# THE EFFECT OF A PRENATAL HYPNOTHERAPEUTIC PROGRAMME ON POSTNATAL MATERNAL PSYCHOLOGICAL WELL-BEING

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Birth is the sudden opening of a window, through which you
look out upon a stupendous prospect. For what has happened?
A miracle. You have exchanged nothing
for the possibility of everything.
*(William MacNeile Dixon, The Human Situation, 1937)*

A mother's happiness is like a beacon, lighting up the future but reflected also
on the past in the guise of fond memories.
*(Honoré De Balzac (1799–1850), French novelist)*

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# SUMMARY

## THE EFFECT OF A PRENATAL HYPNOTHERAPEUTIC PROGRAMME ON POSTNATAL MATERNAL PSYCHOLOGICAL WELL-BEING

**Keywords:** *pregnancy, childbirth, postpartum period, motherhood, psychological well-being, hypnosis, hypnotherapy, Ericksonian therapy, ego state therapy*

The aim of this study was to develop and evaluate the effect of a prenatal hypnotherapeutic programme on the maintenance and promotion of postpartum psychological well-being of a group of first-time mothers.

Relevant literature on pregnancy, early motherhood and psychological well-being were explained in order to abstract important facets and perspectives to use as a background for the development and implementation of an intervention programme for the facilitation of psychological well-being of first-time mothers. Theoretical perspectives on, and practical applications of, clinical hypnosis were further analysed and used as foundation for the development of the hypnotherapeutic intervention. A hypnotherapeutic programme was developed, based on existing theoretical knowledge regarding pregnancy, childbirth and early motherhood, as well as clinical hypnosis, with specific emphasis on Ericksonian principles and ego state therapy techniques, enriched from the perspective of psychofortology.

The empirical study consisted of a quantitative component and a qualitative component. In the quantitative component, a pretest-posttest-follow-up comparative design was implemented, with random assignment of participants to the experimental and control groups within the limits of practicalities. Both groups, each consisting of 23 women in their first pregnancy, completed the following questionnaires: (i) Perception of Labour and Delivery Scale (PLD), adapted from Padawer et al. (1988), Feelings about the baby and relationship with the baby (FRB), adapted from Woollett and Parr (1997), Maternal Self-Confidence Scale (MSC), adapted from Ruble et al. (1990) and Maternal Self-Efficacy Scale (MSE) (Teti & Gelfand, 1991), to explore aspects of psychological well-being related to early motherhood; (ii) The Edinburgh Postnatal Depression Scale (EPDS) of

Cox et al. (1987) and the General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979), to investigate aspects of psychological well-being as evident by the absence of pathology; and (iii) the Satisfaction with Life Scale (SWLS) (Diener et al., 1985), the Affectometer 2 (AFM) (Kammann & Flett, 1983), the Sense of Coherence Scale (SOC) of Antonovsky (1979) and the Generalised Self-efficacy Scale (GSE), developed by Schwarzer, (1993) to measure general psychological well-being. The Stanford Hypnotic Clinical Scale (SHCS) (Morgan & Hilgard, 1978) was used for the experimental group to assess hypnotisability. The qualitative component consisted of in-depth interviews and an analysis of written responses of mothers in the experimental group. They commented on their experience of the programme and its impact at two weeks and ten weeks postpartum.

Results from the empirical study indicated that the experimental group showed significantly more symptoms of depression and symptomatology during the prenatal evaluation than the control group. Since the experimental group was possibly more vulnerable than the control group in a psychological sense, the effect of the intervention programme could not be deduced from a pure comparison of postnatal evaluation scores between the groups. Therefore, it was decided to explore the significance of differences within each of the experimental and control groups, as well as between the experimental and control group, using the mean difference scores between prenatal and postnatal evaluation on each variable.

Results indicate that the hypnotherapeutic programme was effective in enhancing most aspects of psychological well-being within the experimental group. This strengthened sense of psychological well-being was evident both in the immediate postpartum period and at ten weeks postpartum. The control group showed a spontaneous increase in psychological well-being later in the postpartum period. The programme thus assisted mothers in the more vulnerable experimental group to experience a stronger sense of psychological well-being sooner after the baby's birth.

The experimental and control groups were further compared on the mean differences in prenatal versus postnatal scores on measures of psychological well-being. The results suggest that the hypnotherapeutic intervention contributed to an enhanced sense of psychological well-being in mothers in the experimental group, in comparison to the control group, during the early postpartum period, as measured by variables related to motherhood, absence of pathology and general psychological well-being. At ten weeks postpartum, the differences between the experimental and control group were less

obvious. However, a very important finding was that mothers in the experimental group continued to show a significant improvement in psychological well-being as indicated by the absence of pathology. Specifically, there was a continued decrease in depression and general symptoms of pathology. Findings from the quantitative study were supported by remarks by mothers in postpartum and follow-up interviews, as well as their written responses, as part of a qualitative exploration of their experience of the programme and its impact on them. The findings give compelling evidence that a hypnotherapeutic intervention, focusing on the enhancement of strengths and inner resources, could alleviate depression and psychological distress during the perinatal period, as well as prevent the exacerbation of symptoms.

Findings from the current study indicate that the developed prenatal hypnotherapeutic programme was effective in enhancing the psychological well-being of mothers experiencing a first pregnancy. Recommendations for clinical practice and further research were made, based on the current research findings.

The contribution of the current study lies in the fact that it is the first to explore pregnancy, childbirth and early motherhood from a salutogenic/fortigenic perspective, and to utilise hypnosis to facilitate psychological well-being in this context. It contributed to scientific knowledge in the fields of developmental psychology, psychofortology and clinical hypnosis.

# OPSOMMING

## DIE EFFEK VAN 'N PRENATALE HIPNOTERAPEUTIESE PROGRAM OP DIE POSTNATALE PSIGOLOGIESE WELSTAND VAN DIE MOEDER

**Sleutelterme:** *swangerskap, geboorte, postpartum-periode, moederskap, psigologiese welstand, hipnose, hipnoterapie, Ericksoniaanse terapie, egostaat-terapie*

Die doel van hierdie studie was om 'n prenatale hipnoterapeutiese program te ontwikkel en die effek daarvan te evalueer op die handhawing en bevordering van postpartum psigologiese welstand van 'n groep vroue wat 'n eerste swangerskap ervaar.

Relevante literatuur oor swangerskap, moederskap en psigologiese welstand is geanaliseer ten einde die belangrikste fasette en perspektiewe te abstraheer, om as agtergrond te gebruik vir die ontwikkeling en implementering van 'n intervensieprogram vir die fasilitering van psigologiese welstand van moeders wat vir die eerste keer swanger is. Teoretiese perspektiewe op kliniese hipnose, en die praktiese toepassing daarvan, is ondersoek en benut as basis vir die ontwikkeling van die hipnoterapeutiese intervensie. 'n Hipnoterapeutiese program is daarna ontwikkel, gebaseer op bestaande teoretiese kennis oor swangerskap, geboorte en moederskap, en kliniese hipnose, met spesifieke klem op beginsels van Ericksoniaanse terapie en egostaat-terapie, verryk met die perspektief van psigofortologie.

Die empiriese ondersoek het bestaan uit 'n kwantitatiewe en 'n kwalitatiewe gedeelte. In die kwantitatiewe deel is 'n voortoets-natoets-opvolg-vergelykende ontwerp gebruik, met ewekansige toekenning van die eksperimentele en kontrole-deelnemers met enkele praktiese beperkinge. Beide groepe, elk bestaande uit 23 vroue in hulle eerste swangerskap, het die volgende vraelyste voltooi: (i) *Perception of Labour and Delivery Scale* (PLD), aangepas uit Padawer et al. (1988), *Feelings about the baby and relationship with the baby* (FRB), aangepas uit Woollett en Parr (1997), *Maternal Self-confidence Scale* (MSC), aangepas uit Ruble et al. (1990), en die *Maternal Self-efficacy Scale* (MSE) (Teti & Gelfand, 1991), om aspekte van psigologiese welstand wat verband

hou met vroeë moederskap te ondersoek; (ii) die *Edinburgh Postnatal Depression Scale* (EPDS) van Cox et al. (1987) en die *General Health Questionnaire* (GHQ) (Goldberg & Hillier, 1979), om aspekte van psigologiese welstand, soos blyk uit die afwesigheid van patologie te ondersoek; en (iii) die *Satisfaction with Life Scale* (SWLS) (Diener et al., 1985), die *Affectometer 2* (AFM) (Kammann & Flett, 1983), die *Sense of Coherence Scale* (SOC) van Antonovsky (1979), en die *Generalized Self-Efficacy Scale* (GSE) (Schwarzer, 1993), om algemene psigologiese welstand te ondersoek. Die *Stanford Hypnotic Clinical Scale* (SHCS) (Morgan & Hilgard, 1978) is toegepas om die eksperimentele groep se hipnotiseerbaarheid te bepaal. Die kwalitatiewe gedeelte het bestaan uit indiepte-onderhoude met moeders in die eksperimentele groep asook 'n analise van geskrewe response waarin hulle kommentaar gelewer het oor hulle ervaring van die impak van die program, twee weke nadat hulle babas gebore is, en ook weer tien weke postpartum.

Resultate van die empiriese studie het getoon dat die eksperimentele groep tydens die prenatale evaluasie beduidend meer simptome van depressie en simptomatologie getoon het as die kontrolegroep. Aangesien die eksperimentele groep op psigologiese vlak waarskynlik meer kwesbaar was as die kontrolegroep, kon die effek van die intervensieprogram nie vasgestel word deur slegs die postnatale tellings tussen die twee groepe te vergelyk nie. Daarom is besluit om die verskille binne beide die eksperimentele en kontrolegroep, asook tussen die eksperimentele en kontrolegroep te ondersoek deur gebruik te maak van die gemiddelde verskiltellings tussen prenatale en postnatale, en opvolg-evaluasie vir elke veranderlike.

Beduidende verskille binne die eksperimentele en kontrolegroepe dui daarop dat die hipnoterapeutiese program effektief was in die bevordering van die meeste aspekte van psigologiese welstand in die eksperimentele groep. Hierdie verhoogde belewing van psigologiese welstand was teenwoordig beide in die onmiddellike postpartum tydperk (twee weke postpartum) en tien weke na die bevalling. Die kontrolegroep het op twee weke postpartum hulle vlak van psigologiese welstand gehandhaaf, en teen tien weke postpartum 'n spontane toename in psigologiese welstand getoon. Dit dui daarop dat die program daartoe bygedra het dat moeders in die meer kwesbare eksperimentele groep gouer ná die bevalling 'n toename in psigologiese welstand ervaar het.

In die vergelyking van die eksperimentele en kontrolegroepe op grond van die gemiddelde verskille in prenatale teenoor postnatale tellings op alle veranderlikes, blyk dit dat die hipnoterapeutiese intervensie bygedra het tot 'n verhoogde belewing van

psigologiese welstand in moeders in die eksperimentele groep, soos ervaar twee weke na die bevalling. Die beduidendheid van verskille was egter minder opvallend teen tien weke na die bevalling. 'n Belangrike bevinding was dat moeders in die eksperimentele groep steeds verhoogde psigologiese welstand ervaar het soos blyk uit die afname van patologie, spesifiek simptome van depressie en algemene simptomatologie. Bevindinge van die kwantitatiewe studie is ondersteun deur die geskrewe response en kommentaar van moeders in onderhoude wat twee en tien weke postpartum gevoer is as deel van 'n kwalitatiewe verkenning van hulle ervaring van die program en die impak daarvan. Hierdie bevindinge bevestig dat 'n hipnoterapeutiese program wat fokus op die bevordering van psigologiese sterktes en innerlike hulpbronne, depressie en psigologiese simptomatologie tydens swangerskap en die postpartum tydperk kan verlig, en die toename daarvan kan voorkom.

Bevindinge van hierdie studie dui daarop dat die prenatale hipnoterapeutiese program wat ontwikkel is, effektief was in die bevordering van die psigologiese welstand van moeders wat 'n eerste swangerskap ervaar. Aanbevelings vir toepassing in die praktyk, asook vir verdere navorsing, is gemaak.

Die bydrae van die huidige studie is geleë in die feit dat dit die eerste studie is om swangerskap, geboorte en moederskapvanuit 'n salutogeniese/fortigeniese perspektief te ondersoek, en om hipnoterapie in hierdie konteks aan te wend om psigologiese welstand te bevorder. Die studie dra by tot wetenskaplike kennis op die terreine van ontwikkelingspsigologie, psigofortologie en kliniese hipnose.

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# CHAPTER 1

# INTRODUCTION, PROBLEM STATEMENT AND AIMS

## 1. INTRODUCTION AND PROBLEM STATEMENT

The experience of pregnancy, childbirth and early motherhood is a universal developmental step shared by most women at some stage in their lives. From the field of psychology, interest in this developmental phase commenced towards the middle of the previous century, with authors mainly focusing on psychoanalytic aspects of pregnancy, referring to pregnancy as a "developmental crisis" (Bibring, 1959; Deutsch, 1945). Later more attention was given to aspects related to the relationship between mother and infant, especially the role of attachment and bonding shortly after the birth of a baby (e.g. Bowlby, 1969; Klaus & Kennell, 1982). It then started to be generally accepted that the childbearing years could be viewed as a normal developmental phase with certain developmental tasks to be completed (Grossman, Eichler & Winickoff, 1980; Lederman, 1996; Zwelling, 2000a).

Psychological research regarding this life transition has tended to focus on aspects such as pathology associated with pregnancy (e.g. Affonso, Lovett, Paul, Sheptak, Nussbaum, Newman et al., 1992; Elliot, Rugg, Watson & Brough, 1983; Green, 1998; O' Hara, Zekoski, Philipps & Wright, 1990), and the postpartum period (e.g. Campbell, Cohn & Meyers, 1995; Boath & Henshaw, 2001; Cutrona & Troutman, 1986; Elliot, Leverton, Sanjack, Turner, Cowmeadow, Hopkins et al., 2000). There has also been interest in psychological aspects of the birth experience (e.g. Padawer, Fagan, Janoff-Bulman, Strickland, & Chorowski, 1988; Tulman & Fawcett, 1991) and pain control during labour (Lowe, 1991,1993), as well as adjustment to motherhood (e.g. Leifer, 1980; Mercer, 1986; Reece & Harkless, 1998; Rubin, 1984). From the field of nursing much have been written regarding childbirth preparation and education (e.g. Nichols & Humenick, 2000), but understandably the focus was more on the preparation for the physical experience of labour. However, there seems to be growing support for the role of psychological variables in the preparation for childbirth and parenthood (Black-Olien, 1993; Dragonas & Christodoulou, 1998; Midmer, Wilson and Cummings, 1995).

It is clear that existing research has tended to focus more on pathological aspects associated with pregnancy and childbearing (Green & Kaftersios, 1997; Smith, 1999). Although valuable information can be gained from a pathogenic perspective regarding the prevention and treatment of distress during pregnancy, childbirth and early motherhood, it is generally accepted that life transitions also provide an opportunity for maturation and growth. Currently there seems to be a lack of knowledge regarding the nature and manifestation of more positive aspects of psychological functioning during this developmental phase (Wilkinson, 1995), as well as regarding psychological interventions that could maintain or enhance aspects such as positive affect and feelings of self-efficacy. Further, attempts to prepare new mothers for the transition to motherhood, have mostly focused on education for labour and aspects such as breastfeeding in the postpartum period. From the field of psychology, most interventions up to the present have focused on the marital relationship, addressing aspects such as communication and preparation for parenthood (e.g. Black-Olien, 1993; Cowan & Cowan, 1995). Interventions including psychological aspects of pregnancy, childbirth and early motherhood, to prepare the mother individually, are few, and have not been widely implemented.

To address this shortcoming in previous research on the transition to motherhood, the current study is conceptualised from a salutogenic/fortigenic perspective, where the focus is placed on health, strengths, capacities and wellness (cf. Wissing, 2000). The salutogenic perspective or paradigm is closely associated with the work of Antonovksy (1979, 1987), who is generally seen as one of the first researchers to propose the study of health instead of disease. He coined the phrase "salutogenesis", meaning the origins of (physical) health. On a philosophical level, salutogenesis differs from pathogenesis or a pathogenic perspective in the sense that the focus is placed on studying "the mystery of health" (Antonovsky, 1996) in a world where stressors and risk factors are omnipresent. The term "fortigenesis" refers to strengths in general, including physical and psychological factors (Strümpfer, 1995). The salutogenic perspective is also expressed in the current focus on positive psychology (e.g. Seligman & Csikszentmihalyi, 2000).

From a salutogenic/fortigenic perspective, it is important to appreciate the fact that pregnancy, as a developmental transition, provides the opportunity for women to mature and grow in a psychological sense. Further, it suggests that within this stressful transition, there might be factors contributing to the maintenance or promotion of the well-being of women. Finally, a study from a salutogenic/fortigenic

perspective aims to address aspects such as alleviating current distress, preventing future pathology, maintaining current well-being and promoting psychological well-being. The focus is therefore on the utilisation and mobilisation of pregnant women's resources within the context of the transition to motherhood.

Since there seems to be a lack of knowledge regarding the more positive aspects of pregnancy, childbirth and early motherhood, as well as a lack of intervention programmes addressing the psychological changes experienced by new mothers specifically, it can be argued that the development of such a programme deserves research attention. Although there are various therapeutic approaches that could be applied, hypnotherapy can be seen as an approach that could be considered to prepare first-time mothers psychologically for their developmental transition.

Hypnosis has been used for centuries to assist women in coping with the pain of labour and delivery. Recently, hypnosis has also been shown to play an important role in women's health care in general (Hornyak & Green, 2000), and in addressing psychological aspects of labour and delivery specifically (McCarthy, 1998, 2001; Oster & Sauer, 2000). However, there is still a lack of empirically validated hypnotherapeutic interventions to address the psychological changes and challenges associated with the transition to motherhood, and more rigorous research is needed to determine whether hypnosis has a beneficial effect on women's psychological well-being before, during and following childbirth (Irving & Pope, 2002). Two hypnotherapeutic approaches that could be useful in addressing these issues from a fortigenic perspective, are the Ericksonian approach and ego state therapy.

An Ericksonian approach values the inner resources of each individual, that enable her to deal with her life circumstances (Gilligan, 1987; Zeig & Rennick, 1991). Walters and Havens (1994) have explicitly linked the Ericksonian approach to the paradigm shift towards wellness and well-being. Techniques from the ego state therapy model, such as ego-strengthening and the mobilising of inner resources as developed by Phillips and Frederick (1995) as well as Frederick and McNeal (1999), can also be incorporated in an intervention aimed at facilitating psychological well-being. Until recently, most of the research in the field of hypnosis in general has focused on alleviating distress and current pathology. Although Ericksonian and ego state therapy approaches explicitly acknowledge the existence of resources within an individual, there is a virtual absence in the literature regarding the application of

hypnotherapy in the prevention of pathology or the promotion of well-being, with the exception of the work by Walters and Havens (1993, 1994).

Within the context outlined above, the current study mainly attempts to promote first-time mothers' experience of psychological well-being by means of a hypnotherapeutic intervention programme. The main question that needs to be answered, is: Can the psychological well-being of first-time mothers be maintained and/or promoted by a hypnotherapeutic intervention that is based on principles of existing inner resources?

## 2. AIMS

In view of the aforementioned, the aims of this study are:

1. To explore and explicate relevant literature on pregnancy, early motherhood and psychological well-being, in order to abstract important facets and perspectives to utilise as a background for the development and implementation of an intervention programme for the facilitation of psychological well-being in first-time mothers.
2. To explore and explicate theoretical perspectives on, and practical applications of, clinical hypnosis, as a background for the development of a hypnotherapeutic intervention programme for the maintenance and facilitation of psychological well-being of first-time mothers.
3. To develop a hypnotherapeutic programme based on existing theoretical knowledge regarding pregnancy, childbirth and early motherhood, as well as clinical hypnosis, with specific emphasis on Ericksonian principles and ego state therapy techniques.
4. To evaluate the effect of such a hypnotherapeutic intervention programme on the psychological well-being of first-time mothers in a two-group pretest-posttest-follow-up comparative design, as indicated by aspects such as perception of labour and delivery, experience of relationship with their babies, level of maternal self-confidence and maternal self-efficacy, levels of depression and symptomatology, levels of life satisfaction, affect balance, sense of coherence and experience of general self-efficacy.

## 3. BASIC HYPOTHESIS

The basic hypothesis of this study is that women who take part in the intervention programme will, in comparison to the control group, experience higher levels of psychological well-being postpartum as indicated by aspects such as perception of labour and delivery, experience of relationship with their babies, levels of maternal self-confidence and maternal self- efficacy, levels of depression and symptomatology, levels of life satisfaction, affect balance, sense of coherence and experience of general self-efficacy.

