the facts of life until the 1850s, (as cited in Lyons, 2004).

Three lines, especially as a triangle, are commonly interpreted as representing a pubic triangle or vulva, especially if partially bisected (see Figure 17).

Spirals

Spirals have long been associated with goddesses, as in this goddess vase from Anatolia around 6,000 to 5,500 BC (see Figure 18). They have been depicted as, or with, waves like in the vase necks from Valea Lupului, Romania 3,800-3,600 BC (see Figure 19), or on the platter from Chalandriani, Syros C 3,500 BC (see Figure 20), or as Ram horns, as in these tomb wall carving from Perfugas, Italy c 4,000 BC (see Figure 21). A spiral sets you on a journey. And what awaits at the center, no one knows. The spiral draws you in to something beyond

[3] Even today, we have the expression "The Water of Life."

Figure 17 –
Left-Marble Syros, Greece 2,800-2,500 BC
Right-Bone Lovets, Bulgaria 4,500-4,300 BC

Figure 18 – Red Painted Goddess Vases from Anatolia
6,000-5,5000 BC

Figure 19 – Vase Necks from Valea Lupului, Romania
3,800-3,600 BC

Figure 20 – Platter from Chalandriani,
Syros. Note Vulva above Legs.
c 3,500 BC

Figure 21 – Tomb Wall Carving from Perfugas, Italy c
4,000 BC

itself. Therefore, spirals decorated temples, like in Sicily 3,000 to 2,500 BC (see Figure 22), tomb-sanctuaries as in Newgrange, Ireland, 3,200 BC (see Figure 23), and cremation Jars in Slavic areas (see Figure 24). Temples in Malta during 4,000 BC contain these symbols (see Figure 25). A swirl over the pregnant belly of a goddess in Poduri, Romania, around 4,800 to 4,600 BC (see Figure 26) ties the swirl or spiral to pregnancy. A dish in Karanovo Bulgaria from 4,500 to 4,300 BC (see Figure 11c) intersperses eggs in with the spiral, showing a connection of spirals to fertility. According to Gimbutas (1989), models of bread loaves marked with spirals and lozenges, and baked in special ovens shaped like a pregnant belly and/or marked with goddess symbols, were probably examples of bread offerings to the Pregnant Goddess (see Figures in 27). Note the belly button or umbilical stump on the Hungarian oven.

Humans developed different ways to mark or record time, especially lunar and solar cycles[4]. Meanders and spirals are a symbolic way to indicate a cycle, yet not a circle (Baring & Cashford, 1993). One interpretation of a spiral is that of a circle moving through time. A spiral can represent a journey, not only of the moon, but also of the sun. Of the many ways one could organize the length of a pregnancy, trimesters are consistently the measure of choice. As the sun has four cycles in a year, solstice to equinox and so forth, the triskele, or triple spiral on tombs built in womblike shapes are thought to represent the length of time that is expected to bring a child to term, three solar cycles of three months each. This interpretation is strengthened by a megalith in an Irish tomb, adorned by triskeles (see Figure 28), which is positioned in such a way that the only day of the year the sun will shine upon it is the day the goddess gives birth to the sun, the winter solstice (Gadon, 1989). The high degree of astronomical and mathematical knowledge that is exhibited in the architecture of these edifices gives us another reason to consider the possibility that they were living classrooms, where a person could learn just by being in and observing the structure itself.

As spirals are often interconnected in such artwork on the tombs, this could also be interpreted as the soul beginning a new spiral, or lifetime after the soul finishes one. Another interpretation would be that the Triple Goddess was invoked to comfort the grieving

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[4] Anne Barring (1993), exploring Alexander Marshack's work (1972), sees the first recordings of man's abstract thought in the recognition of the full lunar cycle. We see the three phases, but the fourth must be assumed. The cross, dividing a cycle into four, and a crescent are both symbols associated with goddesses

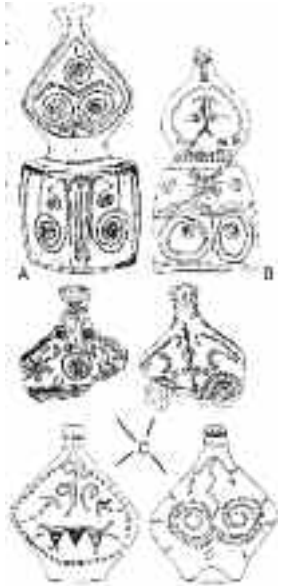

Figure 24 – Cremation Jars from:
A-Serbia, B-Romania, C-Yugoslavia
c 3,000 BC

Figure 25 – Temple Carvings from
Top Two-Malta
c 4,000 BC

Figure 26 – Poduri, Romania
c 4,800-4,600 BC

Figure 27 – Left: Mártély, Hungary 5,000 BC
Right: Vinča, Yugoslavia 5,000-4,500 BC