## 4. POSSIBLE SIGNIFICANCE OF THE CURRENT STUDY

The current research can make contributions to the field of psychology in general, as well as to related fields such as obstetrics and nursing.

Firstly, the study could contribute to scientific knowledge regarding the transition to motherhood, as conceptualised from a salutogenic and fortigenic perspective, while on a practical level, the envisaged programme could complement current childbirth preparation classes by addressing psychological aspects related to childbearing.

Secondly, the current study can make a theoretical contribution to the field of psychofortology, since there is still a need for more research into factors related to the promotion and maintenance of psychological well-being in general, and in understanding psychological well-being as it manifests in specific populations, contexts, and groups.

Finally, the study could make a contribution to scientific and clinical understanding of hypnosis as therapeutic intervention strategy. Since research in the field of hypnosis was often limited to laboratory studies, the current research could make an important contribution in empirically evaluating the effect of a hypnotherapeutic intervention.

In sumary, on a theoretical level the study could contribute to an expanded application of the Ericksonian approach and ego state therapy, by embedding them in a fortigenic meta-perspective. On a practical level, it provides an empirical

evaluation of a strengths-based intervention to maintain and promote psychological well-being.

## 5. OVERVIEW AND SCOPE OF THE CURRENT STUDY

It has been argued that there is still a need for empirical understanding regarding the promotion and maintenance of psychological well-being during pregnancy, childbirth and early motherhood. Further, it has been suggested that hypnotherapy could be a suitable therapeutic approach to achieve this. The aim and hypothesis of the study have been presented and its possible scientific contribution has been indicated. In Chapter 2, pregnancy and early motherhood will be explored from a salutogenic/fortigenic perspective, and the nature of psychological well-being will be explicated. In Chapter 3, hypnotherapy as a therapeutic intervention strategy will be described, with specific reference to the Ericksonian approach and ego state therapy. A prenatal hypnotherapeutic programme will be developed and then presented in Chapter 4, while the empirical study will be outlined in Chapter 5. In Chapter 6 the data will be presented and interpreted. Final conclusions will be given in Chapter 7, against the background of existing literature.

# CHAPTER 2

# PREGNANCY, EARLY MOTHERHOOD AND PSYCHOLOGICAL WELL-BEING

## 1. INTRODUCTION

Pregnancy can be seen as a major life event during which a woman typically experiences profound physiological, emotional and interpersonal changes (Blum, 1980; Deutsch, Ruble, Fleming, Brooks-Gunn & Stangor, 1988; Zwelling, 2000a). Pregnancy, childbirth and early parenting experiences can therefore be seen as important milestone events in the lives of those who experience them. Although much have been written about physical and emotional difficulties related to the transition to motherhood (e.g. Lederman, 1996; Offerman-Zuckerberg, 1980), childbearing is not a state of ill health but rather an altered state of health that requires a unique approach (Tisdall, 1997). While pregnancy is a life event that most women go through without major long-term physical or emotional problems, the tendency in research has been to look for, and cure problematic aspects (pathogenic perspective). According to Smith (1999), this presents a narrow and one-sided picture of the experiences of women during pregnancy. In the current study, childbearing will be viewed from a wellness perspective, focusing on the potential for maintenance and growth in psychological well-being during this life transition. As Offerman-Zuckerberg (1980) points out, women who accomplish this developmental task can come out stronger, more integrated, healthier and more mature. In this chapter, psychological aspects related to the transition to motherhood, the nature of psychological well-being, and the manifestation of psychological well-being in early motherhood will be explicated.

## 2. THE TRANSITION TO MOTHERHOOD

Pregnancy can be viewed as a period of transition between two life-styles or states of being (Bergum, 1997; Colman & Colman, 1971; Lederman, 1996). Moving from pregnancy to childbirth has been described as a developmental process with several incremental steps, in which there can be no return to the former self (Lederman,

1996). In this sense some personal conflict and resistance to change can be expected as part of the adjustment process. Although pregnancy has been described as a crisis (e.g. Bibring, 1959), Lederman (1996) argues that a sense of crisis is only felt when the woman's two life-styles can not be reconciled, and when the developmental step is too large to make in nine months. In similar vein, Zwelling (2000a) maintains that meeting the changes during pregnancy and early parenthood can be seen as a stressful developmental task, but whether it becomes a crisis or not, depends on the expectant parents' resources and their perception of the event.

Lederman (1996) further conceptualises childbirth as a test that comes as part of growth and as a challenge, rather than as a crisis. She maintains that this represents a more optimistic view of childbearing and better recognises the creativity or complexity of the event. Nicolson (1998) similarly points out that motherhood can be rewarding and stimulating, bringing new opportunity for exploring a woman's capacities, while Young (1984) maintains that a woman is not merely waiting: she is moving, growing and changing as a source of and participant in a creative process. The current author is of the opinion that Lederman (1996), Nicolson (1998) and Young (1984) possibly conceptualise pregnancy and childbirth more from a wellness perspective than a pathogenic perspective. Other authors also recognised the adaptive and developmental process of pregnancy, such as Antonucci and Mikus (1988), Grossman, Eichler and Winickoff (1980), and Trad (1991).

It is evident that the transition to motherhood is generally accepted as a normal developmental process, bringing with it potential for maturation and growth. Although much has recently been written regarding psychological experiences during pregnancy, surprisingly little is known regarding the nature and manifestation of psychological well-being during this period. It is, however, important to first consider current knowledge regarding psychological aspects related to pregnancy, birth and early motherhood.

## 3. THE PSYCHOLOGICAL EXPERIENCE OF PREGNANCY, BIRTH AND EARLY MOTHERHOOD

Childbearing is often seen as a stressful event (Tisdall, 1997), and according to Dias and Lobel (1997), a first pregnancy is especially stressful since it is an unfamiliar experience. Being pregnant also includes more than the physical experience. As

Zwelling (2000a) explains, it is a holistic experience that influences the psyche, social interaction and cognitive processes. Stern (1999) describes the psychological experience of the pregnant woman as a psychological pregnancy, consisting of psychological transformations that prepare her for profound identity changes.

Recent work from authors focusing on childbirth education have begun to acknowledge the importance of psychological factors in the preparation for childbirth (e.g. Nichols and Humenick, 2000), but in the field of psychology, little has been written regarding the psychological experience of pregnancy from a salutogenic perspective. Much of the psychological literature has focused on biological and hormonal effects of pregnancy, or on pathological responses to maternity, rather than on normal development (Leifer, 1980). In this section, the psychological aspects of pregnancy, childbirth and the postpartum period will be explored as a foundation for the understanding of the possibilities for growth and psychological well-being.

## 3.1 Psychological aspects of pregnancy

### 3.1.1 General experiences during pregnancy

Psychoanalytic writers were the first to recognise the complexity of the psychological tasks of pregnancy and motherhood. Their focus was, however, primarily intrapsychic and they viewed childbearing and childrearing as the exclusive tasks of women (e.g. Bibring, 1959; Deutsch, 1945). Presently it is generally accepted that pregnancy provides the opportunity to prepare for motherhood (Lederman, 1996; Mercer, 1986; Rubin, 1984; Smith, 1999; Zwelling, 2000a). Zwelling (2000a, p. 35) eloquently describes this psychological experience as follows: "It can be the fulfilment of the deepest and most powerful wish of a woman, an expression of creation and the development of a new 'self' as the woman prepares to assume the mothering role."

Zwelling (2000a) further argues that there is a certain distinctive quality of inner experiences during pregnancy that sets it apart from life at any other time. Similarly, Colman and Colman (1971) consider pregnancy to contribute to the experience of an altered state of consciousness, while Offerman-Zuckerberg (1980) emphasises the increasing role of fantasy and an inward focus during pregnancy. This increased attention to the self can be seen as a process of refuelling, which is vital to

adjustment during pregnancy (Offerman-Zuckerberg, 1980), but it can also be seen as a process of developing a bond with the fetus and to increase psychological preparedness for parenthood (Leifer, 1980).

Despite general acknowledgement of certain psychological experiences during pregnancy there seems to be an absence of objective standards to interpret emotional experiences, since much of the information provided to pregnant women focuses only on the physiological changes (Dias & Lobel, 1997). These physical changes are the most concrete changes during pregnancy, leading to pregnancy often being viewed as primarily a physical experience (Zwelling, 2000a).

Much has been written regarding the psychological experience of pregnancy from the pathogenic view, with conflicting results. Some studies suggest that symptoms of anxiety and depression are common during pregnancy (e.g. Affonso et al., 1992), whereas other studies have found that when such symptoms occur, they are not of clinical significance (Rofé, Blittner & Lewin, 1993). It has also been noted that physiological changes in pregnancy could contribute to emotional distress, especially related to weight gain and changing body shape (Cameron, Grabill, Hobfoll, Crowther, Ritter & Lavin, 1996). Even when "normal adjustment" to pregnancy has been investigated, the focus has been on symptoms such as anxiety, somatic complaints and depression (e.g. Dragonas & Christodoulou, 1998; O'Hara, 1995; Otchet, Carey & Adam, 1999).

When the literature on pregnancy is reviewed from a wellness perspective, some reports do occur of an increased sense of well-being, with feelings such as pride, joy, satisfaction and a sense of purpose, despite the fact that typical anxieties associated with pregnancy also feature (Leifer, 1980). However, a study by Striegel-Moore, Goldman, Garvin and Rodin (1996) does not support the notion that pregnancy is either a time of significant emotional turmoil or of heightened emotional well-being. There is obviously still a lack of knowledge regarding the experience of psychological well-being during pregnancy.

If pregnancy is seen from the perspective of being a preparation for motherhood, two aspects that need to be further explored are role adjustments and maternal attachment. Thereafter the nature of the psychological experience during the stages of pregnancy will briefly be presented.

#### 3.1.1.1 Role adjustments

Pregnancy entails entering into the role of a pregnant woman, and starting to prepare for the role of being a mother (Lederman, 1996; Zwelling, 2000a). This implies adjustments to be made within the family structure as women move from their daughter/partner role to the role of a potential mother (Tisdall, 1997). A good relationship with one's mother is associated with a solid foundation for the development of a motherhood identity (Lederman, 1996; Mercer, 1986).

Rubin (1984) argues that with each childbearing experience, a new dimension is incorporated into a woman's self-system, namely a maternal identity. Rubin (1984) further states that the new mother needs to conserve the intactness of her own identity and family system, while simultaneously accommodating the infant into the same self and family system. According to Lederman (1996), the new mother prepares for her new role by envisioning herself as a mother, thinking about the characteristics one wishes to have as a mother, and anticipating future life changes that will be necessary. Both Lederman (1996) and Trad (1991) view the identification with the motherhood role as the goal of the developmental step from woman-without-child to woman-with-child. It is taken by degrees and is a process of unfolding.

It is clear that the gradual unfolding of role adjustments is an important aspect in the psychological experience of pregnancy and that it should be addressed in any intervention with pregnant women. In the current study, the development of motherhood identity will be facilitated as part of the envisaged programme (see Chapter 4).

#### 3.1.1.2 Developing of maternal attachment

It is now generally accepted that the pregnant mother bonds or affiliates with her unborn child in a way analogous to the formation of the mother-infant relationship after birth (Brockington, 1998; Lederman, 1996), therefore the development of maternal attachment to the infant is part of an overall process that commences well before the actual birth of the baby. During pregnancy, fetal movement often serves as a stimulus from which mothers elaborate and attribute certain human characteristics to the baby in her womb.

According to Lederman (1996) certain behaviours that indicate attachment include recognition of the individuality and attributes of the fetus/child, imaginative role rehearsal, thoughts about giving of oneself to the child, and fantasy about interacting with the child. Maternal attachment in pregnancy is often embodied in the process of envisioning motherhood. It also includes, among others, the selection of names, talking to the fetus and touching and stroking fetal parts through the abdomen (Lederman, 1996). Maldonado-Duran, Lartigue and Feintuch (2000) emphasise the importance of this prenatal relationship with the baby and its role in preparing the pregnant woman for motherhood. It has been suggested that the pregnant mother's tie to her unborn child may be of critical importance for the development of the well-being of the child and the mother (Benoit, Parker & Zeanah, 1997; Priel & Besser, 1999).

There has been evidence of an association between attachment to the fetus during pregnancy and maternal feelings for the baby after the birth (Leifer, 1980). Similarly, some researchers have found that parents' working models of their infants develop prior to birth, and remain relatively stable into early infancy (Zeanah, Keener, Stewart & Anders, 1985). It further seems that prenatal mental representations of their infant were related to infants' behaviour at 6 months postpartum (Zeanah et al., 1985). These findings are important with regard to facilitating prenatal maternal-fetal attachment, and subsequent maternal-infant relationships.

In the proposed programme, the importance of prenatal maternal-infant attachment will be acknowledged by facilitating the process by means of specific hypnotherapeutic interventions (see Chapter 4).

### 3.1.2 Psychological aspects related to the stages of pregnancy

#### 3.1.2.1 The first trimester

Under normal circumstances the first trimester is seen as a time of joy (Colman & Colman, 1971), but it can also be a time of considerable stress if the pregnancy was unplanned or unwanted. Both Mercer (1986) and Lederman (1996) maintain that pregnant women perform certain developmental tasks while making their transition to motherhood. The initial task is to accept the idea of pregnancy and assimilate it into her way of life. Reactions could vary from euphoria to doubt, as the ultimate consequences of her changed reality become clear. It is common to expect some

degree of ambivalence throughout pregnancy, even when clear choices have been made (Colman & Colman, 1971; Lederman, 1996; Zwelling 2000a). Emotional lability, feelings of detachment and a focus on physical changes are common in the first trimester (Brown, 1979; Zwelling, 2000a).

#### 3.1.2.2 The second trimester

During the second trimester there is often a sense of enhanced physical and psychological health for many women (Brown, 1979) and it is often experienced as the high point of pregnancy (Leifer, 1980). The pregnancy and developing fetus is now more real, especially with the onset of quickening (feeling the movement of the fetus). Differentiation from the fetus has been described as an important developmental task during this stage of pregnancy (Mercer, 1986; Offerman-Zuckerberg, 1980), since the pregnant woman has to accept the developing fetus as separate from herself, that is, a future child, rather as a part of the self.

During this stage of pregnancy women are often inclined to focus inward, developing their maternal identity. New interests relevant to childbearing are developed and there is a heightened interest in fetal growth and development. According to Brown (1979), the second trimester provides the time for the pregnant woman to begin examining how life will be after the baby's birth.

#### 3.1.2.3 The third trimester

Colman and Colman (1971) describe the experience of the third trimester as one of pride and fulfilment, together with anxious anticipation of the imminent unknown. During this stage women's focus shifts towards the imminent reality of and preparation for childbirth and wondering what it will be like (Maloney, 1985; Zwelling, 2000a), as well as the practical aspects of parenting (Brown, 1979; Zwelling, 2000a). Lederman (1996) views preparation for labour as a developmental task of the pregnant women during this phase of pregnancy, describing it as preparation for work and stress. The pregnant woman must take steps to reach a state of readiness, both through concrete actions and imaginary rehearsal. Preparation entails confronting one's fears and anxieties, and gearing up or "psyching up" for labour. Preparation for labour further means preparation for the physiological processes of labour, as well as the psychological process of separating from the fetus and becoming a mother to the child (Lederman, 1996; Zwelling, 2000a).

Because most women have some anxiety in facing the unknown, one way to cope with this anxiety is through learning as much as possible about labour beforehand (Lederman, 1996).

From a pathogenic perspective marked mood swings seem to be widely prevalent by the third trimester. In her study of first-time mothers, Leifer (1980) found that sixty percent of the women experienced a marked decrease in their ability to cope with stress, and that even minor frustrations could contribute to irritability and tension. However, Leifer (1980) also reports findings that can be interpreted from a salutogenic perspective. She found that feelings of well-being were less pronounced during the third trimester, but that for some women feelings of pride and fulfilment remained prominent, despite the experience of physical discomfort.

When evidence from the literature is considered, the third trimester provides a good opportunity for intervention with first-time mothers. They are ready to start considering the actual labour and delivery, as well as the reality of being a mother. This is also the time when women might experience more stress than previously in their pregnancy. In the current study the third trimester of pregnancy was therefore selected as an appropriate period for intervention.

### 3.1.3 Summary

The period of pregnancy can be described as a time of preparation for motherhood, associated with changes in the experience of self and relationships. Although references are often made in the literature to the maturational and developmental aspects of pregnancy, attention has mostly been given to pathological responses to pregnancy, and the normative manifestation of symptoms. It further seems that the third trimester could be utilised for interventions, since it is the time when the woman is more focused on the approaching labour and on the practical implications of motherhood.

## 3.2 Psychological aspects of labour and delivery

Childbirth has been described as a transcendent event of great psychological importance in a woman's life, shaping her thoughts about herself and affecting relationships with other family members (Brown, 1979; Nichols, 1996), as well as

having psychological effects long after the physical experience is complete (Nichols & Gennaro, 2000). The birth experience has further been described as a critical element in a mother's adjustment to parenthood and her new role (Antonucci & Mikus, 1988), as well as a test of womanhood, a peak experience and the first act of motherhood (Nichols & Gennaro, 2000). Still, most mothers experience some stress and anxiety during labour (Niven, 1992).

There seems to be a strong association between a woman's prior preparation for labour and delivery, and her actual responses to childbirth. Leifer (1980), in her study of first-time mothers, found that the better a woman was prepared and the more knowledgeable she was about techniques she could use to control the discomfort of labour, the better was her ability to maintain some mastery of the situation, to derive a sense of competence and gratification from childbirth, and to cope adequately with the hospital environment. If the available literature is viewed from a salutogenic perspective, it suggests that a positive experience of labour and delivery could contribute to the maintenance or enhancement of psychological well-being.

To be able to understand the psychological experience of labour and delivery, it is necessary to briefly describe the stages of labour, the experience of pain during labour and delivery and the experience of a caesarean section.

### 3.2.1 Stages of labour and delivery

#### 3.2.1.1 The first stage of labour

During the first stage of labour, the cervix dilates from one to about 10 centimetres, causing contractions to occur (Nolan, 1996). According to Colman and Colman (1971), a woman who is having her first baby might be pleased and excited at finally having reached this point in her pregnancy, but Turrini (1980) maintains that many women report feelings of extreme fright during early labour. At first contractions might be experienced as substantial, but not overwhelming. Towards the end of the first stage, labour contractions are closer to one another and lasts longer. According to Colman and Colman (1971), relaxation will be more difficult to achieve and the woman's attitude to pain will influence her experience of this stage. Towards the end of the first stage of labour the transition phase occurs. This is the phase when the baby is starting to move through the cervix. According to Colman and Colman

(1971), women could experience tremendous emotional turmoil inside, often feeling that they cannot control their contractions and that no-one around them seems to understand what they are going through. This is, however, quite a brief phase, after which the baby starts to move down the birth canal, and the woman can start to push. The first stage of labour usually lasts about 12 to 18 hours for a first baby (Nolan, 1996).

#### 3.2.1.2 The second stage of labour

The second stage of labour is referred to as the "pushing" phase, when the woman actually gives birth to the baby. It generally lasts about two hours for a first baby (Nolan, 1996).

Colman and Colman (1971) consider labour to be a challenging experience, even when it progresses smoothly. Women can face this challenge in various ways; some will see it as a peak experience where they participate in a major moment in the life cycle, whereas others might see it as a test of personal competence or as a test of their womanhood. Colman and Colman (1971) point out that there is no "correct" style of coping with labour and delivery. Rather, the individual life-style of each person and the expectations of the birth environment are important variables. The second stage ends when the baby emerges from the birth canal.

#### 3.2.1.3 The third stage of labour

The third stage of labour begins with the delivery of the baby and ends with the delivery of the placenta. The mean duration of third-stage labour is about 5 minutes. The contractions during delivery of the placenta are generally not painful (Nolan, 1996). At this stage most women have an overwhelming urge to see and hold their baby (Colman & Colman, 1971) and for most women it is particularly hard to be separated from the baby at this stage. The woman is now and forever indisputably a mother.

### 3.2.2 The experience of pain during labour and delivery

Much has been written about the experience of pain, and pain relief during labour and delivery. Although it has not always been explicitly stated, the way in which a woman experiences her delivery could have some psychological consequences (e.g.

Maclean, McDermott & May, 2000). The anticipation of labour pain could cause anxiety for many women, while actual pain in labour could act as a major stressor (Niven, 1992). It has been suggested that an extremely painful and unpleasant delivery could adversely affect the new mother's psychological well-being (e.g. McCarthy, 1998), and therefore it could be argued that the experience of pain during labour may have some bearing on a new mother's psychological well-being.

Nichols and Gennaro (2000) maintain that the birth experience need not be painless to be satisfying. A woman who feels that she was an active participant in the birth experience and that she was able to influence what happened to her, will most likely be satisfied with her delivery. The authors further mention that variables such as anxiety could influence the experience of childbirth pain and maternal coping. Lowe (1991, 1993) reports that there exists an inverse relationship between a woman's confidence in her ability to cope with labour, and perceived pain during the first stage of labour. In a phenomenological study of women's experience during childbirth, Lundgren and Dahlberg (1998) found that pain can be experienced as a natural part of the delivery process, and that the strength and the power to cope came from within the women. This coincides with a salutogenic view of pain as a challenge rather than a stressor.

However, there has been considerable debate for over a hundred years concerning the use of medication to relieve pain during childbirth. Pharmacological pain relief during childbirth has now become much more acceptable than a century ago. Current options to reduce pain in labour include gas and air, pethedine, epidural anaesthesia and spinal anaesthesia (Nolan, 1996). Although these methods seem to relieve pain while in labour, there is some evidence that the mother might have a more distanced experience of childbirth should medication be used (e.g. Leifer, 1980) or may be less satisfied with their labour (Nichols & Gennaro, 2000).

Currently support for non-pharmacological pain relief methods seems to be on the increase. Relaxation is often advocated as a technique for modifying the response to pain in childbirth (e.g. Humenick, Schrock & Libresco, 2000; Niven, 1992). For instance, Humenick et al. (2000) compiled a detailed account of various approaches to relaxation as part of a handbook for childbirth education (see Nichols & Humenick, 2000). Humenick et al. (2000) maintain that the benefits of using relaxation for active participation in birth have been found to carry over into the postpartum period, and include lower anxiety and depression, as well as positive outcomes such as

increased maternal self-esteem and improved immunology. Similarly, Steiner (2000) considers non-pharmacological pain management strategies such as relaxation and breathing techniques as lifelong skills that can be useful during childbirth and in other circumstances. This suggests that the facilitation of relaxation during labour and delivery could contribute to the postpartum experience of psychological well-being. It can be concluded that a prenatal programme should include some coping skills for dealing with pain and discomfort in labour.

### 3.2.3 The experience of caesarean section

Although caesarean childbirth is becoming more prevalent, much has been written about the adverse effects that could follow such an intervention (e.g. Miovech, Knapp, Borucki, Roncoli, Arnold & Brooten, 1994). Zwelling (2000b) mentions that feelings of guilt, anxiety, and loss of control are expressed by many women when delivery of the baby occurs by unexpected caesarean birth. Parents may feel as though they have lost control of a major event in their lives. Research done in the 1970s and 1980s found that women who had a caesarean birth may express negative feelings about themselves and have a lower level of self-esteem (see Zwelling, 2000b for a review).

However, it is possible that these reactions have changed. Lothian (1992) states that if women trusted their ability to give birth, a caesarean birth is not seen as a failure but as a sophisticated intervention in response to their bodies' protection of the baby. In the case of an elective caesarean, parents may have been able to work through negative feelings in advance, but if the birth was an emergency the initial shock may be greater for the parents in the postpartum period. Similarly, Reichert, Baron and Fawcett (1993) are of the opinion that parents' responses to a caesarean today seem more likely to be happiness and excitement surrounding the birth of a healthy baby, although some disappointment may still occur. Earlier Padawer, Fagan, Janoff-Bulman, Strickland and Chorowski (1988) found that, under optimal conditions, caesarean deliveries are not associated with adverse early psychological development. The experience of a caesarean section need therefore not necessarily lead to a decrease in psychological well-being, but there is some evidence that it could be beneficial for mothers to be psychologically prepared for a caesarean section.

### 3.2.4 Summary

Women have intense emotional experiences during childbirth, making it an event of great psychological importance. It has been suggested that a positive experience of childbirth could contribute to feelings of mastery and satisfaction, and therefore indirectly to enhanced psychological well-being, yet little is known about these positive emotions or how they could be facilitated. Most of the psychological literature has focused on the management of pain during labour and on pathological outcomes, and there is still a dearth of knowledge regarding the salutogenic aspects of childbirth. When a prenatal intervention aimed at promoting and maintaining psychological well-being is envisaged, it is therefore important to consider the psychological experience of childbirth and its impact on first-time mothers' psychological well-being.

## 3.3 Psychological aspects of the postpartum period

### 3.3.1 General considerations

The most characteristic mood experienced shortly after delivery seems to be a positive feeling of elation and relief that all has gone well (Brockington, 1998; Leifer, 1980, Niven, 1992). Brockington (1998) further suggests that these feelings of peace, fulfilment and accomplishment help to sustain mothers during the weeks of challenge to follow. However, initial feelings of elation might soon be followed by feelings of sadness and emotional lability (see paragraph 3.3.5 in this chapter). Mothers whose birth experiences have been more negative are likely to experience more negative feelings (Thune-Larsen & Moller-Pederson, 1988). The period immediately following childbirth is further described as a time of transition, a process where a woman assumes maternal tasks and appraises herself as a mother (Pridham & Chang, 1992). The transition continues until infant care and parenting issues no longer seem unfamiliar, usually around the third month postpartum. According to Pridham and Chang (1992), adjustment of mother and infant is at its height at 1 month postpartum. Although the end of the postpartum period is generally defined at 6 weeks after birth, Tulman and Fawcett (1991) report that recovery from childbirth encompasses more than restoration of pre-pregnancy physiological state, and that full recovery could take up to 6 months.

### 3.3.2 The experience of early motherhood

The initial phases of motherhood seem to be a time of emotional upheaval for most women (Barclay, Everitt, Rogan, Schmied & Wyllie, 1997; McVeigh, 1997; Niven, 1992). The rigorous requirements of the mothering role, of nurturing a helpless infant, could be seen as a severe test of a woman's capacities and resources. In her study of first-time mothers, Leifer (1980) found that the early postpartum period is a time of emotional stress far exceeding that experienced during pregnancy, while Mercer (1986) maintains that the first postpartum month is particularly difficult for new mothers, since they are then making many adjustments in their transition to motherhood.

A number of researchers investigated the concerns of mothers in the early postpartum period. Mercer (1986) found that, at one month postpartum, mothers' concerns revolved around their infant, lack of time for themselves, feelings of incompetence and sleep deprivation. Fatigue in particular seems to be a great stress-factor in the postpartum period (Barclay et al., 1997; McVeigh, 1997), and it has the potential to affect the quality of the early postpartum experience (Reeves, Potempa & Gallo, 1991). The new mother's self-confidence may be challenged once she is at home and responsible for childcare (Crouch and Manderson, 1993). A study by Pond and Kemp (1992) found that high levels of anxiety and low self-confidence might hinder the woman's adaptation to motherhood, while Tulman and Fawcett (1990) report that confidence in one's ability to cope and satisfaction with the motherhood role are strong correlates to the woman's capacity to reach functional status again. Other concerns in the immediate postpartum period include difficulties in organising one's life around a small infant as well as the need to have a predictable and manageable routine (Crouch and Manderson, 1993). An interesting finding by Barclay et al. (1997) as well as McVeigh (1997) was that most mothers felt that no-one had prepared them for the demands of early motherhood.

During the postpartum period women undergo a profound reconstruction in self (Barclay et al., 1997), and this process of change is not defined by a specific time frame (Martell, 2001). It is a process through which women reorganise their lives as mothers, described by Martell (2001) as "...heading towards the new normal". Although Rubin (1984) suggests that women become mothers by the end of the first month postpartum, it may take up to 12 months after birth (Mercer, 1986), as confidence improves and anxiety lessens as the baby becomes less demanding.

According to Mercer (1986), the second month postpartum can be described as the start of the achievement phase in the development of the maternal role. It is characterised by a sense of accomplishment, since the mother has become more skilled in caring for the infant and is less tired than in the first month postpartum. This phase can last up to 5 months postpartum.

Ewy-Edwards (2000) points out that the potential for growth and achievement of a higher developmental state exists during the transition to parenthood. Still, new parents often find that they are not ready for the life-style changes that occur when a new baby is incorporated into the family. There are often conflicting emotions in response to all the changes, such as joy, anxiety, confusion, overwhelming responsibility, love, helplessness and guilt. Ewy-Edwards (2000) argues that parents need empowering information, skills and support to help them become comfortable in their new roles.

It is obvious that many difficulties may be experienced in the first few weeks of motherhood, and that more could be done to foster positive experiences and psychological well-being during this period. However, the pathogenic perspective is also important in the current study, since theoretically these difficulties could be prevented or ameliorated by an effective intervention. Literature from a pathogenic perspective suggests that aspects such as fatigue, self-confidence, psychological preparation and coping skills could impact on the new mother's experience of early motherhood, therefore these aspects will also be considered in the compilation of the intervention programme.

### 3.3.3 Adjustment to motherhood

The emotional adjustment to the birth of a child requires that the woman incorporate the role of a mother into her personal identity. Most studies regarding adjustment to motherhood have been done from a pathogenic perspective, focusing on the consequences of failure to achieve satisfactory role attainment on the quality of mother-child interaction (e.g. Belsky, Rovine & Taylor, 1984) and on maternal psychological well-being (e.g. Grossman et al., 1980). Variables that seem to influence women's ability to achieve successful role attainment are, among others, maternal personality factors (Shereshefsky & Yarrow, 1973), social support (Crnic, Greenberg, Ragozin, Robinson & Bashman, 1983), a woman's relationship with her own mother (Shereshefksy & Yarrow, 1973), maternal-self-efficacy (Teti & Gelfand,

1991) and capacity to visualise oneself as a mother during pregnancy (Barnard & Martell, 1995). These findings suggest that an intervention aimed at promoting psychological well-being should consider factors related to the adjustment to motherhood. In the current study, variables such as maternal self-efficacy and ability to visualise oneself as a mother will be included in the intervention programme.

### 3.3.4 Maternal attachment

The attachment between a mother and her baby develops gradually during the first year of the infant's life (Bowlby, 1969; Klaus & Kennell, 1982). This bond is enduring and reciprocal. During the immediate postpartum period there seems to be a cascade of interactions between mother and baby, locking them together and ensuring further development of attachment (Klaus & Kennell, 1982). Leifer (1980) found the degree of emotional attachment toward the fetus during pregnancy to be related to the intensity of maternal feelings shown toward the baby after birth: women who were emotionally attached to the fetus before birth, were more likely to form more intense bonds with their infants initially and to experience a sense of continuity between their feelings toward the fetus and toward the actual baby.

These findings suggest that the fostering of maternal attachment has some implications for maternal psychological well-being, and that facilitating prenatal attachment could be beneficial to postnatal maternal psychological well-being.

### 3.3.5 Postpartum mood

Approximately 25-50% of all postpartum mothers develop a mild affective distress that may be short-lived (postpartum blues) within the first week following delivery (Brockington, 1998; Ewy-Edwards, 2000; Miller, 2002). The onset is usually within several days after childbirth, and the symptoms typically last for less than a week, although Miller (2002) states that it could last up to a few weeks. Frequent and prolonged bouts of crying, emotional lability and a sense of vulnerability are the most common symptoms (Brown, 1979). According to Brockington (1998), the essence of this experience is not depression, but a sudden, fleeting and unexpected mood change. Since this reaction is so common, it is often regarded as a normal reaction resulting from childbirth (Niven, 1992). It has been argued that maternity blues is simply the ending of the euphoria experienced shortly after delivery (Brockington,

1998), while Miller (2002) refers to the hypothesis that the mood changes could result from abrupt hormone withdrawal.

However, during the first months after delivery, 10-15% of mothers suffer from a longstanding depression that requires clinical intervention. Unfortunately, as Ewy-Edwards (2000) points out, women often hide their distress due to a sense of shame and guilt regarding their failure as a good mother. Postpartum depression is considered in more detail in paragraph 5.3.2 in this chapter.

### 3.3.6 Impact on the marriage

Much has been written on the effect of a new child on marriage, especially the first child. The birth of a new infant results in the reorganisation of the family system, with many changes in the roles and responsibilities of each family member. The transition to parenthood has often been described as a crisis for couples, with the premise that becoming a parent is a risk factor for individual and marital distress (Cox, Paley, Burchinal & Payne, 1999). However, Ewy-Edwards (2000) argues that the more prepared parents are for these changes, the more optimal their early parenting experience could be.

Cross-sectional studies have found a negative correlation between the presence of children and marital satisfaction (e.g. Glenn & McLanahan, 1982), while longitudinal studies showed linear declines in marital satisfaction (e.g. Feldman & Nash, 1984). However, parenthood may actually enhance some relationships and have little effect on others (Cox, 1985; Huston & Vangelisti, 1995). Cox et al. (1999) assumed that a variety of adaptations to the birth of a child are possible. In a longitudinal study that focused on the impact of a first child on the marriage, Cox et al. (1999) found little or no decrease in marital satisfaction among couples in which at least one of the spouses showed good problem-solving ability before the birth of the child, and where neither spouse had high symptoms of depression. In contrast, there seemed to be a risk for declining marital satisfaction when both spouses suffered from high levels of depression, neither spouse showed good problem-solving skills and the pregnancy was unplanned. Findings regarding the impact of a first child on the marriage during the first weeks of parenthood are inconsistent, but it remains an important aspect to be considered. However, in the current individualised programme the impact on the marriage will only be indirectly addressed by increasing the internal resources of the mother.

### 3.3.7 Summary

Early motherhood seems to be experienced by most mothers as exhausting and difficult. This is the period when the mother makes the actual transition to motherhood, acquiring her new role and making many adjustments. Much has been written regarding the difficulty of this period, but less is known about the experience or facilitation of psychological well-being. Since the transition to motherhood is a major life event, it is necessary to explore current practices to prepare new mothers for this transition.

## 3.4 Preparation for the transition to motherhood

### 3.4.1 Overview of childbirth preparation practices

The focus of prenatal intervention has mostly been on the preparation for the childbirth experience. The roots of formal childbirth education can be traced back to the period 1900 to 1950. During this time, Russian scientists Velvovsky and Nikolayev developed a method referred to as psychoprophylaxis, implicating the prevention of labour pain by psychological strategies rather than medication (Ondeck, 2000). At the same time in England, Grantley Dick-Read stated that pain is not necessarily inherent in labour and delivery, but rather is a result of cultural conditioning (Dick-Read, 1979, cited by Ondeck, 2000). Dick-Read developed the "Read-method", based on the belief that mind and body is an interacting whole (see paragraph 3.4.2 in this chapter).

The formalisation of childbirth education commenced with the work of Ferdnand Lamaze, a French physician who visited Nikolayev's clinic in Russia. This marked the spread of the psychoprophylactic method to Western Europe (Ondeck, 2000), where Lamaze modified the Russian method to suit French culture (see paragraph 3.4.3 in this chapter).

Nowadays childbirth education programmes are widely attended and continue to have an important impact on prenatal care. Most programmes have three elements in common (Ondeck, 2000):

- Information about the processes and procedures related to birth;
- Coping skills for comfort related to pain, and

- Emphasis on support from the labour partner.

There has also been a trend towards more openness to the inclusion of alternative therapies in childbirth education, such as mind-body techniques, one of which is hypnosis (see paragraph 3.4.4 in this chapter).

### 3.4.2 The Dick-Read method of childbirth education

Grantley Dick-Read believed that the fundamental cause of pain was fear. In his well-known work, *Childbirth without fear* (1944), Dick-Read advocated education for childbirth from the first prenatal visit. He further believed that civilisation had brought with it the fear of childbirth, with fear leading to tension and tension leading to pain. He postulated that if fear could be overcome, tension and pain will disappear. The training method Dick-Read developed included lectures on pregnancy, labour and delivery; a program of physical exercises to promote general health; relaxation exercises to reduce muscular tension and breathing exercises for pregnancy, labour and delivery (Ondeck, 2000).

Several large-scale studies have been done regarding the effectiveness of the Dick-Read method. Summarising these results, Hilgard and Hilgard (1994) conclude that these reports indicate that the Dick-Read method of childbirth preparation contributed to a decrease in the use of pharmacological pain relief during labour. In another review, Duncan and Markman (1988) conclude that outcome research suggests that women who went through these childbirth preparation programmes tended to report less negative affect during labour and delivery, experienced less pain during childbirth and used less medication.

### 3.4.3 The Lamaze method

The Lamaze method was named after the French obstetrician, Ferdnand Lamaze. Elements of the Lamaze method can be summarised as follows:

- Objective and specific teaching, including what to expect during a normal pregnancy;
- Utilising the Pavlovian thesis of relieving pain by eliminating fear;
- Respiratory exercises;
- Neuromuscular control through relaxation;

- Information regarding the appropriate responses during labour and delivery;
- Active participation by the expectant mother; and
- Including the expectant father in the training (Hilgard & Hilgard, 1994).

The effectiveness of the Lamaze method was evaluated in France by Chertok and his associates (Chertok, 1973). More than 200 women were involved in the study, which was based on the women's experience of the delivery. It was found that 49 percent of the prepared women experienced a "good" labour and delivery, compared to 27 percent of the unprepared group. Lamaze classes further seem to facilitate more positive feelings about the birth as well as the infant (see Duncan & Markman, 1988, for a review).

### 3.4.4 The role of hypnosis in childbirth education

The use of hypnosis training during pregnancy is well known and referred to by various authors such as Harmon, Hynan and Tyre (1990), Hilgard and Hilgard (1994), Irving and Pope (2002), McCarthy (1998, 2001), and Oster and Sauer (2000). The aim is usually to assist the mother in eventually coping with the pain of labour. Some women are then able to give birth solely with the use of hypnoanaesthesia, while others use it as an adjunct to chemical anaesthesia.

There have been many comparisons of self-hypnosis to the Lamaze technique when used for childbirth. Zahourek (1990) states that both hypnosis and the Lamaze technique could raise the woman's pain threshold through suggestion, while Marks (2000) points out that the Lamaze techniques resemble the hypnotic process, since the woman is taught relaxation, breathing exercises and imagery prior to labour. Hilgard and Hilgard (1994) note that there is some overlap or similarity between the third element of the Dick-Read method and hypnosis, but also point out that the mere fact that two methods overlap in their psychological consequences does not mean that they are identical. Features in common between the non-hypnotic methods and the hypnotic ones include the following:

- Relaxation;
- Controlled breathing; and
- Reassurance regarding the woman's ability to manage the stresses to be experienced.

According to Marks (2000), hypnosis differs from the Lamaze method in the sense that the woman possibly goes deeper into a state of relaxation with each breath while entering trance. Hilgard and Hilgard (1994) argue that hypnosis has an advantage over the Dick-Read and Lamaze methods because of its greater flexibility. Since hypnotherapists have been trained for a wider scope of problem situations, they tend to be more flexible and are therefore able to include any or all of the techniques used in the Dick-Read or Lamaze methods appropriate to their abilities and the characteristics of their practice and the client.

Hypnotic practices in childbirth preparation training will be discussed in more detail in Chapter 3. Here it is sufficient to say that traditional hypnosis childbirth preparation focused primarily on the reduction of pain during delivery, using hypnotherapeutic intervention strategies such as pain control, relaxation and posthypnotic suggestions. Only recently did McCarthy (1998, 2001) as well as Oster and Sauer (2000) begin to address psychological aspects of childbirth, such as reducing anxiety and enhancing satisfaction with the childbirth experience.

### 3.4.5 The role of childbirth education classes in promoting postpartum psychological well-being

Most childbirth education programmes focus on preparation for labour and birth, as well as reduction of pain in labour, although there is an implicit longer-term goal of fostering happier interpersonal relationships in the family (Duncan & Markman, 1988; Midmer, Wilson & Cummings, 1995). Authors focusing on childbirth education have recently begun to advocate a wider scope in these programmes. Humenick et al. (2000) suggest that in a good childbirth preparation course participants should acquire relaxation skills on which they could build for a lifetime, while Midmer (2000) similarly proposes that pregnant women could be helped to develop their internal locus of control and store of support, which could help them through childbearing but also through the difficult years of child-rearing.

However, in most childbirth education classes the adjustment to pregnancy or parenthood is rarely addressed (Barclay et al., 1997; Cowan & Cowan, 1995; O'Hara, 1994).) Indeed, a study by Nichols (1995), comparing couples who attended prenatal childbirth education classes to couples who did not, found no differences between the two groups on measures of prenatal attachment, childbirth satisfaction, parenting sense of competence and ease of transition to parenthood. Similarly,

Lumley and Brown (1993) found no differences in emotional well-being between women who attended childbirth education classes and women who did not. Further, Niven (1992) reviewed literature regarding the effect of antenatal classes on the experience of pain in labour, concluding that although pain and stress in labour were reduced to some extent, anticipatory anxiety was not lowered. Finally, Hayes, Muller and Bradley (2001) recently developed an antenatal education intervention that was tailored to the information needs of first-time mothers about perinatal depression, and examined its effect on postnatal depression. They found no difference between the experimental and control groups with regard to depression. These findings suggest that traditional childbirth education classes do not adequately address psychological aspects of the transition to motherhood.