Figure 22 – Tomb Facings Hewn from
Rock, Sicily, Italy 3,000-2,500 BC

Figure 23 – Newgrange, Ireland c 3,200 BC

(Gimbutas, 1989). In Ireland, Brigit was known to be both Fire or Sun Goddess and Triple Goddess (Gwydion, 2009).

Sets of Three

In addition to the above mentioned tombs, lines, spirals, and other symbols were often grouped in threes as early as 10,000 BC in Abri Mège, Southern France (see Figure 29), and in Thessaly Greece (see Figure 30). In physics, as well as world mythology, three is an important number. In pregnancy and birth lessons, three is an important number to teach, trimesters being the most obvious.

Anthropomorphic and Anatomical

When not constrained by the shape of the material, such as bone, branch, or antler, a female image will usually be plump by modern standards whether as in the famous Venus of Laussel of Southern France, 25,000 BC (see Figure 31), Austria- the Venus of Willendorf[5], 25,000-23,000 BC (see Figure 32) or Thessaly, Italy 6,000-5,800 BC (see Figures in 33), or Bulgaria 5,500 BC (see Figure 34). Smaller women had, and do have more trouble delivering healthy babies. As well, malnutrition interferes with the ability to bear healthy children[6]. Additionally, this would be an important lesson to teach in a society that may look upon swelling in other circumstances as indicating some form of edema. These images not only taught acceptance of weight gain during pregnancy, they idealized the beauty of a woman in her fullness. Teaching with these images might even encourage weight gain during pregnancy, thus enabling a woman to retain her self-image of attractiveness even after the pounds pregnancy might put on.

In the birthing houses of Çatal Hüyük (see Figure 35) as well as other places, a bull's head is a common motif. When one considers the female anatomical knowledge written about in 1825 BC (Arab, 2008), and the resemblance between the anatomy of the uterus and the shape of a bull's head (see Figure 36), the appropriateness of this symbol becomes clear. In Clyclades, Greece 2,000 BC, placement of the

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[5] Originally both the Venus of Laussel and the Venus of Willendorf were covered in red ochre. In India covering an image with red ochre is traditionally part of a worship service.

[6] Encouraging women to nurture themselves, and not be overly judgmental about achieving a sexy, anorexic look may be a teaching we could use even today.

Figure 29 – Abstract Female on Bone
Abri Mège, France c 10,000 BC

Figure 28 – Newgrange, Ireland c 3,200 BC

Figure 31 – Venus de Laussel 25,000 BC

Figure 30 – Zarkou, Thessaly c 5,000 BC

Figure 33 – Top Sesklo, Thessaly c 5,800 BC
Bottom Magula, Thessaly c 6,000-5,800 BC

Figure 35 – Birthing House at Çatal Hüyük c 7,000 BC

Figure 32 – Venus of Willendorf (4 ½ inches)
25,000-20,000 BC

Figure 34 – Pazardžik, Bulgaria 5,500 BC

bull's head below the abdomen on this anthropomorphic vase would lead one to the same conclusion (see Figure 37). This would also explain why people in Crete, around 700-600 BC might also use such a symbol (see Figure 38).

Other Animals

Cave paintings in Southern France, from 15,000-10,000 BC (see Figure 39) depict pregnant animals. Some animals, such as bears, become associated with birth because of their reputation for ferociously defending of their young (see Figure 40), or maybe other qualities. In ancient Slavic cultures, barren women sought the bear's blessing to bear children (Moszynski, 1934). In Brauron, Greece,

> …Attic girls between the ages of five and ten years…performed a propitiatory rite in which they imitated bears… the bear was sacred to Artemis… all women, before they could marry, should have taken part once in this festival, and have been consecrated to the goddess (Schmitz, 1875).

Other animals, such as the Sow, possibly became associated with pregnancy because of their great swelling when full of babies. Figurines of Pregnant Goddesses wearing sow masks indicate masks like this one was used in rituals related to the Pregnant Goddess (see Figure 41).