### 3.4.6 Psychological preparation for labour and the transition to motherhood

There has been interest from the field of psychology regarding the psychological preparation for childbirth and parenthood, but few empirical studies have been done and even fewer have been as widely implemented as general childbirth education programmes. In one of the earliest studies, Gordon and Gordon (1959) showed in a pioneering study that prenatal education focusing on parenthood significantly improved maternal psychological health after delivery, but Stamp, Williams and Crowther (1995) could not replicate these results. Later Shereshefsky and Yarrow (1973) developed a prenatal programme for couples, focusing on helping women anticipate the stresses of pregnancy, childbirth and early parenting, as well as encouraging them to generate strategies for dealing with problems that are likely to emerge. Women who took part in the programme were found to be more successful in visualising themselves as mothers, to be more closely identified with their new family, to have functioned better during labour and delivery, and to be more positive about their postnatal marital relationship.

Various programmes focusing on the marital relationship have recently been developed (Black-Olien, 1993; Cowan & Cowan, 1995), and research indicates that such programmes contribute to postpartum marital adjustment. Midmer, Wilson and Cummings (1995) found that prenatal parenting communication classes had a significant impact on postpartum anxiety, postpartum marital satisfaction and postpartum adjustment of both parents. Although there has been some encouragement for the incorporation of such programmes in childbirth education

(Martell, 2001), curiously, not one of these programmes has been integrated and implemented on a wider scale.

Although early researchers have recognised the readiness of pregnant women to receive psychotherapy (see Shereshefsky & Yarrow, 1973, for a review), little has in fact been written regarding the role and application of psychotherapy as it specifically applies to pregnant women. In the available literature the focus was again mostly on pathology, such as the treatment of anxiety and depression during pregnancy (e.g. Brockington, 1998). There has been some recent interest in the preventive aspects of antenatal psychotherapy (e.g.. St-André, 1993; Trad, 1991), although the content of these interventions is only centred around the alleviation of current or previous pathology as seen from a psychodynamic perspective (e.g.. Raphael-Leff, 1991; St-André, 1993). There is clearly a lack of knowledge regarding the utilisation of pregnancy as a period for promoting and maintaining general psychological well-being.

### 3.4.7 Summary

Childbirth education is a common and generally accepted practice in modern obstetrics. While such programmes provide valuable information to new mothers regarding practical aspects of labour and the managing of an infant, there seems to be a lack of attention to the psychological aspects of their experience. From the perspective of the field of psychology there have been contributions regarding preparation for parenthood and some interest in psychotherapy during this specific developmental period, but there is still a need for more knowledge, especially regarding the facilitating of psychological well-being.

## 3.5 Conclusion

The transition to motherhood is characterised by profound psychological changes, and like most transitions in life, it has the innate potential for growth and maturation. Each stage of this transition, that is pregnancy, labour and the early postpartum period, has the potential for experiences that could maintain or promote psychological well-being. The literature reviewed indicates that much is known regarding pathological aspects during the transition to motherhood, but there is still a lack of knowledge regarding psychological well-being, and how it could manifest during this period. Further, there is also a lack of preparation programmes to address

the psychological experience of the transition to motherhood. There seems to exist a need for intervention to alleviate existing psychological distress experienced by pregnant women, to prevent pathology and to promote and maintain psychological well-being. To address this need in childbirth preparation, it is necessary to first explicate the nature of psychological well-being.

# 4. PSYCHOLOGICAL WELL-BEING

## 4.1 Introduction

Historically, the subject matter of psychology mainly focused on psychological dysfunction (Christopher, 1999; Ryff & Singer, 1996, Strümpfer, 1990). During the past two decades, however, a new paradigm seems to have emerged in the field of psychology (Strümpfer, 1990, 1995; Wissing, 2000; Wissing & Van Eeden, 1994, 1997). This paradigm is characterised by a focus on wellness and health, in contrast to the traditional focus on pathology. The essence of this paradigm will be explicated in this section. Relevant models and perspectives regarding psychological well-being will be described, and the selection of indicators that will be used to measure psychological well-being in the current study, will be motivated.

## 4.2 The evolving salutogenic and fortigenic paradigm

Psychology in general has long been associated with a pathogenic orientation, with the emphasis being placed on illness and vulnerabilities (Strümpfer, 1990). In reviewing possible reasons for this bias, Walsh and Shapiro (1983) suggest that much of psychopathology is obvious, readily observable, and measurable, while the definition, identification and measurement of psychological well-being is less concrete. Although research emerging from a pathogenic perspective led to important insights into human behaviour and experience, Wissing and Van Eeden (1997) are of the opinion that it is still limited in scope since no light is shed on human strengths and capabilities. In a similar vein, Christopher (1999) argues that although the concept of psychological well-being is crucial in psychotherapy, it receives little scientific attention. He notes that there are numerous publications devoted to increased understanding of pathology, while there are no journals specifically focused on psychological well-being. More recently, Seligman and

Csikszentmihalyi (2000) maintain that the exclusive focus on pathology resulted in a model of human beings lacking positive features that make life worth living.

However, interest in wellness and positive psychological functioning is not new. In the previous century, the focus on psychological well-being and positive mental health seemed to have peaked between the late 1950s and 1970s (Christopher, 1999). An important contribution to the field was the work of Jahoda (1958), who described positive criteria of mental health to replace descriptions of well-being as the absence of illness. Personality theorists also described well-being in terms of specific concepts such as self-actualisation (Maslow, 1968) or the fully functioning person (Rogers, 1961). However, empirical investigations and research regarding psychological well-being seemed to have been absent. It was only in the 1990s that a strong move towards empirical exploration, understanding and promoting of psychological wellness became evident again.

Antonovsky (1979, 1987) is generally seen as one of the first researchers to propose the study of health instead of disease. He coined the phrase "salutogenesis", meaning the origins of health. On a philosophical level, salutogenesis differs from pathogenesis in the sense that, in the former, the focus is placed on studying "the mystery of health" (Antonovsky, 1996) in a world where stressors and risk factors are omnipresent. Antonovsky (1987) developed the explanatory concept of "sense of coherence" to describe how people manage to stay well despite experiencing stressors. Strümpfer (1990, 1995), following Antonovsky (1987), proposes that interest in this field can be viewed in light of a new scientific paradigm that is evolving, describing it as a salutogenic paradigm rather than a pathogenic paradigm. Strümpfer (1995) suggests the more extensive concept of "fortigenesis", which means "origins of strength" and which could serve as a more holistic and embracing concept. In a salutogenic or fortigenic paradigm, the focus is placed on health, strengths, capacities and wellness (Wissing, 2000).

Wissing (2000) proposes using the term psychofortology (the science of psychological strengths) to refer to the scientific domain in which psychological wellness can be studied. In this sub-discipline of psychology, the nature, manifestations, patterns and origins of psychological well-being can be studied, as well as the ways in which psychological well-being can be enhanced.

Currently research into the field of psychological wellness is burgeoning (Ryan & Deci, 2001). The importance attributed to this evolving paradigm is evident in the fact that the millennial issue of *American Psychologist* (2000, Vol. 55, no 1) was devoted to the topic of "positive psychology". Seligman and Csikszentmihalyi (2000, p. 5) state: "The aim of positive psychology is to begin to catalyse a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities."

Recently Lampropoulos (2001) noted that positive psychology seems to be emerging as a renewed humanistic approach to the potential for happiness, strengthened by solid empirical research. What is especially significant to the current study is his view that psychotherapy should also be evaluated in terms of the ability to make life more fulfilling for clients, and that it should include aspects such as increasing positive experiences and promoting coping strategies, rather than merely eliminating symptoms.

It is clear that there is a strong move towards understanding and promoting psychological health and wellness. The current study is conceptualised from this salutogenic and fortigenic paradigm, and focuses on the enhancement and maintenance of psychological well-being during the life transition to motherhood. This conceptualisation differs largely from previous research in the field, where studies from a pathogenic paradigm have focused only on aspects such as depression, anxiety and difficulties in maternal-child attachment. As Walsh and Shapiro (1983) point out, explanatory models are powerful determinants of the way in which the world is perceived and interpreted. Such models function as filters, and often do so in self-fulfilling, self-prophetic ways. This study attempts to view the life changing event of early motherhood through another "filter", which could possibly contribute to a salutogenic understanding of pregnancy, birth and motherhood. It could also contribute to the enhancement of the psychological well-being and quality of life of women in this life phase.

To facilitate understanding of psychological well-being during early motherhood, it is first necessary to clarify what is meant by the concept of psychological well-being.

## 4.3 Perspectives on wellness

Despite the increased interest in psychological health, wellness and well-being, there seems to be no single definition of psychological well-being or no general explanatory model that is universally accepted. Several perspectives, models and constructs have been presented with the aim of explicating the essence of wellness. Some researchers such as Crose, Nicholas, Gobble and Frank (1992), Seeman (1989) and Witmer and Sweeney (1992) have proposed holistic models of wellness. Others have focused on different aspects related to psychological well-being, such as affect balance (Bradburn, 1969) and subjective well-being (Diener, 1984), while Ryff and Singer (1998) proposed a multidimensional model, describing six dimensions of psychological well-being. Models relating specifically to psychological well-being are beginning to emerge (e.g. Frederickson, 2001; Kumpfer, 1999; Lightsey, 1996; Ryan & Deci, 2000). However, there is still an absence of a coherent theoretical framework regarding the explanation or prediction of psychological well-being (Wissing & Van Eeden, 2002).

For the purpose of the current study, relevant holistic approaches to wellness will be briefly mentioned, and then models regarding psychological well-being in particular will be explicated.

### 4.3.1 Holistic models of wellness

Several researchers have presented a holistic model of wellness and well-being in an attempt to grasp the essence of optimal functioning. Seeman (1989) suggests a model from a human-system framework, where optimal functioning is achieved when organismic integration takes place. Witmer and Sweeney (1992) propose a holistic model that includes 11 characteristics desirable for optimal health and functioning. These characteristics are expressed through five life tasks. For the scope of this study, the holistic multimodel systems model of Crose et al. (1992) is relevant.

Crose et al. (1992) propose an expanded view of wellness, by presenting a multidimensional systems model (see Figure 1), which was developed for application within counselling psychology. Moderating variables such as culture, age and gender differences are taken into account. The model further emphasises individual strengths, coping patterns, adaptive mechanisms and potential for growth in individuals.

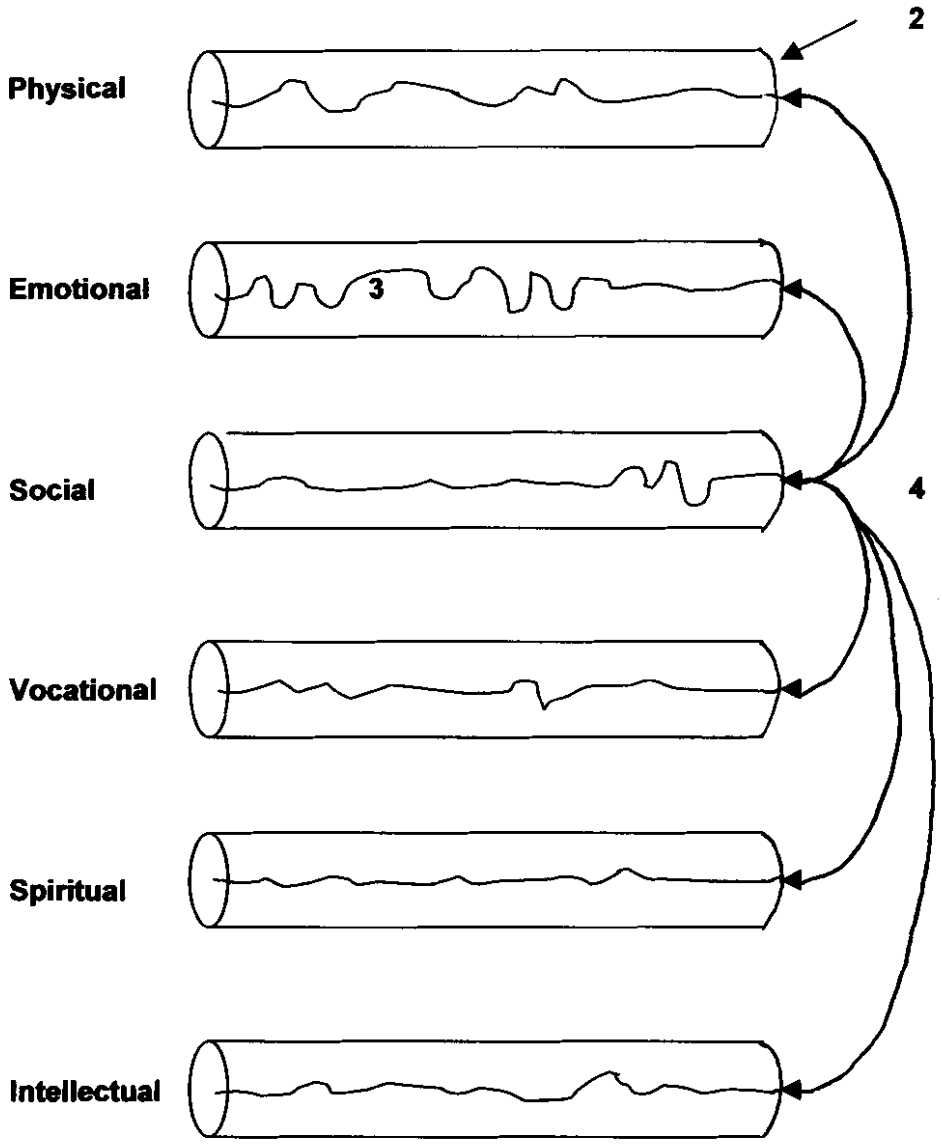



**FIGURE 1: A SYSTEMS MODEL OF WELLNESS**

Crose et al. (1992) distinguish four basic principles of health, which are:

- **Health is multidimensional:** According to this principle, health is seen as a construct consisting of various health domains or life dimensions. The dimensions suggested are: physical, emotional, social, vocational, spiritual and intellectual. All these dimensions could affect optimal psychological functioning.

- **Health is variable, not static:** Health is seen as a dynamic, fluctuating state that exhibits normal degrees of variability around upper and lower limits. This principle is illustrated graphically by cylindrical tubes. The upper and lower limits, as represented by the tube, set the range of normal variability. Within each tube there is constant fluctuation, as represented by the curving lines within each tube. Crose et al (1992) describe these patterns of variability as "reverberations" within each life dimension. Reverberations are defined as the unique differences that occur across gender, persons and culture.
- **Health is self-regulating within life dimensions:** The wave pattern inside each tube represents this principle. It fluctuates within normal range of variability, beginning at midrange, experiencing increased variability, and finally returning to midrange. This occurs via the cybernetic, self-regulating feedback process. According to this model, there is a normal range of variability within each life dimension.
- **Health is self-regulating across life dimensions:** Crose et al. (1992) propose that there are self-regulating, cybernetic feedback processes across life dimensions. This implies that a change beyond a certain threshold in one life dimension could potentially affect each of the other dimensions. The arrows in Figure 1 indicate this principle.

An important aspect of the model presented by Crose et al. (1992) is that health or well-being is variable and is affected by variables such as age and gender. This could imply that levels of well-being experienced by pregnant women might differ from levels of well-being experienced by non-childbearing women. Since this model addresses the uniqueness of the individual with regard to well-being, and because it draws attention to the fact that various dimensions of health (e.g. physical, emotional, social etc.) are important and may influence each other, it is a relevant model to be considered in the current study.

### 4.3.2 Models of psychological well-being

In an extensive review of literature related to psychological well-being, Ryan and Deci (2001) comment that the definition of psychological well-being is still controversial and unresolved. Christopher (1999) suggests that different theories and measurements of psychological well-being may best be thought of as different "takes" on the ideal person, which could be different for different cultural groups.

Perspectives on psychological well-being can be grouped by their focus on structure or dynamics in the conceptualisation of well-being.

#### 4.3.2.1 Models related to the structure of psychological well-being

On a meta-level, two perspectives can be distinguished with regard to the conceptualisation of the nature or the structure of psychological well-being. Following Waterman (1993), Ryan and Deci (2001) named these hedonism and eudaimonism.

##### 4.3.2.1.1 Hedonic perspective

From a hedonic perspective, psychological well-being consists of subjective happiness. It also concerns the experience of pleasure versus displeasure and includes judgements regarding the good and bad elements in life (Ryan & Deci, 2001). Within this perspective, the focus of research and intervention is on promoting and maximising happiness.

❒ Subjective well-being

Most research from the hedonistic perspective consists of assessing subjective well-being (e.g. Diener, 1984, 2000). The scientific study of SWB has developed in part as a reaction to the strong emphasis psychology has placed on negative states (Diener, Suh, Lucas & Smith, 1999). Subjective well-being (SWB) consists of three elements: life satisfaction, presence of positive affect, and absence of negative affect. These three elements are often combined to refer to happiness. SWB has been used as the primary indicator of well-being for the past 15 years, according to Ryan and Deci (2001).

Diener (2000) defines SWB as people's cognitive and affective evaluations of their life. High levels of SWB is hypothetically experienced when a person experiences many pleasant emotions and few unpleasant emotions, when she is engaged in interesting activities and when she is satisfied with her life. Diener (2000) identifies four separable components of SWB:

- *Life satisfaction*, which can be seen as a global judgement of one's life;
- *Satisfaction with important domains*, such as work satisfaction;

- *Positive affect,* as reflected by the experiencing of many positive emotions; and
- *Low levels of negative affect,* as reflected by the experience of few unpleasant emotions.

SWB should be seen as a general area of scientific interest, rather than a single specific construct (Diener et al., 1999). Subjective well-being or happiness can be measured in various ways. Two frequently used approaches are the measurement of life satisfaction (for example by means of the Satisfaction with Life Scale of Diener, Emmons, Larsen and Griffen, 1985), and the measurement of affect balance (e.g. by the Affectometer 2 of Kammann and Flett, 1983).

*(i) Life satisfaction*

Global life satisfaction refers to a cognitive judgement, based on the individual's own criteria, that she is satisfied with her life as a whole (Diener, 2000). Research regarding life satisfaction has shown that global life satisfaction is associated with the frequency of positive emotions (Emmons & Diener, 1985), as well as self-esteem and optimism (Lucas, Diener & Suh, 1996). Life satisfaction further seems to be related to satisfaction with self (Diener & Diener, 1995) and self-confidence (Diener & Fujita, 1995). In a South African sample, life satisfaction was found to be part of a general psychological well-being factor (Wissing & Van Eeden, 2002). In the current study, life satisfaction will be measured by the Satisfaction with Life Scale (Diener et al., 1985).

*(ii) Affect balance*

The presence of positive affect, together with the absence of negative affect, has often been used to describe a component of subjective well-being (Diener, 1984, 2000; Diener & Larsen, 1993; Ryan & Deci, 2001). This component of subjective well-being has also been described as emotional well-being, referring to experiencing mostly pleasant rather than unpleasant affect in one's life over time (Diener & Larsen, 1993). Therefore, it is rather the balance between positive and negative affect (with preponderance of positive affect) that is important, than a complete absence of negative affect.

According to Diener and Larsen (1993), emotion plays a central role in subjective well-being. They argue that people seem to feel some affect during most of their

waking life, and all affect seems to be either pleasant or unpleasant. Affect or emotion will consequently influence people when they evaluate their well-being, as affect continually contributes pleasantness or unpleasantness to an individual's personal experience. Diener and Larsen (1993) further maintain that affect is related to a person's evaluation of life because emotion arises from the cognitive evaluations made of events as they occur. Finally, a person's emotions can fluctuate over time because the emotional system is reactive to immediate events and the current psychological state of the person.

In empirical studies on the nature of happiness as indicated by positive affect and absence of negative affect, Diener, Sandvik and Pavot (1991) found the amount of times a person experiences pleasant emotions to be a better prediction of happiness than the intensity of positive emotions. Further, most people report to be happy or experience positive affect most of the time (Diener & Diener, 1996). It appears that factors such as income, physical attractiveness and health may only have a modest effect on long-term levels of affect, suggesting that the emotional system adjusts to current circumstances (Diener & Larsen 1993). Finally, Diener and Larsen (1993) state that the correlates of emotional well-being vary in different cultures. In an overview on SWB, Diener (2000) concludes that intense experiences are not necessary for happiness, but that experiencing mild-to-moderate pleasant emotions seems to be enough for most people to report that they are happy.