What started as pubic triangles evolved and diversified into, for one example, hour-glass shapes at least as early as 4,000 BC in Romania (see Figure 42) and earlier in Yugoslavia and Malta (See Figure 43). Similar shapes, such as possible butterflies, are seen in Bohemia around 5,000 BC (see Figure 44). Rebirth seems to be the enduring meaning of the butterfly symbol.

On hundreds of images from Vinča Yugoslavia around 3,000 BC, a symbol composed of facing chevrons, <>, was common (Gimbutas, 1989). At shrines in Çatal Hüyük, Bull's heads on the wall are covered with these symbols from at least 7,000 BC. Vulva stones (see Figure 45), along with the *Fish Goddess* (see Figure 46), who holds her genitalia open, were found on the same altar. We will see these themes repeated often in Christian Churches.

To early man, fish spontaneously appeared. As animal husbandry became more widely practiced and sexual reproduction understood, certain fishes' drive to spawn came to symbolize a strong drive to produce young. They also gave life to plants as well as animals. Hence fish have long been associated with the generative power of women. Fish depictions are reminiscent of uterine shapes in the Minoan Art of

Figure 40 – Kosovska, Yugoslavia 4,5000-4,000 BC

Figure 41 – Leskavica, Yugoslavia c 4,500 BC

Figure 42 – Traian dealul Fintinilor, Romaina c 4,000 BC

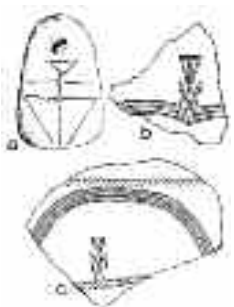

Figure 43 – A Loom Weight Gumeinița, Yugoslavia c 5,000 BC b&c Maltese Funerary Pot Shards 5,500-5,000 BC

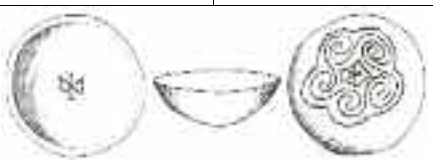

Figure 44 – Statenice, Bohemia c 5,000 BC

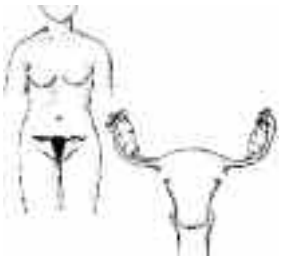

Figure 36 – Source of Bull's Head Connection to Birth?

Figure 37 – Clyclades, Greece. c 2,000 BC

Figure 38 – Vase painting Cyprus, Greece 700-600 BC

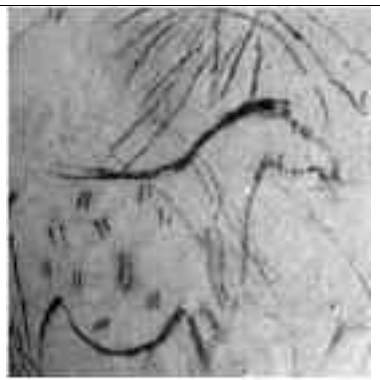

Figure 39 – Cave of Pileta near Gibraltar c 10,000 BC

1,100 BC (see Figure 47), and are found later in Thebes, Greece, around 700 - 675 BC (see Figure 48). The Greek tradition of using animals in teaching can be seen in Aesop's Fables. The fish, as a teaching symbol, was directly imported into Greek Christianity and has since spread to many Christian denominations.

Architecture

Birth and death are part of the cycle of life. Though we do not know the philosophy of early man, many burial sites had vaginal shapes, such as tree hollows, or were in womb-like hills with vaginal entrances (see Figure 49). The bodies were put into a fetal position, facing the east, towards the new born sun, presumably in preparation for their next adventure (see Figure 50). Ancient floor plans in Ireland reveal the container for end of life resembling the container for the beginning of life (see Figure 51).

Whether one's philosophy sees death as a birth into another dimension or existence, or one simply needs to give birth to creative ideas, as in civil meetings, drawing upon inspiration and strength from sources of life are important. Many ancient buildings and structures configure in a pattern consistent with the shape of a pregnant woman. Not only are the shapes based on pregnant women, the most important or chief focal point is placed at the point of birth. We will find interesting descendants of this practice as we move towards Christian Europe.