In a large South African sample, Wissing and Van Eeden (2002) found that an affect balance, as seen by the preponderance of positive affect over negative affect, seems to be part of a general psychological well-being factor. In the current study, affect balance will be measured by means of the Affectometer 2 (Kammann & Flett, 1983).

❑ Evaluation of the hedonic perspective

The hedonic view of psychological well-being has received some criticism, most often from researchers adhering to an eudaimonic view of well-being (see paragraph 4.3.2.1.2 in this chapter). For example, Ryff and Singer (1998) argue that measuring of SWB does not adequately measure or define psychological wellness. In response Diener, Sapyta and Suh (1998) maintain that SWB is an indispensable component of positive psychological health, although it is not a sufficient condition for it. More recent research on SWB has increasingly started to recognise that factors such as goals, coping efforts and personality dispositions also influence psychological well-

being (see Diener et al., 1999, for a review). Diener (2000) acknowledges that SWB could not be seen as a sufficient condition for mental health, but argues that people's own evaluations of their lives deserves a prominent position in evaluating quality of life.

It is the opinion of the current author that a subjective evaluation of a person's life should be included in the assessment of wellness, but it should not be seen as the only indicator of well-being.

❑ Relevance of the hedonic perspective for the current study

The hedonic approach to well-being, and the *concept* of subjective well-being or happiness in particular, is relevant in understanding how first-time mothers experience their current life situation. In colloquial terms, SWB refers to happiness (Diener, 2000), and usually pregnancy and becoming a mother is seen as a happy event in the life cycle. Paradoxically, there is also evidence of intense experiences of negative emotions such as anxiety and depression. It is necessary to understand whether first-time mothers' cognitive and affective evaluations indeed indicate that they are happy with their lives. Further, as Suh, Diener and Fujita (1996) point out, the extent to which life events influence SWB is not yet fully understood. It appears that SWB is mostly influenced by recent events and that impact of most life events on SWB diminishes in less than three months (Suh et al, 1996). Since SWB in the current study, SWB was measured at different times during the transition to motherhood, it could shed more light on the temporal nature of SWB during this life transition.

4.3.2.1.2 Eudaimonic perspective

The eudaimonic perspective has its foundation in Hellenic philosophy, and more specifically, in the work of Aristotle (Waterman, 1993). This perspective on psychological well-being maintains that well-being is experienced when people live in accordance with their daimon, or true self (Ryan & Deci, 2001; Waterman, 1993). The daimon is described by Waterman (1993) as various potentials in each person, which will lead to fulfilment in living when realised. The daimon includes potentials shared by all humans, but may also include unique potentials for each person.

Waterman (1993) states that eudaimonia occurs when people's life activities are congruent with their deeply held values and when they are holistically engaged. According to Waterman, people are able to feel intensely alive and authentic under such circumstances, being who they really are. He describes this as a state called personal expressiveness (Waterman, 1993).

The work of Ryff and colleagues (Ryff & Keyes, 1995; Ryff & Singer, 1996, 1998, 2000), as well as Deci and Ryan (2000) and Ryan and Deci (2001) can be categorised as having been conducted in line with an eudaimonic perspective. It is the opinion of the current author that the work of Antonovksy (1979,1987) can also be seen as belonging to the eudaimonic perspective.

❑ The multidimensional model of psychological well-being of Ryff and colleagues

Ryff and her colleagues (Ryff & Keyes, 1995; Ryff & Singer, 1996, 1998) developed a multidimensional model of psychological well-being. In an extensive review of the literature of personality theorists and lifespan development, Ryff and Keyes (1995) as well as Ryff and Singer (1996) conclude that many theorists wrote about similar features of positive psychological functioning, although they named the features differently. Ryff and her colleagues propose a multidimensional model of psychological well-being consisting of six core dimensions, which can briefly be described as follows:

- *Self-acceptance* is viewed as a positive appraisal of oneself and one's past. It is often defined as a central feature of mental health.
- *Positive relations with others* can be described as the presence of warm and trusting interpersonal relationships.
- *Autonomy* is seen as a sense of self-determination, independence and the regulation of behaviour from within.
- *Environmental mastery* is viewed as the capacity to effectively manage one's life and environment.
- *Purpose in life* is described as the belief that there is purpose and meaning to life. Someone who has purpose in life thus has goals, intentions and a sense of direction, which contribute to the feeling that life is meaningful.
- *Personal growth* is a sense of continued growth and development as a person.

❑ Self-determination theory (SDT) of Ryan and Deci (2001)

Ryan and Deci (2001) conceptualise psychological well-being from an eudaimonic perspective, in terms of self-determination theory (SDT). SDT posits that self-realisation is a central aspect of well-being, and attempts to specify both what it means to actualise the self and how it can be accomplished. According to SDT, there are three basic psychological needs: autonomy, competence and relatedness. Fulfilment of these needs is seen as essential for psychological growth, integrity and well-being. Deci and Ryan (2000) maintain that fluctuation in satisfaction of these three basic needs would directly predict fluctuations in well-being.

According to Deci and Ryan (2000), need fulfilment can be viewed as a natural aim in life that delineates many of the meaning and purpose underlying human behaviour. These authors are of the opinion that well-being is therefore more than a subjective experience of positive affect. It is also an organismic function where the individual experiences psychological flexibility and a deep inner sense of wellness.

SDT further posits that fulfilment of these three needs (autonomy, competence, and relatedness) fosters well-being, whereas Ryff and Singer (1998) use it to define well-being. According to Ryan and Deci (2001), the SDT perspective posits that satisfaction of the basic psychological needs fosters both subjective well-being and eudaimonic well-being. They argue that measures of subjective well-being should be supplemented with assessments from an eudaimonic perspective. In this sense, their approach can be seen as including both hedonic and eudaimonic aspects of well-being.

❑ Antonovsky's (1987) concept of sense of coherence

The concept of sense of coherence (SOC) is central to Antonovsky's (1979, 1987) salutogenic model, where it is proposed to be related to effective coping and good health. From a salutogenic paradigm, the concept of SOC provides a theoretical understanding of why resources, such as ego strength and social support, for example, promote health (Antonovsky, 1993). Although Ryan and Deci (2001) do not include the SOC in their classification, it is the current author's view that Antonovsky's construct resonates well with an eudaimonic perspective on psychological well-being as conceptualised by Waterman (1993).

*(i) The salutogenic model*

The salutogenic model (as explicated in paragraph 2.4.2.) emphasises health rather than illness. Within this model, health is seen as measurable along a continuum, between a salutary end (ease) and a point of breakdown or "dis-ease". The interplay of opposing forces of environmental threat and individual resistance determine an individual's position and direction along this continuum. Stressors are seen to be omnipresent in life and because there is wide variation in the response of many persons to any given stressor, it is hypothesised that the nature of a person's response to stress is crucial. Stressors can also be happy events, such as the birth of a healthy infant (Antonovsky,1987), but still the individual has entered a state of tension that has to be acted upon. Confronting a stressor results in a state of tension, and the outcome will depend on how an individual manages this tension. Stress itself may have negative, neutral, or salutary health effects (Antonovsky, 1979).

*(ii) Generalised resistance resources*

The adequacy of available resources is an important factor in determining whether a stressful situation will lead to negative or salutary consequences. Antonovsky (1979) identifies broad categories of resources that promote successful management of stressors, called generalised resistance resources. He categorises these resources as follows: material resources; knowledge-intelligence; ego identity; flexible, rational and far-sighted coping strategies; social support and ties; commitment to a social group; religion or a stable set of answers to life's questions; a preventive health orientation and genetic strengths. The primary function of these resources is to make sense of stimuli that are constantly perceived and to manage the implied demands. These generalised resistance resources can further be viewed as potential resources, which the person with a strong SOC can mobilise to address stressors (Antonovsky, 1987).

*(iii) The sense of coherence*

Sense of coherence (SOC) is the central concept in Antonovsky's salutogenic model and assumes paramount importance in the movement of individuals along the health continuum. A person's SOC can be described as a dispositional orientation that develops over time (Antonovsky, 1987). It can be defined as the extent to which one

has an ongoing feeling of confidence that internal and external stimuli are predictable, structured and explicable (comprehensibility), that one has the resources to cope with challenges (manageability), and that there is some meaning or sense in taking up these challenges (meaningfulness) (Antonovsky, 1987).

To perceive events as **comprehensible** does not imply that they are necessarily benign or that they are entirely predictable. It rather suggests that the individual finds a certain logic in the sequence of events, that there is a degree of consistency from one experience to another and that, as a general rule, inexplicable events do not occur (Sullivan, 1993).

**Manageability**, experiencing that one has the available resources to meet demands, does not necessarily mean that those resources are under one's direct control. It may rest with legitimate others, such as parents or God, but still the person expects to be able to endure adversity.

According to Sullivan (1993), **meaningfulness** refers to the degree of commitment an individual has to various life domains. A person with a high SOC has a sense that certain areas of life matters, that they are worth the investment of time and effort. Antonovsky (1987) maintains that meaningfulness seems to be a most crucial component of the sense of coherence, since without it, comprehensibility and manageability would be temporary.

A strong sense of coherence does not depend on goal achievement or need satisfaction, but rather on one's logical expectancy of events. According to Antonovsky (1979), an individual who has a strong sense of coherence may experience hardship without significant decrease in coherence if such misfortune is experienced as logical and predictable under the circumstances.

The SOC is further seen as a dynamic aspect of personality that is formed throughout childhood and adolescence. It is generally accepted that a person's SOC is stabilised by the age of 30, and that it will be maintained despite continuing stressors of life (Antonovsky, 1996). However, Wissing, De Waal and De Beer (1992) found that the enduring experience of severe stress may erode the sense of coherence.

Antonovsky (1991) proposes that SOC originates through the following experiences:

- *Consistent experiences*, relating to the human need for stability and providing the basis for the component of comprehensibility;
- *Balanced load experiences*, described as those which demand that resources be mobilised to act, providing the basis of manageability; and
- *Experiences of participation in shaping outcomes*, which lays the foundation of the motivational component of the SOC (meaningfulness).

However, Antonovsky (1996, p. 175) later points out that "...there are many roads to a strong SOC", and that a social structure which provides a set of fundamental principles, facilitates behaviours which are to be performed and rewards such behaviours, will foster a strong SOC.

Antonovsky (1996) emphasises that SOC is a broad construct rather than a specific style or coping resource, even though there are some similarities between SOC and constructs such as self-efficacy (Bandura, 1977) and hardiness (Kobasa, 1979). Antonovsky explains that no specific resource or style is universally appropriate, therefore a person with a strong SOC will select the most appropriate coping tool for the specific task. Further, Antonovsky (1996) maintains that the SOC distills the core of specific coping or resistance resources and expresses their commonality, namely increasing one's sense of comprehensibility, manageability and meaningfulness. The SOC can therefore be seen as offering an explanation of how these resources may contribute to health. Coherence is also conceptualised as occurring along a continuum, rather than being a dichotomous entity (Sullivan, 1993).

The SOC is generally accepted as being cross-cultural and cross-situational (Antonovsky, 1993). It can be seen as a construct which is universally meaningful and which cuts across lines of gender, social class and culture.

Strümpfer (1995) is of the opinion that the SOC could directly be related to aspects of successful living, like effective interpersonal relationships, or especially valid for this study, effective parental relationships. He also maintains that it is possible that a person with a strong SOC could be strengthened by a developmental transition, which in turn could contribute to general well-being. This implies that women with a strong SOC, having a first pregnancy, could even experience an enhanced SOC thereafter.

*(iv) Empirical studies related to SOC*

Empirical studies related to the SOC have been done in 20 countries (Antonovsky, 1996), and there has been general support for the SOC's construct validity.

On an empirical level, research done regarding SOC showed high scores on the meaningfulness subscale to be related to lower levels of reported pain intensity in chronic pain patients (Petrie & Azariah, 1990). In South Africa, several studies by Strümpfer and his associates have used SOC in investigating stressors related to the work situation of black and coloured workers (see Edwards and Besseling, 2001, for a short review), confirming that SOC seems to be a distinctive personal quality which can moderate the impact of stressors. Studies with a large general South African sample further indicated that SOC seems to be a good indicator of general psychological well-being (Wissing & Van Eeden, 1994, 2002). In a review of South African data on the SOC, Strümpfer and Wissing (1998) confirm the applicability of the SOC in a South African context.

❑ Relevance of an eudaimonic perspective for the current study

The eudaimonic perspective on psychological well-being emphasises aspects such as meaningfulness, values, needs, personal growth and competencies. These perspectives provide a deeper understanding of psychological well-being. In the current study, an eudaimonic perspective on psychological well-being could promote an understanding of pregnant women's experience of growth and meaningfulness in their life transition. Psychological well-being will be measured from an eudaimonic perspective in the current study by using the Life Orientation Test (also called the Sense of Coherence Scale) of Antonovsky (1987).

4.3.2.1.3 Pragmatic perspective

Theoretically, another perspective on psychological well-being can be distinguished, namely a pragmatic perspective where the focus is on behavioural-related aspects. A large body of research has been done on the antecedents and consequences of successful goal completion, following the work of Bandura (1977). The construct of self-efficacy represents one of the core aspects of Bandura's social-cognitive theory. Self-efficacy (SE) therefore relates to expectancies or beliefs that one can perform particular behaviours required to obtained specific outcomes (Bandura, 1997b).

A sense of efficacy has in previous research been associated with higher levels of subjective well-being (McGregor & Little, 1998), but little research has been done in terms of the role of efficacy when broader measurements of well-being were applied, such as measuring meaningfulness or purpose. According to McGregor and Little (1998), people feel better when they are doing well and expect to do well in the future. Lightsey (1996) proposes a framework to explain the dynamics of wellness, which he refers to as process theory. One of his hypotheses is that thoughts and beliefs about the self (such as generalised self-efficacy), and outcomes (such as optimism) are central to human appraisal and successful adaptation. Further Ryan and Deci (2001) maintain that a sense of efficacy and competence is important to eudaimonic psychological well-being. It seems then that there is growing interest in the role of beliefs and outcomes in the eventual experience of psychological well-being, and that psychological well-being could also be conceptualised in terms of behaviours or behavioural outcomes that are related to happiness, meaningfulness, adaptation or successful goal attainment. In this sense, the Self-determination Theory of Ryan and Deci (2001) could also fit in here. For purpose of the current study, the focus will be on self-efficacy beliefs.

❑ Perceived self-efficacy

The construct of self-efficacy (SE) was initially conceptualised by Bandura (1977). According to self-efficacy theory, expectations of self-efficacy determine what activities people engage in, how much effort they will expend and how long they will persevere in the face of adversity. Persons who are high in SE would exhibit more willingness to engage in particular behaviours, more tenacity in domain-specific tasks and greater domain-specific performance accomplishments (Bandura, 1982). According to Schwarzer and Scholz (2000), a person who believes that she is able to produce a desired effect, has a sense of control over her environment. It can be regarded as a self-confident view of one's capability to deal with certain life stressors.

According to Bandura (1997a), a belief in one's personal capabilities regulates human functioning in the following ways:

- *Cognitive:* People with high self-efficacy are more likely to have high aspirations and commit themselves to meeting challenges. They guide their actions by visualising successful outcomes instead of dwelling on personal deficiencies or ways in which things might go wrong.

- *Motivational*: People motivate themselves by forming beliefs about what they can do, anticipating the likely outcomes, setting goals and planning courses of action. Motivation will be stronger if an individual believes that her goals are attainable.
- *Affect:* The amount of stress or depression that a person experiences in a difficult situation depends to a large extent on how well they think they can cope. People who believe they can manage threats are less distressed by these threats, and they also lower their stress by acting in ways that make the environment less threatening. People with high self-efficacy also have better control over disturbing thoughts. They are able to relax, seek support from others and divert their attention.

It is obvious that self-efficacy makes a difference in how people feel, think and act (Bandura, 1997b). A low sense of self-efficacy is associated with feelings of depression, anxiety and helplessness. In terms of thinking, a strong sense of self-efficacy or competence facilitates cognitive processes and performance in a variety of settings. As far as action is concerned, people experiencing a high level of self-efficacy may have a sense of enhanced motivation, enabling them to select challenging tasks and to stick to them. As Schwarzer and Scholz (2000) explain, actions are pre-shaped in thought, and individuals anticipate either pessimistic or optimistic scenarios in accordance with their level of self-efficacy.

According to Bandura (1997a), psychotherapy could enhance self-efficacy by providing tools for managing any situation that may arise. He mentions four main ways of accomplishing this:

- *Experience of success or mastery* in overcoming obstacles;
- *Social modelling*, implying that a person will be more inclined to believe that she can succeed if she sees other people like herself succeed;
- *Social persuasion*, meaning that if people are persuaded to believe in themselves, they will exert more effort and increase their chances of success; and
- *Reducing stress and depression, building physical strength and learning how to interpret physical sensations.* People tend to rely on their physical and emotional states to judge their capabilities and often read tensions as a sign of personal deficiency.

Self-efficacy is generally accepted as being domain-specific, referring to the fact that one can have more or less firm self-beliefs in different domains or particular situations of functioning. Bandura (1997b) argues that SE-theory acknowledges the diversity of human capabilities. SE-beliefs are not seen as an omnibus trait, but as a differentiated set of self-beliefs related to distinct domains of functioning. Earlier, Bandura (1986) maintained that particular measures of self-efficacy are preferable because self-efficacy is focused on specific performances and varies from task to task. However, there seems to be growing support for the existence of a generalised sense of self-efficacy (e.g. Schwarzer, 1993; Tipton & Worthington, 1984).

❑ Generalised self-efficacy

Schwarzer and Scholz (2000) conceptualise a generalised sense of self-efficacy as a global confidence in one's coping ability across a wide range of demanding novel situations. It reflects a broad and stable sense of personal competence to deal effectively with a variety of stressful situations. It can further be described as an optimistic self-belief and a positive resistance resource factor (Schwarzer, 1993). Lightsey (1996) describes generalised self-efficacy (GSE) as a trait belief in one's perseverance in difficult situations and that it consistently acts as a stress buffer. He suggests that GSE is malleable, citing research (Eden & Aviram, 1993; Eden & Kinnar, 1991) that found that even relatively simple verbal persuasion may lead to changes in GSE. Lightsey (1996) further maintains that persons high in GSE may return to an optimal state of subjective well-being after stressful life events, more rapidly and successfully, than persons low in GSE. This implies that GSE may moderate the effects of stress on well-being.

It can be concluded that GSE differs from domain-specific SE in the sense that emphasis is placed on a broad sense of personal competence to deal with various stressful situations, rather than focusing on one specific domain of efficacy.

❑ Empirical studies related to self-efficacy

There seems to be a large body of research pointing to the fact that feeling competent and confident with respect to important goals is associated with a higher sense of well-being (Carver & Scheier, 1999; McGregor & Little, 1998). Empirical studies have found that domain-specific SE predicts increased pain tolerance (Bandura et al., 1987) and better adjustment to abortion (Cozzarelli, 1993). As far as

generalised self-efficacy is concerned, empirical evidence suggests that higher GSE is associated with better behavioural outcomes (Eden & Kinnar, 1991), more endurance (Tipton & Worthington, 1984) as well as lower depression (Mahalik & Kivlighan, 1988). However, some studies found that GSE does not predict performance (e.g. Ferrari & Parker, 1992). Recently, Jerusalem (1993) found that GSE is one of several personal resources that may buffer stress during the stress appraisal process. In a South African sample, Wissing and Van Eeden (2002) report a positive relationship between generalised self-efficacy and other measures of psychological well-being such as life satisfaction, affect balance and sense of coherence.

Empirical evidence therefore gives direct and indirect support that both domain-specific and generalised self-efficacy could be related to psychological well-being.

❑ Relevance of a pragmatic perspective for the current study

SE-theory suggests that beliefs about efficacy could influence behaviour and affect. In the current context, higher levels of self-efficacy could contribute to the expectation of positive outcomes regarding labour, delivery and postpartum adjustment. Further, domain-specific self-efficacy in care-giving capabilities could possibly be related to other, broader aspects of well-being, while GSE, being more salient in novel situations (Lightsey, 1996), could be important in the new mother's experience of psychological well-being in general.

The relevance of self-efficacy in the study of psychological well-being is further supported by Antonovsky's (1991) view of self-efficacy as a salutogenic strength, and by Schwarzer and Scholz's (2000) conceptualisation of self-efficacy as a personal coping resource. In the current study, generalised self-efficacy will be measured by the Generalised Self-Efficacy Scale of Schwarzer and Jerusalem (1995). Domain-specific self-efficacy will be defined in terms of maternal self-efficacy (see paragraph 5.2.4 in this chapter), as measured by the Maternal Self-efficacy Scale (Teti & Gelfand, 1991).

#### 4.3.2.1.4 Summary

The structure of psychological well-being can be viewed from different perspectives, based on what is meant by well-being. The hedonic perspective focuses on

subjective well-being or people's subjective perception of their own happiness, while the eudaimonic perspective defines psychological well-being more broadly in terms of the fully functioning person. As Ryan and Deci (2001) point out, these two approaches overlap yet seem to ask different questions regarding well-being. Finally, the pragmatic perspective addresses behaviours and behavioural outcomes related to psychological well-being, and emphasises the role of self-efficacy beliefs in these outcomes. In the current study, these three perspectives are incorporated in exploring well-being to facilitate a broader and richer understanding of the nature of psychological well-being during women's life transition to motherhood.

#### 4.3.2.2 Models related to the dynamics of psychological well-being

Several researchers focused on explicating the dynamics of psychological well-being. For purpose of the current study three such models will be described, namely the stress and coping model of Moos (1994), the transactional framework of Kumpfer (1999) and the broaden-and-build model of Frederickson (1998, 2000, 2001).

##### 4.3.2.2.1 The Stress and Coping Model of Moos (1994)

Moos (1994) developed a broad, heuristic framework to describe the relationships between environmental stressors, social resources, personal factors, acute life events, coping responses and psychological well-being. According to this model, environmental stressors and resources, as well as individual factors and life experiences, have an impact on the individual's cognitive appraisal of a situation. Consequently, this will determine the coping strategy selected, and this in turn influences the degree of well-being or dysfunction manifested in the individual. This model is graphically presented in Figure 2.

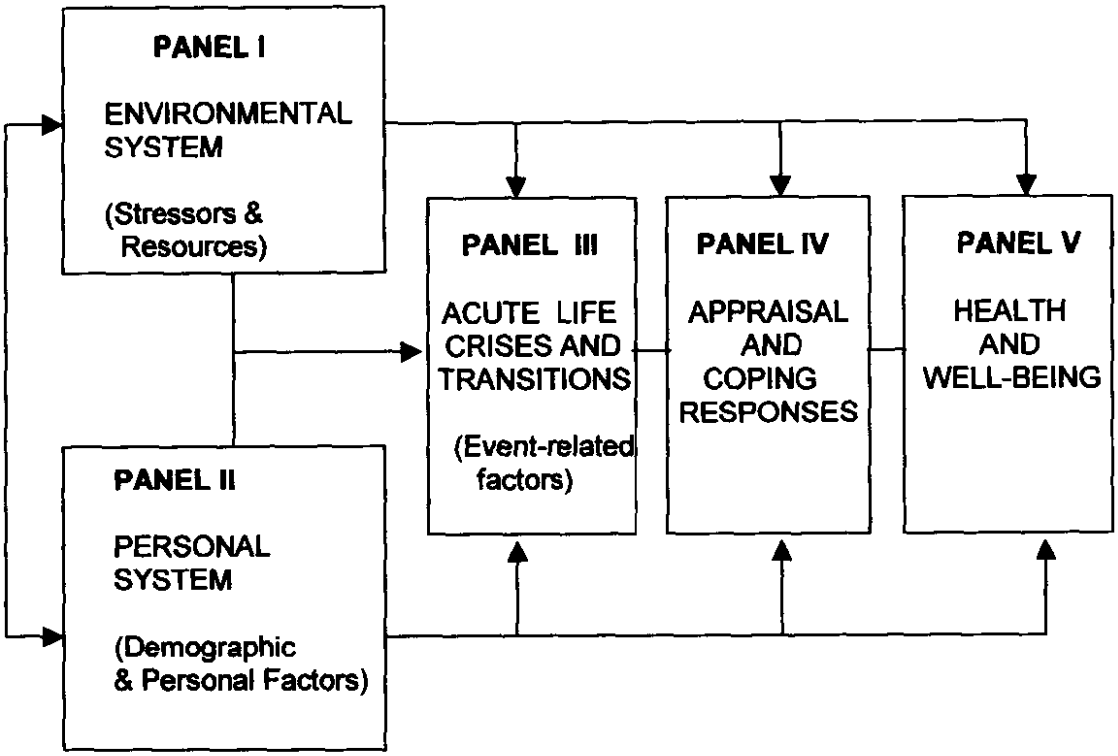



**FIGURE 2: THE STRESS AND COPING MODEL OF MOOS (1994)**

The environmental system (panel I) consists of ongoing life stressors as well as social coping resources. The personal system (panel II) refers to the individual's socio-demographic characteristics and personal coping resources. These are seen as relatively stable environmental and personal factors, which eventually influence the major life transitions and crises encountered by the individual (panel III). These combined influences shape health and well-being (panel V), both directly and indirectly through cognitive appraisal and coping responses (panel IV).

Holahan, Moos and Schaefer (1996) posit that this framework emphasises the central mediational role played by cognitive appraisal and coping processes in the stress process. The existence of bi-directional paths in the framework indicates that reciprocal feedback can occur at any stage.

Pregnancy and first-time motherhood is generally accepted as a life transition. In the context of Moos's (1994) model, it can be placed in panel III (acute crises and life transitions). It can then be argued that women's adaptation to pregnancy and

motherhood will depend on certain appraisal and coping responses, which in turn can lead to enhanced well-being or dysfunction. The manner in which appraisal and coping will take place, will be influenced by the individual's environmental system (stressors and resources) as well as personal factors. In the current study, the aim is to maintain and enhance well-being (panel V) by means of hypnotherapy which could influence the individual's appraisal of the life transition and the coping responses selected (panel IV).

4.3.2.2.2 Kumpfer's transactional framework (Kumpfer, 1999)

Kumpfer (1999) developed a broad framework to organise factors and processes predictive of positive outcomes in high-risk children. This is a transactional model that explains how resilient children adapt to stressful life experiences. Although this framework was developed specifically with children in mind, it is the current author's opinion that it can be seen as equally relevant to adults facing life crises or stressful situations.

Kumpfer (1999) distinguishes 6 major constructs. Four are domains of influence, namely the acute stressor or challenge, the environmental context, the individual characteristics, and the outcomes. There are also two points of transactional processes, which are the confluence between the individual and the environment, and secondly, the individual and the choice of outcome. Kumpfer's model is graphically presented in Figures 3 and 4.

**Stressors or challenges** are incoming stimuli that create disequilibrium or a disruption of homeostasis in the individual. The degree of stress experienced by an individual depends on her perception of the stimulus, cognitive appraisal, and interpretation of the stressor as threatening or aversive. In the context of the current study, pregnancy and first-time motherhood are obvious stressors or challenges since it is generally accepted to be life change events. When defined as a challenge, the experience of pregnancy and new motherhood could promote growth and could lead to resilience in facing new stressors or challenges.

Kumpfer (1999) describes **the external environmental context** domain as the balance and interaction of risk and protective factors in critical domains of the individual's life, such as age, culture, family and even geographical location and historical period. The environmental context could serve as a buffer for the impact of

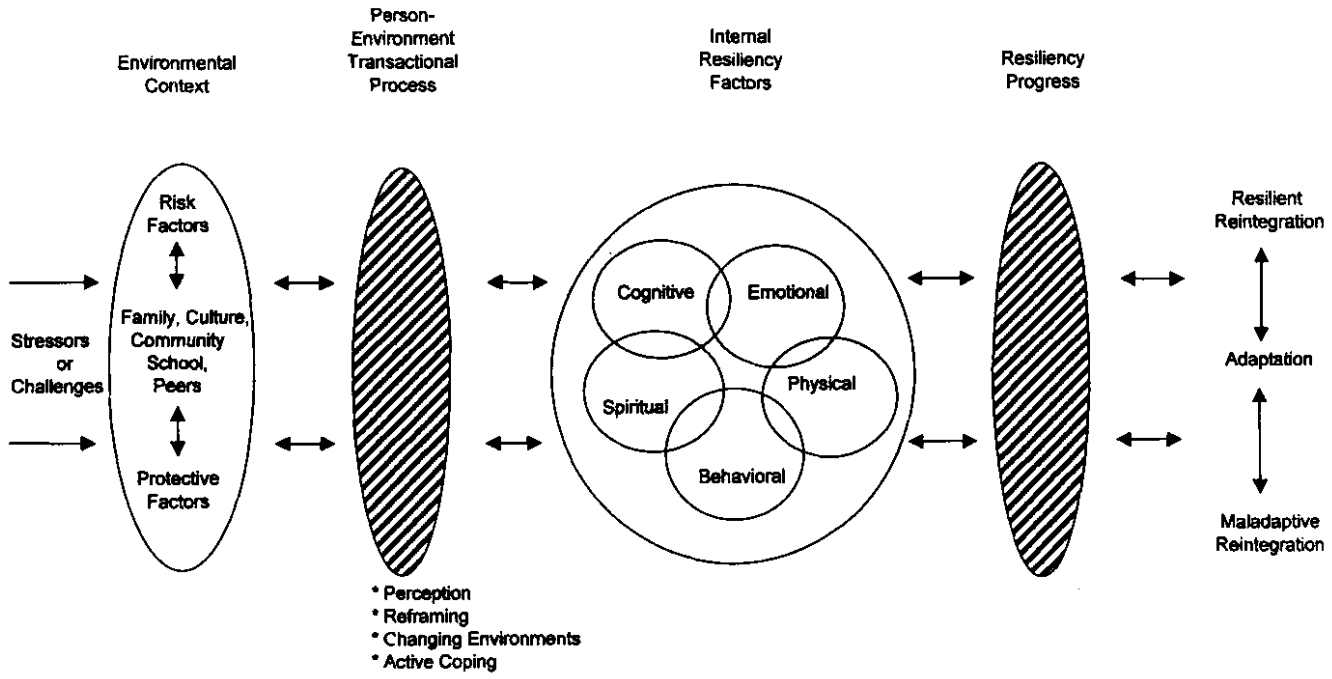



**FIGURE 3.** RESILIENCE FRAMEWORK
(Kumpfer, 1999)

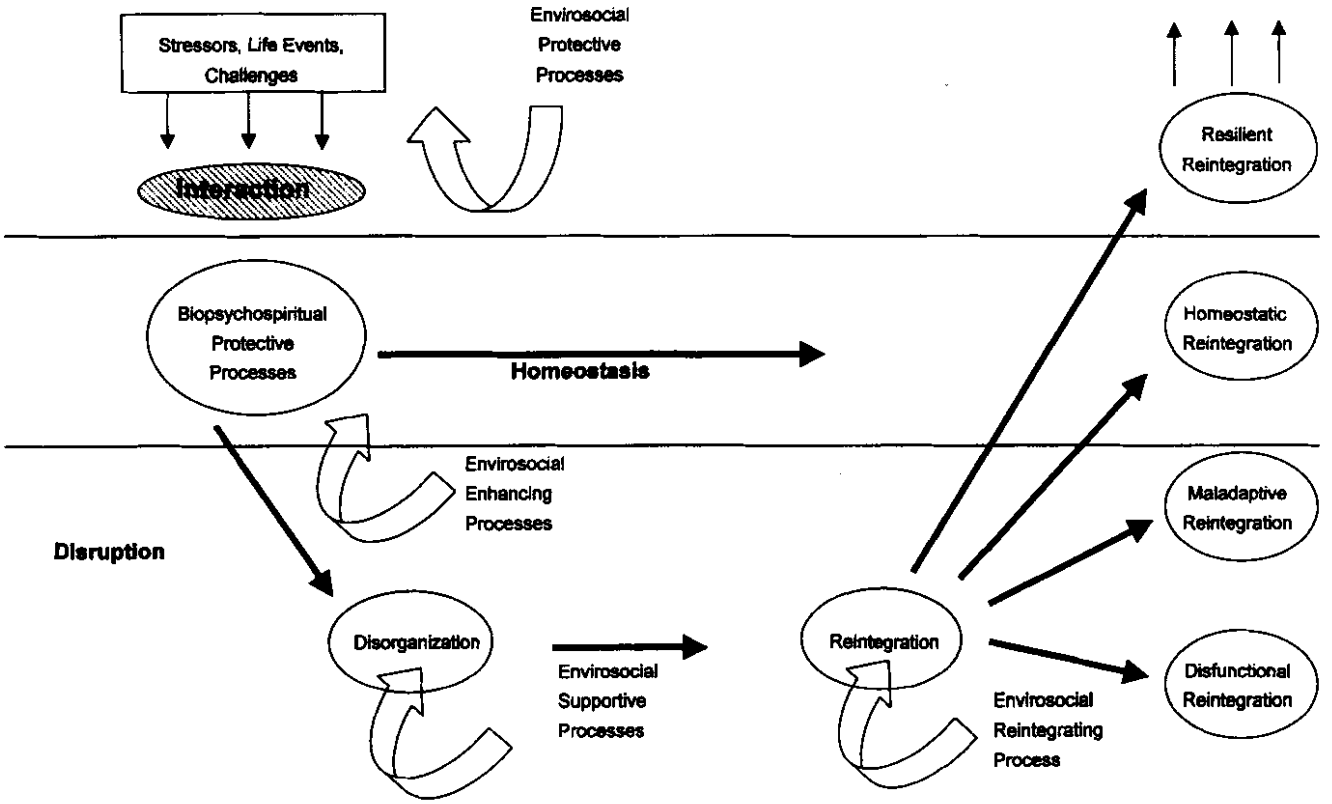



**FIGURE 4.** THE RESILIENCY PROCESS MODEL
(Kumpfer,1999)

negative experiences. In the current study, factors such as family support and a stable marital relationship could provide a buffer to the impact of the transition to motherhood.

**Person-environment interactional processes** refer to the transactional processes between the individual, her environment and the social group in an active or passive attempt to perceive, interpret and surmount threats, challenges or difficult situations. This attempt is aimed at constructing more protective environments. Kumpfer (1999) mentions interactional processes such as selective perception, cognitive reframing and active coping as possibly contributing to transforming a high-risk environment into a more protective one.

The domain of **internal self-characteristics** includes internal individual spiritual, cognitive, social/behavioural, physical and emotional/affective competencies or strengths needed to be successful in different developmental tasks, different cultures and different personal environments:

- *Spiritual or motivational characteristics* include primarily cognitive capabilities or belief systems that serve to motivate the individual and direct her efforts. Kumpfer (1999) mentions variables such as dreams and goals, internal locus of control, hopefulness and optimism, and determination and perseverance, among others.
- *Cognitive competencies* include cognitive abilities that help the individual to achieve her goals, such as intelligence, ability to delay gratification, and self-esteem, among others.
- *Behavioural and social competencies* include social skills, problem solving skills and communication skills.
- *Emotional stability and emotional management* refer to characteristics such as happiness, recognition of feelings, emotional management skills, humor and hopefulness.
- *Physical well-being and physical competencies* include variables such as good health and health maintenance, among others.

In the current empirical study several of these internal self-characteristics will be taken into consideration, such as spiritual and motivational competencies, cognitive competencies, emotional stability and emotional management, in exploring psychological well-being.

**Resilience processes** refer to unique short-term or long-term resilience or stress and coping processes that the individual has learned through gradual exposure to increasing challenges and stressors. These help the individual to bounce back with resilient reintegration.

According to Kumpfer (1999), **positive outcomes** in specific developmental tasks may later promote adaptation to specific new developmental tasks, and may later culminate in a higher likelihood of becoming a resilient individual. In this dynamic model, a positive outcome could therefore be seen as being predictive of later resiliency when facing stressors. In the current context, this dynamic model suggests that a positive adaptation to the transition to motherhood could contribute to positive adaptation to further developmental tasks related to parenthood and adulthood in general.

Kumpfer's (1999) model provides a framework for understanding how pregnant women adapt to the life transition to motherhood. The stressor can be viewed as a challenge that could promote growth, and the nature of the woman's environmental context (e.g. marital relationship, family support) could provide a buffer to the impact of the transition to motherhood. The woman's internal self-characteristics could possibly be enhanced by means of the envisaged hypnotherapeutic programme, resulting in positive outcomes or successful adaptation.

#### 4.3.2.2.3 Frederickson's "Broaden-and-build" Model (Frederickson, 1998, 2000, 2001)

Frederickson (1998, 2000, 2001) has developed a new perspective on positive emotions, which she describes as the "broaden-and-build" model. In essence, this perspective maintains that experiences of positive emotions broaden people's momentary thought-action repertoires, resulting in the building of enduring personal resources. These resources could range from physical and intellectual resources, to social and psychological resources (Frederickson, 2001).

❑ <u>Perspectives on positive emotions</u>

The nature and manifestation of emotions can be seen as an important focus area in the general field of psychology. In clinical settings as well as research, however, the focus has until recently been on exploring negative emotions such as sadness, grief

and despair, rather that positive emotions such as joy, contentment, interest and love (Frederickson, 1998). This may be due to the fact that positive emotions are rarer and they are also rather diffuse (Ellsworth & Smith, 1988), but it could also be partly explained by the pathogenic paradigm of psychology's main focus on pathology and therefore, on negative emotions.

Frederickson (2001) argues that emotions are a subset of the broader class of affective phenomena, and can be conceptualised as multi-component response tendencies. These tendencies unfold over relative short time spans. According to Frederickson (2000, 2001), an emotion process starts with the person's assessment of the personal meaning of a specific antecedent event. Following this appraisal, a cascade of response tendencies is triggered, which could then manifest in subjective experience, facial expressions, cognitive processing or physiological changes. Frederickson (2001) distinguishes between affect and emotion, describing affect as a more general concept, which refers to consciously accessible feelings. However, positive emotions are seen to be inclusive of a component of positive affect.

Frederickson (2000) concludes that positive emotions are more than the absence of negative emotions, arguing that the capacity to experience positive emotions remains a largely untapped human strength. She bases her view on the theory that certain discrete positive emotions, such as joy, interest, contentment and love, have the ability to broaden people's momentary thought-action repertoires.

❑ Breadth of the momentary thought-action repertoire

Traditional models of emotion, focusing mostly on negative emotion, associated emotion with urges to act in specific ways. These urges have been described as specific action tendencies (Frijda, 1986; Frijda, Kuipers & Schure, 1989; Lazarus, 1991). From this perspective, the emotion of anger would create the urge to attack, and fear would create the urge to escape, for instance. People do not invariably act on these urges, but their ideas regarding a possible course of action eventually narrow in on a specific set of behavioural options (Frederickson, 1998, 2001). This narrowing can be seen as an evolutionary adaptive action to cope in life-threatening situations. These specific action tendencies are also associated with physiological changes, with the body often mobilising certain autonomic responses such as running or attacking. When a life-threatening situation exists, such a narrowed thought-action repertoire therefore promotes quick decision-making and action.

Frederickson (1998) notes that traditional models linking emotions with action tendencies do not fit many positive emotions. Firstly, action tendencies described for positive emotions are vague and unspecified (Frederickson & Levenson, 1998). Secondly, Frederickson (1998) is of the opinion that although positive emotions often produce urges to act, they appear to be less prescriptive than negative emotions regarding the specific action that has to be taken. Accordingly, positive emotions can be said to yield non-specific action tendencies. Thirdly, Frederickson (1998) argues that some positive emotions lead to changes primarily in cognitive activity, with any changes in physical activity resulting from these cognitive changes. Finally, Frederickson (2001) posits that the typical context within which positive emotions occur, are not typically life-threatening, therefore a narrowing of an individual's thought-action repertoire might not be necessary. Following these arguments, Frederickson (1998, 2000, 2001) elaborates on the broadening effects of positive emotions on momentary thought-action processes.

❑ The broaden-and-build theory as related to specific positive emotions

*(i) Joy*

According to Frederickson (1998), joy does not necessarily refer to a single affective state, but rather a family of related states. It is often used interchangeably with happiness (Lazarus, 1991) and is associated with high-arousal positive emotions such as amusement, elation and gladness. Frederickson (1998, 2000, 2001) posits that joy broadens an individual's momentary thought-action pattern by creating the urge to play and be playful in the broadest sense, encompassing both physical and social play as well as intellectual and artistic play. Joy can also have the incidental effect of building physical, intellectual and social resources that are durable and can be drawn on later (Frederickson, 2000).

In the current study, the positive emotion of joy could possibly be induced by utilising the hypnotic phenomenon of age progression (see Chapter 3), where the mother could have a sense of wonder and joy in holding her baby after the birth. This could be seen as broadening of the thought-action repertoire and therefore may be beneficial to psychological well-being.

*(ii) Interest*

Frederickson (2000), citing the work of Izard (1977), describes interest as one of the most frequently experienced emotions. She associates interest with related affective states such as curiosity, wonder, excitement, intrinsic motivation and flow. Interest can broaden the momentary thought-action repertoire by creating the urge to explore, take in new information and experiences and expand the self in the process (Csikszentmihalyi, 1990; Frederickson, 2001; Ryan & Deci, 2000). Earlier, Ellsworth and Smith (1988) described interest as a general response to situations subjectively perceived as important, which motivate high levels of attentional activity. This attention might encourage further appraisal of the situation, leading to emotional differentiation and possibly effective coping.