Early Historical

From at least 6,000 BC, we find images of goddesses exposing their genitalia. From 500 BC into the Christian era in Priene and other parts of the Hellenic empire, realistic images, representing a goddess known as *Baubo*, are found (see Figure 52). As of 100 AD a historian, Hyginus supplies us with a story to go with these particular images[7]. Agnodice was a Grecian woman who wished to practice medicine, at that time, an exclusively male profession in Greece. Disguising herself as a man, she learned the art, but having been discovered, was forbidden by law to practice. One day, she heard a woman cry out in labor. The woman who cried out, thinking Agnodice was a man, refused assistance. Agnodice lifted her skirt, exposing her genitalia, thus

[7] Besides the Hyginus account (Apollodorus & Hyginus, 2007, pp. 180,181), there is also another myth tradition that Baubo exposed herself to Demeter to relieve Demeter's depression. The laughter worked. Some refer to Baubo as the Goddess of mirth and laughter and the healing that laughter, light-heartedness, and letting go can bring (Baring & Cashford, 1993).

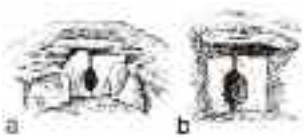

Figure 49 – Vaginal Entrances to English tombs c 3,000 BC

Figure 50 – Fetal Burial in Womb of Earth-Boscombe Down, England c 3,000 BC (awaiting carbon dating confirmation)

Figure 51 – Shanballyemond, Ireland c 4,000 BC

Figure 52 – Baubo from Hellenistic Areas c 0 AD

Figure 45 – Vulva Stone Lepenski Vir, Yugoslavia 6,000 -4,560 BC

Figure 46 – Fish Goddess Found on Same Alter as Vulva Stone

Figure 47 – Armenoi, Greece c 1,100 BC

Figure 48 – Thebes, Greece 700-675 BC

proving her sex. The woman accepted assistance, and so Agnodice began her career as the first female obstetrician. Practicing openly as a woman, she became increasingly popular. As she took business away from the men, they hauled her into court and began prosecution. The women of the city created so much civil unrest, they influenced the lawmakers to change the law and allow free-born women to study and practice medicine. While some historians question the veracity of Hyginus' account, the power of the myth, empowering female birth professionals to stand their ground, openly protest against being marginalized, and refusing to be subjugated under men, seems to have been reason enough to popularize the image. (Encyclopedia of World Biography, 2008).

As we go from pre-history, through classical to early Christian times, a good point to keep in mind is that the Apostolic Fathers of the Christian faith planned on a diverse church. After a few fundamental beliefs, similar to Buddhist doctrine, all other areas of ritual, practice and belief were left up to local populations. Christianity did not have the monolith of doctrine that it does now. Local practices, rituals, and beliefs were left intact. In the Bible, Acts 16:14 (King James Version), we hear of people who "worshipped God" and yet were not Christian. Irish Christianity, on the other hand, was so non-conformist to Roman Religion that in the 1100s the Pope authorized the invasion of Ireland by Norman forces to make the Celtic Christians conform to the Roman version of Christianity. One will find much evidence of earlier rituals, practice, and beliefs in many forms of Christianity, East and West. This very diversity is a hallmark of early Christian religion.

Sheela-na-gigs

In the Bible, we discover that Saint Paul and his companions "… have neither robbed temples nor blasphemed our goddess [Artemis]" Acts 19:37 (New International Version). Though the early Church did not have any problems with goddess worship, art was another matter. Modern Christians do not embrace explicit sexual art in any way, and most people have the impression that the early Church was the same[8]. Therefore, the prevalence of Sheela-na-gigs, as they are known today, is interesting. These are stone carvings of females holding open and exposing their genitals (see Figure 54). They are found on homes, bridges, town walls, gateposts, and, most commonly, on churches

[8] It is interesting to note that in Medieval Churches, in addition to homoerotic scenes (p. 84), exhibitionism, and masturbation, there is, in Maillezais, a graphic sexual scene in which a lustful couple wears halos (see Figure 53) (Weir & Jerman, 1986, p. 90).

Figure 53 – Siantonge, France- Notice the halos

Figure 54 – Sainte-Radegonde, Poitiers France

Figure 55 – Our Lady of Amiens, France

Figure 56 – Old Roman Mosaic Sousse, Tunisia
200 AD

Figure 57 – Greek Helmet 350 to 325 BC

(Freitag, 2004). The <> symbol, as seen on the earlier *Fish Goddess*, is more pronounced in the Sheela-na-gigs. Some even have the wavy lines, triangles, parallel lines etched on their faces, reminiscent of some of the aforementioned goddess images (ibid). There are indications that some Sheela-na-gigs were taken from older, so-called pagan buildings, and were kept or incorporated when the buildings were converted into early Christian churches (Clibborn, 1840/1844; Guest, 1936).