This openness to new ideas, experiences and actions can be seen as especially important in the development of an intervention programme. By allowing the pregnant woman an opportunity to explore possible positive experiences associated with pregnancy, labour, delivery and motherhood by means of hypnosis, it can be hypothesised that the positive emotion of interest is being induced. In return, interest could be a catalyst for personal growth (Izard, 1977, cited by Frederickson, 2000) and could build the mother's individual reservoir of knowledge and cognitive abilities. Since Frederickson (2000) posits that these could become durable resources that can later be accessed, they might stand a mother in good stead when she has to attend to the needs of her baby in real life.

*(iii) Contentment*

According to Ellsworth and Smith (1988), contentment and related emotions such as serenity and tranquillity arise in situations that are appraised by the individual as being safe and as having a high degree of certainty and a low degree of effort. Contentment can be described as an emotion that allows individuals to savour their current life circumstances and recent successes (Frederickson, 1998). It can further be seen as a mindful broadening of a person's self-views and world views by integrating these circumstances within the self (Frederickson, 2001).

*(iv) Love*

Frederickson (1998), following Izard (1977), conceptualises love as the combination of many positive experiences, including interest, joy and contentment. These experiences usually surface within specific love relationships, such as romantic relationships, friendships and caregiver relationships. The positive emotion of love can broaden the momentary thought-action repertoire by creating recurring cycles of urges to play (joy), savour (contentment) and explore (interest) experiences with loved ones (Frederickson, 2001). Although the momentary experience of love leads to obvious intrinsic enjoyment, Frederickson further argues that interactions inspired by love help to build and strengthen social bonds and attachment. This can again be seen as resources that can accumulate and be retrieved at a later stage.

The proposed programme will focus extensively on the experience of the ability of the mother to love and be loved (see Chapter 4). In this sense it can be argued that, following the theory of Frederickson (1998, 2000, 2001), by inducing these emotions, a broadening of the momentary thought-action repertoire is facilitated and resources are being strengthened.

❑ Positive emotions as resources

Frederickson (1998, 2000, 2001) maintains that positive emotions do more than broadening an individual's momentary thought-action repertoire: they also build personal resources that are more durable than the transient emotional states that led to their acquisition. Consequently, the incidental effect of experiencing a positive emotion could be seen as an increment in enduring personal resources that can be drawn upon in other contexts and other emotional states at a later stage in the individual's life. This assumption is especially relevant in the current study, where positive emotions can be induced by means of hypnosis. It could be argued that, by inducing these positive emotions, an attempt is made at strengthening individual resources to be retrieved in the postpartum period.

❑ Implication for treatment and prevention

In addition to the broadening and building effect of positive emotions, Frederickson (2000) maintains that these emotions could also undo the effects of negative emotions. She goes even further by stating that intervention strategies that cultivate

positive emotions are more than methods for preventing illness. Rather, these strategies could be regarded as optimising health and well-being.

Frederickson (2000) mentions a few strategies that could be conducive to the cultivation of positive emotions, such as relaxation therapies and interventions focused on finding positive meaning. In the context of the current study her view of relaxation therapies is especially relevant, implicating that an intervention programme must have a strong relaxation component. According to Frederickson (2000), relaxation therapies are effective since they cultivate the positive emotion of contentment. Contentment, as described previously, is a mindful emotion, which initiates cognitive changes, enabling the individual to integrate momentary experiences into an enriched appreciation of one's place in the world. Contentment may also undo anxiety or stress (Frederickson, 2000).

❑ Empirical studies related to the broaden-and-build model

Frederickson (1998) reviewed empirical studies within several subdisciplines of psychology, finding indirect evidence for the broaden-and-build model. In summary, she found empirical studies pointing to the possibility that positive emotions seem to broaden the scope of attention, cognition and action. Furthermore, positive emotions seem to build physical resources as well as intellectual and social resources.

Following up on these studies that were indirectly supporting the broaden-and-build model, Frederickson (2001) mentions specific empirical investigations, aimed at directly testing the theory, that were recently completed. Frederickson and Branigan (2000, cited by Frederickson, 2001) tested the hypothesis that distinct types of positive emotions could broaden the momentary thought-action repertoire, while distinct negative emotions could narrow these repertoires. Frederickson and Branigan found that joy and contentment produced a broader thought-action repertoire than does a neutral state. Fear and anger produced a narrower thought-action repertoire. Frederickson (2001) maintains that this pattern supports a core proposition of the broaden-and-build model.

Frederickson, Mancuso, Branigan & Tugade (in press, cited in Frederickson, 2001) further found support for the undoing effect of positive emotions on the effect of negative emotions, by first inducing a high-activation negative emotion and then randomly subjecting participants to films aimed at evoking either joy, contentment

sadness, or a neutral condition. Afterwards the respondents' rates of cardiovascular recovery were assessed. They found that participants in the two positive emotion conditions exhibited faster cardiovascular recovery than did those in the neutral condition, with participants in the negative condition showing the most protracted recovery.

Frederickson (2001) mentions further studies carried out in co-operation with her colleagues that suggested that positive emotions could fuel resiliency and trigger upward spirals toward improved emotional well-being.

❑ Relevance of the broaden-and-build model for the current study

Frederickson's (1998, 2001) model of the building and broadening effects of positive emotions suggests that an intervention aimed at increasing the experience of positive emotions could eventually enhance psychological well-being. This could occur because a potential reservoir of resources is being filled. Frederickson's model provides a theoretical base for the currently envisaged intervention programme. The programme will focus on eliciting positive emotions and facilitating inner resources (see Chapter 4).

### 4.3.3 Conclusion

There is currently not just one single perspective on psychological well-being. However, it seems that different perspectives provide different contributions to the understanding of psychological well-being. Models related to the structure of psychological well-being provide insight into the subjective experience of happiness (hedonic perspective), as well as the role of aspects such as meaningfulness, values, needs and personal growth (eudaimonic perspective). Further, pragmatic perspectives shed light on the role of self-efficacy beliefs in behaviour and behavioural outcomes. Models related to the dynamics of psychological well-being seem useful in exploring the role between stressors and well-being (e.g. Kumpfer, 1999; Moos, 1994), and the role of positive emotions in well-being (Frederickson, 1998, 2000, 2001). In the current study, all three perspectives related to the structure of psychological well-being will be included to obtain a broad understanding of psychological well-being as it is manifested during the transition to motherhood. The model of Frederickson (1998, 2001) will further be used to provide a theoretical base for the development of the intervention programme, focusing on the eliciting of

positive emotions as resources during this phase in a woman's life. It is, however, necessary to briefly analyse specific facets of psychological well-being in pregnancy and early motherhood.

# 5. PSYCHOLOGICAL WELL-BEING IN EARLY MOTHERHOOD: SPECIFIC FACETS

## 5.1 Introduction

Pregnancy and childbirth are important events that profoundly affect the lives of women and their families (Zwelling, 2000a). From a wellness paradigm these important life change events provide opportunity for growth and maturation. Yet, as Green and Kaftersios (1997) point out, studies of women's postnatal experiences have tended to emphasise the negative, and positive experience of early motherhood have been relatively neglected. In their study of more than 1200 women, they found that for most women motherhood is a positive experience. Further, very little has been written regarding psychological well-being, pregnancy and motherhood, with some exceptions (Black-Olien, 1993; Reading, 1983). Recently Wijma, Ryding and Wijma (2002) explored the relationship between women's psychological functioning during pregnancy and postpartum psychological well-being after emergency caesarean section. The research was, however, done from a pathogenic perspective, focusing on aspects such as traumatic stress symptoms as well as general mental distress after delivery. Similarly, Symon, MacDonald and Ruta (2002) investigated postnatal quality of life, focusing on physical, psychological and economic concerns of postpartum women rather than more positive aspects such as life satisfaction.

From an analysis of literature regarding pregnancy, labour and motherhood on the one hand, and literature on psychological well-being on the other hand, it can be concluded that specific aspects are relevant and can be taken into account when an intervention programme is being envisaged and evaluated. These facets can be grouped into three broad areas: Firstly, facets related to early motherhood include perception of labour, the experience of her relationship with the baby, maternal self-confidence and maternal self-efficacy. Secondly, the presence or absence of symptoms of psychopathology should also be taken into account, and finally, general

facets of psychological well-being, namely satisfaction with life, affect balance, a sense of coherence and experience of self-efficacy, will be explored.

## 5.2 Aspects of psychological well-being related to early motherhood

### 5.2.1 Perception of labour and delivery

Knowledge regarding the subjective experience of childbirth has obvious importance in understanding women's psychological well-being. Simkin (1991), for example, found that the birth experience has a powerful effect on women, with potential for a permanent positive or negative impact. However, the literature provides little empirical information regarding the relationship between the perception of labour and psychological well-being specifically. Much research has been generated from a pathogenic perspective, focusing on aspects such as pain or obstetrical complications (e.g. Maclean, McDermott & May 2000), giving indirect evidence of the importance of the experience of childbirth to women's psychological well-being.

**Prenatal expectations regarding** the birth experience seem to have some effect on the actual experience of childbirth. Green, Coupland and Kitzinger (1990) found that women who had high expectations of childbirth had higher levels of satisfaction and fulfilment than did other women. Similarly, Lowe (1991) argues that the more confident a woman is in her ability to cope with childbirth, the less perceived pain she will have and the better she will cope. A study by Green (1993) indicates prenatal anxiety about the pain of labour to be a strong predictor of negative experiences during labour, lack of satisfaction with the birth, and postnatal depressed mood. These findings coincide with the literature from the field of psychological well-being, where Holahan and Moos (1990) describe certain cognitive appraisals as resources that could contribute to effective coping under periods of stress. Lazarus and Folkman (1984) stated earlier that resources may increase coping through the appraisal process by fostering positive beliefs about one's ability to manage a stressful experience.

Research from a pathogenic perspective further provides indirect support that **perception of the actual childbirth experience** could have an effect on postpartum psychological well-being. For example, a recent study by Maclean, McDermott and May (2000), found that women who gave birth assisted by instrumental delivery

reported the childbirth event to have been distinctly more distressing than women delivering vaginally or by emergency caesarean section. Earlier, Tulman and Fawcett (1991) found that prolonged labour and caesarean delivery could become a hindrance to recovery after childbirth. Green et al. (1990) found that women's sense of personal mastery and sense of control further influenced their perception of the childbirth experience. Theoretically Green et al.'s findings could possibly be linked to those in the field of psychological well-being, specifically with the manageability component of the sense of coherence (Antonovsky, 1987). It is possible that women who have a stronger sense of coherence could experience childbirth more positively.

Some authors have commented on more **positive aspects related to the birth experience** (e.g. Nichols & Gennaro, 2000; Salmon & Drew, 1992). In an early empirical study Tanzer (1972, cited by Nichols & Gennaro, 2000) reported that some women have peak experiences or near mystical bliss during childbirth. Recently, Humenick et al. (2000) also suggested that active participation in childbirth could result in an experience similar to a flow experience (Csikzentmihalyi, 1990). Further research findings reported an increase in mothers' experience of independence, decisiveness and confidence from the prenatal to the postnatal period (Humenick & Bugen, 1981), and an increase in self-esteem (Mercer, Hackley & Bostrom, 1983). Fisher, Astbury and Smith (1997) found that women who had spontaneous vaginal deliveries were more likely to experience an improvement in such subjective states as mood and self-esteem. These findings give support to the conceptualisation of pregnancy and birth as a developmental task with the inherent potential for growth.

In summary, findings from the literature indicate that a woman's experience of labour and delivery could ultimately impact on her psychological well-being. Specifically, a negative birth experience could lead to the development of psychopathology, while a positive birth experience could contribute to a stronger sense of psychological well-being as indicated by increased self-esteem and positive mood, for example. Since prenatal perceptions seem to influence the ultimate experience of labour, intervention during pregnancy could play an important role in preventing pathology and promoting psychological well-being. It is evident that a new mother's perception of labour and delivery, both prenatalily and postpartum, should be taken into account when the effect of an intervention programme is being evaluated. In the current study, the perception of labour and delivery will be assessed by a scale adapted from the Childbirth Perceptions Questionnaire (Padawer et al., 1988).

### 5.2.2 Experience of relationship with the baby

The literature reviewed earlier in this chapter suggests that the developing of maternal attachment is an important task of motherhood (Leifer, 1980; Rubin, 1984; Mercer, 1986; Zwelling, 2000a). It commences during pregnancy and continues to develop after the baby has been born. Several authors have referred to the importance of a positive attachment with the baby, such as contributing to maintaining a positive sense of self and for achieving self-actualisation in the mothering role (Deutsch, 1945; Leifer, 1980; Rubin, 1984; Stern, 1995). Experiencing a positive relationship with the baby could possibly also be associated with positive attachment to the baby. Further, getting to know the baby and developing a bond with the baby is seen as a major psychological task during the postpartum period (Affonso, 1987; Woollett & Parr, 1997).

Prenatal expectations of motherhood seem to be related to the eventual experience of motherhood (Green & Kaftersios, 1997). Indirectly this suggests that women who experience positive feelings about their baby and their relationship with the baby, both during pregnancy and the postpartum period, could have a stronger sense of psychological well-being. This has an important implication for intervention and indicates that the facilitation of more positive expectations of motherhood during the prenatal period could theoretically contribute to a more positive experience of motherhood and the relationship with the baby.

Studies from a pathogenic perspective, focusing on disturbances in the early mother-child relationship, have received much attention (see Brockington, 1998 for a review). Recently, Condon and Corkindale (1997) found that depression, anxiety, and lack of support in pregnancy could negatively affect antenatal attachment, which is generally accepted to be a predictor of future maternal-child attachment. These reports from a pathogenic perspective provide support for the importance of an intervention programme that could alleviate distress during pregnancy and facilitate positive mother-infant attachment. In the current study, a positive relationship with the baby will be measured by a scale specifically compiled for purpose of the study, focusing mainly on the mother's experience of her relationship with the baby.

### 5.2.3 Maternal self-confidence

The role of maternal self-confidence in the experience of psychological well-being among new mothers has not been examined extensively, yet available literature suggests that maternal self-confidence should be considered when evaluating psychological well-being. In an early study, Ball (1987) found that maternal self-confidence within the first week of delivery was an important factor contributing to the mother's emotional well-being. It further seems that mothers' prenatal maternal self-confidence could be related to postnatal maternal self-confidence (Lederman, 1996; Pond & Kemp, 1992). From a pathogenic perspective, Fleming, Ruble, Flett and Shaul (1988) report a strong association between prenatal and postnatal depressed mood and lowered feelings of maternal adequacy after the baby was born.

In summary, although there is scant direct evidence regarding the role of maternal self-confidence as it specifically relates to psychological well-being, available literature suggests that the prenatal experience of maternal self-confidence could influence postnatal maternal self-confidence, and that depressed mood could negatively affect maternal self-confidence. These findings imply that an intervention programme should address maternal self-confidence during pregnancy and that it should be included as a variable in the evaluation of new mothers' psychological well-being. In the current study, maternal self-confidence will be measured by means of a scale adapted from the Childbirth Attitudes Questionnaire (Ruble, Brooks-Gunn, Fleming, Fitzmaurice, Stangor & Deutsch, 1990).

### 5.2.4 Maternal self-efficacy

Several authors have assessed the role of self-efficacy beliefs during pregnancy, labour and the postpartum period. Quite a number of studies have focused on the role of self-efficacy on the experience of pain during labour and delivery specifically (e.g. Larsen, O'Hara, Brewer & Wenzel, 2001; Lowe, 1991; Manning & Wright, 1983). Other studies have investigated the role of self-efficacy in the experience of parenting. In a longitudinal study, Williams, Joy, Travis, Gotowiec, Blum-Steele, Aiken et al. (1987) found that perceived parenting efficacy played a key role in adaptation to parenthood. Mothers who had strong beliefs in their care-giving capabilities, as measured before the birth of a first child, experienced more positive emotional well-being, closer attachment to their baby and better adjustment in the parental role postpartum. Similarly, Teti and Gelfand (1991) evaluated the role of

mothers' self-efficacy beliefs on parenting behaviour. They found that maternal self-efficacy correlated significantly with maternal depression and feelings of maternal competence. Reece and Harkless (1998) recently reported an inverse relationship between stress and perceived parenting self-efficacy, and further found that self-efficacy and stress were modest predictor variables in explaining adaptation to parenthood. It has also been suggested that self-efficacy could have a mediational effect on postpartum depression (Cutrona & Troutman, 1986).

Since these findings suggest that feelings of maternal self-efficacy could be related to psychological well-being, it should be included in the evaluation of an intervention programme. In the current study, the focus is placed on maternal self-efficacy, which can be described as feelings of efficacy in the maternal role (Teti & Gelfand, 1991), and can be viewed as domain-specific efficacy. Hypothetically then, stronger feelings of competence in the maternal role could be related to psychological well-being. Relevant items from the Maternal Self-Efficacy Scale (Teti & Gelfand, 1991) will be used to assess maternal self-efficacy.

## 5.3 Aspects of psychological well-being as evident by the absence of pathology

Literature on the prevalence of psychopathology during pregnancy and early motherhood is voluminous. Offerman-Zuckerberg (1980) compiled a list of psychological "warning signals" that warrant psychological intervention during pregnancy, while Brockington (1998) recently published a comprehensive work on motherhood and mental health. Similarly, Bernazzani, Saucier, David and Borgeat (1997) investigated psychosocial factors related to emotional disturbances (depressive symptoms, excessive fears and ambivalence) during pregnancy. In the realm of psychopathology during this period in a woman's life, the focus has mostly been on depression during and after delivery.

### 5.3.1 Depression during pregnancy

Prenatal depression has recently been receiving more attention (Evans, Heron, Francomb, Oke & Golding, 2001; Green, 1998). Previously, prenatal mood has only been examined as a predictor of postnatal depression, but a recent study by Evans et al. (2001) found that depression is common in pregnancy and that self-reported

scores for depression might be higher in pregnancy than in the postpartum period. The data further suggest that depression is no more likely after childbirth than during pregnancy. These findings coincide with those reported by Green (1998), namely that prenatal dysphoria is at least as prevalent as postnatal dysphoria. Depression during pregnancy seems to be highly associated with adverse circumstances and psychosocial stressors (Cooper & Murray, 1998), and could have some negative effects that could spill over into the postpartum period. Miller and Shah (1999, cited by Miller, 2002) found that women who developed major depression during pregnancy are at risk of exacerbation of depression in the postpartum period, and also of increased obstetric complications. Maldonado-Duran et al. (2000) point out that severe depression during pregnancy could lead to feeling disconnected and distant from the baby in the womb, which has obvious consequences for the mother-infant relationship after the birth. Early detection of symptoms of depression during pregnancy and prompt initiation of treatment is therefore important in reducing adverse consequences (Miller, 2002).

It is evident from recent findings that a prenatal intervention programme should include strategies to ameliorate existing distress such as depression, since it seems to be more prevalent than previously accepted. Such an intervention could be seen as contributing to psychological well-being by reducing depressed mood during pregnancy, and possibly preventing the escalation of depression during the postpartum period.

### 5.3.2 Postpartum depression

Boath and Henshaw (2001) describe postpartum depression as the least well defined postpartum mood disorder. Although there is still considerable debate on whether postpartum depression is a distinct syndrome (Boath & Henshaw, 2001), there seems to be general agreement that it can be viewed as a serious disorder. Common symptoms include: depressed mood, sleep disturbance, appetite disturbance, fatigue, irritability, anhedonia, loss of concentration, ideas of not coping, self-blame and guilt, thoughts of self-harm, rejection of the baby, thoughts of harming the baby, impaired libido, worry, tension and anxiety, and somatic features of depression, such as headache (Cooper, Campbell, Day, Kennerley & Bond, 1988; O'Hara, 1994).

When the literature on postpartum depression is considered, it appears that many of the mother's risk factors for a negative experience in the postpartum period include pre-existing psychological characteristics such as anxiety, fragile self-esteem, lack of assertiveness or a previous history of psychological disorder (Cooper & Murray, 1997), as well as depression during pregnancy (Beck, 2001; Miller, 2002). Postpartum depression may have a considerable impact on the woman and her long-term relationships and adjustment (O'Hara, Zekoski, Philipps & Wright, 1990), the mother-infant relationship (Edhborg, Lundh, Seimyr & Widström, 2001; Righetti-Veltema, Conne-Perréard, Bousquet & Manzano, 2002), infant emotional development (Murray, Cooper & Stein, 1991), as well as cognitive ability during middle childhood (Hay et al., 2001).