Some view these images as portraying a type of female pagan exorcist who, as a part of her banishing ritual, would display her genitals(or door through which blessings and life come) to drive away the Evil Eye (harbinger of curses and death) (Freitag, 2004). Thomas Wright in 1866, reminded us of the common dual purposes of depictions of the phallus[9] and vulva, fertilization and protection (ibid). Both are needed for both. Rolt, stated unequivocally in1875 that Sheela-na-gigs originated from a "pagan cultus" (as stated in Brash, 1875 p. 60).

Descendants of the Spiral

The spiral or swirl diversified into the swastika[10] and is found all over the world from classical times; Europe is no exception. For instance, swastikas are found on Grecian vases from 700 BC (see Figure 48). In Greco-Roman architecture the symbol was mostly used in floors and walls as in Amiens (see Figure 55) and Rome (see Figure 56). Certain Greek key patterns are considered to be interlocking swastikas. Grecian helmets from about 350 to 325 BC invoked protection and inspiration with a swastika on top (see Figure 57). In Bosnia-Herzegovina, tombstones from the 1200s retained many Goddess symbols of power and rebirth, including spirals, crescent moons and swastikas (see Figure 58). The stole, part of the ritual garb of Christian priests, is an insignia and symbol of the power of the priesthood. Therefore, it is logical that the early church would decorate stoles with insignias of the divine feminine Holy Spirit (see Figure 59).

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[9] There are many explicit phallic examples in church architecture (Weir & Jerman, 1986).

[10] The Swastika was a common symbol of power in prehistoric Indo-European cultures and has been found in Asia and Pre-Columbian America as well. Because this powerful symbol was all over the world, or uber alles, Hitter saw it as appropriate to his self-concept and political ideals. It is a sad note however, that this one man has now ruined this historic symbol of divine Motherhood, as many now consider it a symbol of evil. The fact that Hitler chose to relegate to himself a feminine symbol, rather than a male power symbol, might make an interesting topic for another paper.

Figure 58 – Bosnian Grave c 1200 AD

Figure 59 – Tombstone of Abbot Simon de Gillans C 1345 AD

Figure 60 – Bulgarian Coins Under King Clovis c. 466-511 AD

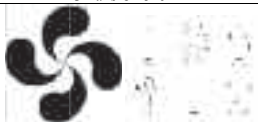

Fig 61 Basque and Other Cross Types

Figure 62 – Example of St Brigit's Cross

Figure 63 – Greek Key Pattern Around Building

Figure 64 – King Arthur Receives Sword and Power from the Lady of the Lake

Figure 65 – Christian Lamp from C 200 AD

In the world of more mundane items, swastikas have been found on beauty items from 300 AD in Nydam Mose, Denmark and coins from the Celts of the late 400's AD (see Figure 60). As a form of a cross, the more curved swastika can adapt as a lauburu or Basque cross (see Figure 61). Truncated, the swastika becomes an equal bar or Greek cross.

According to Catholic tradition, Saint Bridget[11] lived in the 300-400s AD when the lines between Druid and Christian were still blurred in Ireland. Many today look upon her as the fertility goddess Bridget of earlier origin. Irish folklore tells of her weaving a simple cross out of rushes to transmit some of her blessings and power, or Bright Fire to others (see Figure 62). Usually, this shape is thought of as a cross, yet when seen as representing fire, or energy, the *Bright Fire* cross has a spiral or swastika quality.

Wavy Lines

The signs of water became formalized into the Greek key pattern seen on Classical temples (see Figure 63) and used today. The goddess/water connection was also kept alive in myth as in Arthurian Legend. The sword Excalibur, borne by the hand of a goddess, rose from the water (see Figure 64). Pre-Roman Bath, England, was a sacred healing shrine dedicated to the veneration of the Triple Goddess called the Suleviae (Littleton, 2002). An old Celtic myth tells of the goddess Morrigan haunting the waterways of Ireland (ibid.) In one version of the myth of *Odinallfather* or Odin the All-father of the Norse, Odin gained some of his mystic power and wisdom from a sacred well (ibid.) Many Irish goddesses such as Aine, Airmid, and Danu were associated with water, rivers, and holy wells (Heath, 2009).

The famous Oracle at Delphi derives the goddess's name from *Delphos* meaning both *fish* and *womb*. The Roman goddess of love and fertility, Aphrodite Salacia, was also a fish goddess, whom her devotees honored by partaking of fish on her sacred day, Friday. In Scandinavia, the goddess Freya, whom Friday is named after, was honored by eating sacred fish. We find mermaids and fish with goddesses on sacred liturgical vessels (see Figure 65) as well as in many churches, such as in France (see Figure 66).

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[11] As Bridget is transliterated, and an old name, there are many spellings. For example Bride, Brigit, Bridgit, and Bríd are all common spellings too.

Figure 66 – A England Misericord - St Laurence, Ludlow (Shropshire) - 1430 – 1450 AD
B France Auvergne Basilique St-Julien c 1050 AD
C Italy Pavia S Pietro in Ciel d'Oro, c 500 AD
D France Otranto (Puglia) Cattedrale di Santa Maria Annunciata Large floor mosaic (c1150),

Figure 67 – Church brought to Life through Mary

Figure 68 – Madonna and Child (detail), Sta Prassede, Rome

Figure 69
Our Lady of the Sign

The Pregnant Goddess Refined

One of the first indications in the New Testament we have of Mary's position in the Christian hierarchy comes when, at the wedding of Cana, she asks Jesus to turn the water into wine. When Jesus began to object, saying it wasn't God's will, she ignored him and, "saith unto the servants, Whatsoever he [Jesus] saith unto you, do it" John 2:5 (King James Version). Jesus obeyed her request without further comment. She did not justify her request, nor did she even honor Jesus' protest with an answer. St. John is showing the reader the status of the Mother of God, that is, the will of God is second to her wishes. The goddess arrived in full power in the Christian religion.

Art historian Thomas F. Matthews (1993) was referring to Christian art when he noted, "the images were their way of thinking out loud ...Indeed, the images are the thinking process itself." (p. 141). Christian iconographers developed a symbolic style in painting built on previous styles. As Michael Goltz (2009) says,

> The earliest Christian defense of iconography was that of the icons use as a teaching tool. Through different periods in the history of the Church, people have not always been educated and literate. Thus a church full of icons served as a method to teach the Gospel to the masses. The images of the saints and feasts were preferential to the plain cross because with their colors the icons effectively communicated to the masses what was otherwise unreadable … one of the practical reasons for the use of icons in Orthodox life are as a teaching tool … In this role of education, the uniform style of iconography does much to assist with its teaching function.

Mary the Dawn, Christ the Perfect Day (Mulcahy & Cross, 1956), so starts the Medieval English hymn. In keeping with the religions of old, focus was not exclusively on the Mother aspect, Mary. Jesus was also worshipped[12]. When early Christian art depicted the inception or empowerment of The Church on the day of Pentecost, Mary is portrayed as the great source, channel, or transformer of the power of the Most High (see Figure 67). For from her flows the "power of the Holy Spirit" spoken of in Acts, Chapter Two. According to these ancient icons, Mary is the source, not only of the incarnation of Jesus, but of the power of the Church, especially the priestly powers.

History says St. Luke was the first iconographer. According to Christian iconography, baby Jesus is depicted as a small adult, because the artists wished to express the belief that Jesus had full divinity at birth, or rather before. Following Coptic tradition, the size of the figures relative to each other shows their importance. Faces are shown meditative and reflective. How does one express the mystery of She who contained the uncontainable? How can we depict her who is *More Spacious than the Heavens?*[13] The pregnancy symbol of choice has been

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[12] There are many assorted male and phallic symbols from the same times and places I refer to in this paper. I do not mean to infer that those symbols do not exist, rather, I am focused on symbols of pregnancy and fertility.

[13] Many of the classical compositions in early Christian art have acquired names such as *Holy Kiss, Our Lady of Perpetual Help, Holy Protection*, or *More Spacious than the Heavens*. This provides a framework within which a traditional artist may be expressive.

Figure 70 – Remaining Door of Church on Tor Hill, Glastonbury

Figure 71 – Santiago de Compostela (Note the crowns on the females either side of Mary)

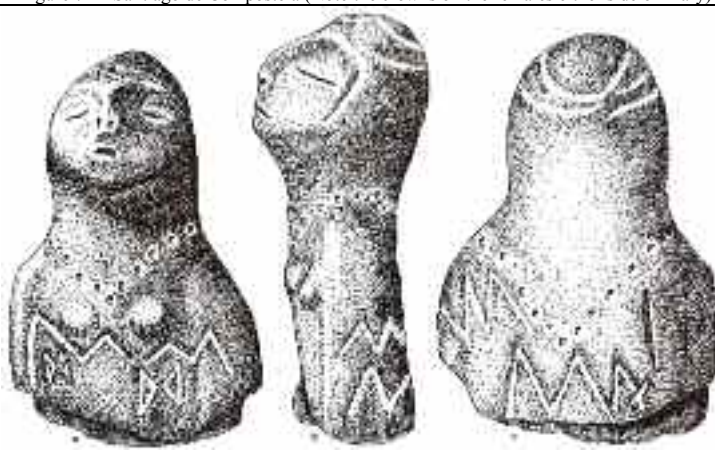

Figure 72 – Near Foggia Italy Capital M c 5,700- 5,300 BC

to depict Jesus the son/sun, pun intended, in a halo at the womb level, or, with artistic license, a little higher. As in St. Luke's gospel, his art focused on the Virgin Mary as well.

Long before any churches were built, Christians followed the tradition of earlier mother goddess cults by using tombs, that is catacombs, and burial sites for their rituals of renewal, re-birth, and resurrection. Often those catacombs reserved the central, most prized position for the Mother of God, pregnant, containing Life in her womb. Christ enthroned in the Virgin Mary, (see Figure 68). The popular composition, referred to as Our Lady of the Sign, keeps alive the honoring of pregnancy in depicting that great mystery of carrying a divine child for nine months, containing an uncontainable soul (see Figure 69).

Once Christians began building places for worship, how did they design entrances? How did one begin the journey into a temple of that ancient mother-goddess worshiping cult, Christianity? In keeping with the tradition of using sacred elements to make sacred dwellings, entrances to medieval churches were often shaped similar to the life-giving portal of birth, sometimes even imitating the labia majora and labia minora (see Figure 70). Often, the Virgin Mary stands as the matriarch, under whom you must pass, entering between her doorposts (see Figure 71). But sometimes the builders were not so cryptic.

If one went to the small 1226 AD Käppli-Joch chapel in Basel Switzerland, as did Boswell in 1764, behind the picture of the Virgin Mary over the door, you will find a graphic depiction of a woman's "thighs wide open and all her nakedness fully displayed." (Pottle, 1953 as cited in Freitag, 2004, p. 24). As one might imagine, not many Sheela-na-gigs survived the Victorian Era.

Not only had the needs of empire changed the older mother goddess worshiping cults, but the needs of empire were soon to change the character of the new one as well. If citizens emulated the worshipped, and the worshipped one was a loving, nurturing mother, how could the worshippers be induced to go around the earth killing other people? If the focus of religion honored life-giving principles, can the populous be inspired to government approved death-giving? If a people worship the nurturing and life-giving of women, then could they build an empire built upon the oppression of the poor? Who would wage war against the great *them*? Emperors feared for their lives and that of their kingdoms. Great leaders of Europe destroyed crops, decimated and enslaved populations around the globe. What if someone did the same to them?

Religion is a major influence on a population. At the turn of BC to AD, in the Europe of the Roman Empire, the old religions had lost their spark. There is an old Jesuit saying, “Give me a child... until he is seven, and I will give you the man" (Alhamedi, 2009). European rulers looked upon infant Christianity in a similar fashion. Rather than try to again remake the old, so-called pagan religions, simply embrace and remake the new, up and coming religion, Christianity. The rulers saw no need for a new name. The most popular practice seemed to be simply call in the religious leaders, get yourself declared holy, as the emperor Justinian did, and begin defining, or rather redefining religion as you want. And thus the Mother Goddess worshipping cult known as Christianity was transformed into a The Great Male worshipping state religion. Despite this denaturing, many pregnancy and birth symbols survived.

Symbols to Written Word

As humankind spent more time developing the arts, depictions of goddesses inspired and awed viewers with more beauty and grace. The skill and time needed to produce fine art made it limited, for only the rich, the temples, or churches could afford the great works. Though we can go to a university to learn *about* art, books are the common pedagogical medium, not the art itself.

As symbols developed, they split into two groups. Some symbols were relegated to decorate borders or provide interesting patterns filling in empty spaces. Some symbols were codified into written language beginning circa 1,600 BC. (Drucker, 1995). Cuneiform seemed to be the marking system of choice when our ancestors created an alphabet from pictographs, though the exact nature of this evolution is unknown (Stieglitz, 1971). This root script then branched out to become Canaanite (ibid). P. Wilson (2006) feels the Phoenicians, who shared the Canaanite language base, codified their written language around 1,100 BC. F.M. Stawell (1931) sees the Hebrew script being updated with Phoenician characters around 1,500-1,000 BC. The first letter in Phoenician, aleph, was written like a sideways Capital A. Cuniform letters could be written at any angle (ibid, p.136) and the A began to take the shape we recognize. In this paper I am not addressing who borrowed what letters from whom or who codified the letter A first. But I do think it worth noting how many scripts start, or give birth to the written word with the letter *A*. As a shape symbolizing two widespread legs with the sacred womb in the center of the letter, we have seen this shape earlier in architecture (see Figure 51). As

mentioned earlier, wavy lines represented water. In at least Italy and Greece, *M* was associated with water and with the goddess from before 5,000 BC (see Figure 72). In ancient Crete, and other Greek cultures, we saw ancient Birthing Centers and tombs decorated with bull's heads, and horns, and ram horns, we find their first letter's associate is the goat and bull (Stawell, 1931, pp. 10-11). While we may not with certainty assert the letter *A* was associated with birth: we may see many correlations.

There was a further evolution of language when, in western Greece, a small tribe gained in prominence. This Grecian tribe, the Latins, founded Rome. So our Rome script has Coptic, or Phoenician roots[14]. The beginning of the alphabet, earthly life, heavenly life, intellectual life, and life on this planet, all begin with a birth of some kind. These lessons may have been imbedded in the very shape of the letters that make up our alphabet. Today, these lessons seem all but lost. But what if there was a reason for using pregnancy shapes in the very form of the alphabet? What if they wanted to pass down a teaching that was so precious, so intimate, so needed for humankind, that the founders of our society inexorably intertwined into our very language the fundamental shapes that spoke to so many previous generations?

Conclusion

Generally, we do not keep old computers, old televisions, or old eight track cassettes. After all, why would we keep information systems that are centuries old? We might well ask, then why bring up the subject of pedagogical tools of primitive peoples? One reason is that pregnancy and fertility are central to the survival of life on the planet. Human beings around the world have been contributing to our store of knowledge for thousands of years. Who knows what bit of knowledge combined with some other fact might inspire some, as yet unthought of, revolution in science or improved prenatal care.

Throughout history, humans have sought not only the best education for a Mother about to deliver a child into this world, but to understand, honor, and even worship these sacred events. Birth-giving is a limit situation[15]. Therefore, words alone often fall short of providing the best

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[14] Traditionally, the Greeks are said to have imported their written symbols from the Phoenicians. The Roman modified their ancestral Greek tongue, so the Roman alphabet is Phoenician twice removed (Unknown, 2006).

[15] H. Shulman (2008) defines a limit situation as one in which the ability to comprehend, understand, process and communicate are limited. Used in trauma work, limit situation emphasizes the inability to properly communicate a traumatic experience.

prenatal, perinatal, and postnatal education possible. Often, the focus of education is on providing the essential skills and knowledge to hold a job and integrate into one's culture. When I speak of education in this paper, I am referring to the handing down of information that enlightens the heart and soul to enhance the art of birth-giving. The symbols mentioned, as well as other archetypal symbols, strike a deep cord in the human psyche. Many of the symbols mentioned actually span the globe in their history. Today, ancient European symbols are being used in various pedagogical contexts throughout the world by therapists, shamans, priests, counselors, mid-wives, and others to teach prenatal classes, help reduce stress, and otherwise enhance the health and well-being of mothers, babies, with good results (Achterberg, 1985; Ansa, 2008; Oaklander, 1988). Once you have the key to that kind of understanding, you'll find mother goddess worship and teachings about pregnancy in forgotten places (see Figure 73). When one familiarizes one's self with the pedagogical symbols of the sacred event of birth, one has simultaneously ancient and new tools to aid in the revered act of teaching and assisting goddesses bringing life into the world.

Figure 73 – *Maria Platytera* (*Mary, more spacious than the heavens*). Dahlem Museum, Berlin

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