The incidence rate of postpartum depression is estimated at around 13 % (O'Hara and Swain, 1996), but in a South African sample the incidence rate was found to be 27,2 % (Spangenberg & Pieters, 1991). Despite the fact that there does not exist a uniform approach to the treatment of postpartum depression (Boath & Henshaw, 2001), there have been findings that support the application of cognitive-behavioural and interpersonal psychotherapy, suggesting that depression following childbirth could be prevented by brief interventions in the prenatal period (Elliot et al., 2000; Spinelli, 1999).

In a study that provides support for the view that absence of pathology may be related to psychological well-being, Green and Kaftersios (1997) found that negative mood, as indicated by the Edinburgh Postnatal Depression Scale, had a correlation of –0.46 with a variable termed "positive experiences of motherhood". This led them to conclude that a positive postnatal experience is more than simply the inversion of negative mood.

It is evident that postpartum depression remains a serious disorder, thereby implying that the absence of depression in the postpartum period could be expected to be related to a stronger sense of psychological well-being.

### 5.3.3 Implications for investigating psychological well-being

From a salutogenic/fortigenic paradigm, well-being is seen as distinctly different from pathology (Antonovsky, 1987; Heady & Wearing, 1992; Wissing, 2000). However, as Heady and Wearing (1992) point out, an investigation focusing only on well-being

might be one-sided and therefore it seems sensible to include indications of the absence or presence of psychological distress or psychopathology in the current study. Massé, Poulin, Dassa, Lambert, Bélaire and Battaglini (1998) have similarly suggested that the assessment of mental health in general populations should include concomitant measures of psychological distress and well-being.

In research done with a large South African sample, Wissing and Van Eeden (1997) report a significant relationship between psychological well-being and the absence of general symptoms of mental disorder as measured by the GHQ (Goldberg & Hillier, 1979). Wissing and Van Eeden (1997) conclude that well-being and psychopathology could be viewed as separate dimensions of human functioning. While high scores on indicators of wellness may indicate well-being, low scores do not necessarily indicate pathology. Accordingly, the absence of pathology does not necessarily indicate well-being. It is, however, probable that high scores on one dimension will accompany low scores on the other.

In the current study, a measure of pathology related specifically to pregnancy and the postpartum period is the Edinburg Postpartum Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987). The absence of pathology as reflected by low scores on the EPDS have been used by Green (1993) and more recently by Windridge and Berryman (1999) to indicate emotional well-being in postpartum women. The EPDS will be included in the current study since it has previously been administered in studies related to well-being and because it is relevant to the population of the study. A second measure to be included investigates the degree of mental (ill) health, namely the General Health Questionnaire (Goldberg & Hillier, 1979). The GHQ has recently been found effective in detecting postpartum depression in Chinese women in Hong Kong (Lee, Yip, Chiu, Leung & Chung, 2001). The GHQ is aimed at detecting common symptoms that are encountered in various syndromes of mental disorders, and will thus differentiate individuals with psychopathology from individuals considered to be mentally healthy.

## 5.4 Aspects related to general psychological well-being

Contemporary research related to psychological well-being has mostly centred on the variables that enhance or diminish well-being within a specific population, through the use of some pre-existent measure of well-being (Christopher, 1999). In

an empirical investigation with a large South African sample, Wissing and Van Eeden (1997, 2002) identified a general psychological well-being factor that is characterised by a sense of coherence in life, an affect balance and general satisfaction with life judged by subjective criteria. These researchers concluded that psychological well-being seems to be a multidimensional phenomenon with regard to aspects of the self that are involved (such as affect, cognition, behaviour), and with regard to the domains of life in which these facets manifest themselves (intra- and interpersonal, social and contextual, love and work). In accordance with the findings of Wissing and Van Eeden (1997, 2002), the constructs of life satisfaction, affect balance, sense of coherence, as well as generalised self-efficacy are regarded as relevant in exploring psychological well-being in the current study.

### 5.4.1 Life satisfaction

Satisfaction with life can be described as a cognitively based or a rational evaluation of well-being (Diener et al., 1999). Little has been written regarding life satisfaction during pregnancy or early motherhood. The only relevant study retrieved during the literature review was that of Jambunathan and Stewart (1997), who explored the relationship between postpartum family support and life satisfaction among a group of Vietnamese women living in Wisconsin. The authors used semi-structured interviews rather than standardised scales assessing global life satisfaction.

Although not specifically related to the concept of life satisfaction, a related study that should be mentioned here is that of Leifer (1980). Leifer explored the psychological experience of first-time mothers by means of structured interviews during various phases of pregnancy. She found that, despite the increase of psychological stress during pregnancy, feelings of joy, pride, satisfaction and happiness were also experienced. Women in their second trimester seemed to experience the most intense feelings of well-being, while well-being was less pronounced during the last part of pregnancy.

Support for the importance of life satisfaction has been confirmed by the work of various researchers in the field of psychological well-being (e.g. Wissing & Van Eeden, 2002). An evaluation of life satisfaction can therefore be viewed as an important aspect in examining the psychological well-being of first-time mothers. In the current study, the Satisfaction with Life Scale is included to get an indication of first-time mothers' cognitive evaluation of their life as a whole, according to their own

criteria. This operationalisation further serves to assess psychological well-being from a hedonic perspective.

### 5.4.2 Affect balance

The balance between positive and negative affect (with preponderance of positive affect, rather than absence of negative affect) is generally accepted as being important in the exploration of psychological well-being (Diener, 2000). Some researchers have investigated the role of affect balance during pregnancy and early motherhood. For instance, Black-Olien (1993) evaluated the effect of a prenatal educational programme for married couples (based on communication skills and relaxation training skill) on postpartum psychological well-being. Black-Olien evaluated both spouses on the Bradburn (1969) Affect-Balance Scale during pregnancy and again two months postpartum, comparing their responses to a control group. She found no significant difference between the experimental and control group with regard to either positive affect scores or negative affect scores. However, there was a significant ($p = 0.03$) difference between the experimental and control group with respect to scores obtained by subtracting the negative from the positive subscale scores. Black-Olien (1993) concluded that the data suggests that couples who participated in the programme experienced a stronger sense of emotional well-being than those in the control group did.

In another study, Priel, Gonik and Rabinowitz (1993) examined the role of hardiness and affect on appraisals of the childbirth experience. They reported that positive affect, measured during the second trimester, did not predict post- delivery outcomes, while negative affect was related to painful perceptions of labour, negative appraisals of coping and negative perceptions of the baby. A recent study by Dimitrovksy, Lev and Itskowitz (1998) investigated the relationship of maternal and general self-acceptance to pre- and postpartum affective experience, using Bradburn's (1969) affect balance scale, among others. They found a positive correlation between depression and negative affect both during pregnancy and in the postpartum period, a significant negative correlation between depression and positive affect postpartum, and a significant inverse relationship between positive and negative affect postpartum.

Finally, research from a life-span perspective gives some indirect evidence that major life events could lead to changes in positive and negative affect. Stallings and

Dunham (1997) found that desirable life events predicted changes in positive affect, while negative life events predicted changes in negative affect. These authors argued that the birth of a child could be seen as a normatively positive event. However, research on the relationships between various life events and positive well-being failed to find consistent or substantial evidence (Avison & Turner, 1988; Kessler, Price & Wortman, 1985). This inconclusiveness has been especially true for positive life events (Zautra & Reich, 1980, 1983). According to Stallings and Dunham (1997), part of this inconsistency may be due to a tendency of researchers to focus on negative outcomes such as depression rather than looking at positive and negative affect independently.

It seems then that positive affect, in particular, could play an important part in postpartum psychological well-being, but results have not been consistent. Further research is needed to understand the contribution of affect balance in postpartum psychological well-being. In the current study affect balance will be measured by Affectometer 2 (Kammann & Flett, 1983). It has been widely used in South African studies to measure affect as part of psychological well-being (e.g. Wissing et al., 1999; Wissing & Van Eeden, 2002).

### 5.4.3 Sense of coherence

In stressful circumstances, a sense of coherence may make the difference between pathological stress and salutogenic tension management. According to Antonovsky (1979), in tension states a strong sense of coherence (SOC) promotes the mobilization of generalised resistance resources to facilitate effective coping, resolve tension in a salutary manner and reinforce the initial level of the sense of coherence. The transition to parenthood is often seen as a stressful event, therefore it is relevant to explore the role of SOC in women's general adjustment to motherhood. No literature could be found regarding the role of a sense of coherence in the transition to motherhood. However, one study included the construct of hardiness, which is often mentioned in articles covering the sense of coherence construct. Priel, Gonik and Rabinowitz (1993) found that women with a high level of hardiness had more positive perceptions of their experience of childbirth and their new-born babies. Although hardiness is theoretically a different construct from sense of coherence, it could be seen as indirect support that dispositional personality factors could have some relationship to the psychological well-being of first-time mothers.

In the current study, SOC will be measured by the Sense of Coherence Scale (Antonovsky, 1987, 1993). The SOC has been included in several studies regarding psychological well-being in South Africa (e.g. Strümpfer & Wissing, 1998; Wissing et al., 1999; Wissing & Van Eeden, 2002).

### 5.4.4 Generalised self-efficacy

Generalised self-efficacy has been described as a broad and stable sense of personal competence to deal effectively with a variety of stressful situations (Schwarzer, 1993). Since Schwarzer and Scholz (2000) conceptualise perceived self-efficacy as a coping resource, and Antonovsky (1991) describes it as salutogenic strength, a strong sense of self-efficacy can be considered to be a component of psychological well-being.

Little research has been done regarding the role of generalised self-efficacy during pregnancy and early motherhood. A study by Mikus (1981, cited by Antonnuci and Mikus, 1988), could provide some indirect evidence to the role of generalised self-efficacy in early motherhood. Mikus found that mothers of young children felt less in control of their lives than women who did not have children, yet there was no evidence of lowered self-esteem, increased levels of depression or more negative self-opinions. According to Antonucci and Mikus (1988), these findings should be viewed in terms of the reality of having to look after young children, rather than mothers' diminished views of themselves as active agents in the world. A further interesting finding in Mikus's (1981) study was that a moderate sense of self-efficacy was related to a more positive experience of parenthood, while a strong sense of self-efficacy was related to a negative response to motherhood. However, the permanence of this sense of self-efficacy has not been examined.

Research in the field of psychological well-being in general lends further indirect support for the importance of generalised self-efficacy in the experience of well-being. For instance, a large body of research points to the fact that feeling competent and confident with respect to important goals is associated with enhanced well-being (Carver & Sheier, 1999; McGregor & Little, 1998). It is therefore important to include the construct of self-efficacy in the evaluation of psychological well-being during the transition to motherhood.

Generalised self-efficacy has previously been measured by the General Self-efficacy Scale of Tipton and Worthington (1984) and the Generalised Self-efficacy Scale (Schwarzer & Jerusalem, 1995). In the current study, a generalised sense of self-efficacy will be measured by means of the Generalised Self-efficacy Scale (Schwarzer & Jerusalem, 1995). It seems to be a universal construct with similar characteristics being found in many cultures (Schwarzer & Scholz, 2000).

## 5.5 Conclusion

When psychological well-being during pregnancy, childbirth and early motherhood is considered, various facets should be taken into account. In the current study, these facets have been grouped into three broad areas, focusing on specific aspects of early motherhood, aspects of pathology as well as aspects of general psychological well-being.

By including a more comprehensive assessment of psychological well-being, shortcomings in previous research could possibly be addressed. Most of these studies did not include a comprehensive assessment of psychological well-being, and focused only on a particular aspect of well-being such as affect (Black-Olien, 1993) or absence of pathology (Green, 1993). Another problem in this area of research seems to be inconsistency in the meaning and operationalisation of the psychological outcomes (Wilkinson, 1995). The current study is an attempt to broaden understanding of psychological well-being during the life transition of first-time mothers.

# 6. EVALUATION AND INTEGRATION

Pregnancy, birth and early motherhood are normative events in the lives of most women. It is a transitional period providing opportunity for growth and discovering of new strengths. However, there is scant evidence regarding the nature of positive experiences and the existence of psychological well-being during this life transition. Further, evidence from research done from a pathogenic perspective suggests the importance of utilising this period to prevent distress during pregnancy and after childbirth, and to prepare new mothers for the adjustment to their new role. Although childbirth education programmes are widely implemented, most current programmes seem to neglect psychological aspects such as preparation for motherhood, and emotional management of the pregnancy, labour and postpartum period.

The author's interest in the positive aspects of childbearing results from the current interest in wellness and psychological well-being in the field of psychology. It is evident that a new paradigm is evolving, focusing on health, strengths, capacities and wellness, referred to as the salutogenic or fortigenic paradigm (Strümpfer, 1990, 1995). This paradigm is distinctly different from the pathogenic paradigm, that has traditionally been prominent in scientific studies in the field of psychology.

However, despite the increased interest in psychological health, wellness and well-being, there is still no single definition or explanatory model of psychological well-being that is generally accepted. Several models of psychological well-being have been presented in this chapter, each contributing to an understanding of specific facets of psychological well-being. These models can broadly be grouped into models on the structure of psychological well-being (hedonic, eudaimonic and pragmatic models) and models on the dynamics of psychological well-being.

After having considered literature regarding pregnancy and early motherhood, as well as literature on psychological well-being, it was proposed that psychological well-being during this specific developmental period be explored within three clusters: aspects of psychological well-being related to early motherhood (including perception of labour and delivery, relationship with the baby, maternal self-confidence and maternal self-efficacy); aspects of psychological well-being related to the absence of pathology (depression and general symptomatology); and aspects of psychological well-being related to general psychological well-being (life satisfaction, affect balance, sense of coherence and generalised self-efficacy).

Since there is a lack of scientific knowledge regarding the more positive aspects associated with childbearing, and there seems to be a need for more comprehensive preparation for motherhood, it can be argued that an intervention from a salutogenic/fortigenic perspective that acknowledges the salutogenic strengths of pregnant women and that could provide them with coping skills for the challenges they are experiencing in the transition to motherhood, should be developed. Further, in light of evidence from a pathogenic perspective, there is also a need for therapeutic intervention to address existing pathology and prevent the development of pathology. In the current study, hypnotherapy was selected as therapeutic approach in serving this purpose. The clinical application of hypnotherapy will be explicated in the next chapter.

# CHAPTER 3

# CLINICAL HYPNOSIS AS THERAPEUTIC INTERVENTION STRATEGY

## 1. INTRODUCTION

Hypnosis has been used as a therapeutic approach since the early nineteenth century. At that time, it was seen as a distinct mode of treatment (Kirsch, Lynn & Rhue, 1997). Since the 1980s, hypnosis has become increasingly accepted in scientific and scholarly circles (Barton, Strauss & Reilly, 1995; Lynn & Rhue, 1991), and applications of hypnosis are on the increase. Gravitz (1991) states that the current wave of worldwide scientific and clinical interest is the strongest and most enduring in the long history of this modality. According to Baker (1987), the recent surge of interest in clinical applications of hypnosis stems in part from a more solid research base, but there is growing acknowledgement of the need to conduct more rigorous investigations (Lynn & Rhue, 1991).

In this chapter, hypnosis will be examined as an approach that could contribute to the promotion of psychological well-being in general and the psychological well-being of new mothers in particular. The choice of hypnotherapy as therapeutic approach in this study is based on the fact that clinical research generally substantiates that hypnotic procedures can ameliorate some psychological and medical conditions, as well as being cost-effective (Lynn, Kirsch, Barabasz, Cardena & Patterson, 2000).

The use of hypnosis in contemporary psychotherapy is usually embedded in a broader therapeutic approach (Barber, 1991; Frederick & McNeal, 1999; Kirsch, Lynn & Rhue, 1997; Yapko 1995). One such example is an empirical study done by Kirsch, Montgomery and Sapirstein (1995), where it was found that hypnosis could be a useful adjunct to cognitive-behaviour therapy for treating obesity. The authors suggest that more research is needed to establish the range of treatments and conditions that can be enhanced by the addition of hypnosis. Hammond (1990c) also advocates an eclectic, multidimensional orientation that seeks to be comprehensive,

incorporating methods from many hypnotic approaches, which he refers to as "integrative hypnotherapy".

In the current study, hypnotherapy will be conceptualised from the framework of both the Ericksonian approach to psychotherapy and the ego state therapy approach. It is however, necessary to first give a short overview regarding the history of hypnosis after which it will be defined and conceptualised. The main theoretical models regarding hypnosis will be mentioned, and then the therapeutic approaches applied in the current study will be explicated in more detail. The chapter concludes with an analysis of relevant empirical research regarding the use of hypnosis in obstetrics.

## 2. OVERVIEW OF THE HISTORICAL BACKGROUND OF HYPNOSIS

Hypnosis can be seen as one of the oldest mind-body approaches and has been used by ancient peoples in healing practices that used the medium of induced states of altered awareness (Hornyak & Green, 2000). It is generally agreed that the modern history of hypnosis can be traced back to the work of Franz Anton Mesmer (Kirsch, Lynn & Rhue, 1997). He was a flamboyant Viennese physician who believed that an invisible magnetic fluid permeated the universe, that certain diseases were produced by an imbalance of this fluid and that these conditions can be cured by restoring the body's magnetic balance. Mesmer believed that the healer's body is itself permeated by animal magnetism, and that it could redirect the patient's magnetic fluid by various means, including touching and making "passes" over the body.

In 1785 mesmerism, as it became known, was investigated and discredited by a Royal Commission in Paris. It was concluded that the observed effects were not due to animal magnetism but to imagination. Thereafter mesmerism fell into decline.

Early In the 19th century, James Braid, a physician, witnessed a somnambulist state in his patients, which he called "nervous sleep". He concluded that the mesmerists had discovered an important medical procedure but stated that it was not due to animal magnetism. Rather, it was produced by fatigue of the eye muscles due to staring at a fixed point that was slightly above the normal line of vision. Braid named the phenomenon "hypnotism", derived from the Greek word "hypno", which means sleep (Kirsch, Lynn & Rhue, 1997).

Later in the 19th century, Bernheim and Liebeault experimented with similar techniques as did Jean-Martin Charcot, a neurologist from the Salpetrêriére hospital in Paris. There was considerable dispute between Bernheim and Liebault (later referred to as the Nancy school) and Charcot (Hilgard & Hilgard, 1994). Bernheim and Liebeault believed that hypnosis was an entirely natural phenomenon and attributed it to the influence of suggestion, while Charcot regarded hypnosis as essentially hysterical and limited to people suffering from abnormality of the nervous system. On the positive side Charcot showed how conversion symptoms could be removed by posthypnotic suggestion and also held the idea that certain thoughts could be dissociated from conscious awareness. This later led to Freud's adoption of the unconscious. Freud studied with Bernheim and Liebeault but later denounced hypnosis, which appeared to have been a fatal blow for its clinical application (Kirsch, Lynn & Rhue, 1997).

In the twentieth century, a new life for hypnosis began at the end of World War I, when the soldiers with "shell shock" were treated by English psychologist William McDougall using hypnosis (Hilgard & Hilgard, 1994). In the 1930s, hypnosis was further revived by a classic research programme initiated by Clark Hull. One of his students, Milton H. Erickson continued to develop therapeutic techniques that are still widely used today (Kirsch, Lynn & Rhue, 1997). Erickson developed a technique that was naturalistic, permissive and indirect, utilising each person's own unique capabilities to facilitate change. He has been accredited with revitalising hypnosis in the United States (Sthalekar, 2000). Erickson's approach is explicated in more detail in paragraph 5.1. A further contribution to the development of hypnosis that should be mentioned, is the work of John and Helen Watkins (J.G. Watkins, 1987, 1992; J.G. Watkins & H.H. Watkins, 1997), who created ego state therapy. This is a hypnoanalytic form of treatment based on the integration of individual, group and family therapy techniques, founded on the theory of the existence of different subselves or ego states that are unique to each individual. Ego state therapy is described in more detail in paragraph 5.2.

Hilgard and Hilgard (1994) conclude that although hypnosis has had a cyclical history of acceptance and rejection since the time of Mesmer, it has now gained a significant place in medical and psychological science.

## 3. DEFINING HYPNOSIS

There seems to be no commonly accepted definition of hypnosis (Kirsch, Lynn & Rhue, 1997; Nadon, Laurence & Perry, 1991; Rossi, 1993; Watkins, 1987; Yapko, 1995), or an explanation that is satisfactory to all involved in the field. Watkins (1987) ascribes this to the fact that hypnosis may not be a single, unitary entity, while Baker (1987) believes that an increasing pragmatic and technological emphasis has supplanted the drive to understand hypnotic phenomena and the complexities of human behaviour. Lynn and Rhue (1991) also point out that it could be due to the fact that the field of hypnosis is far from reaching a consensus about how to explain hypnotic phenomena.

Hypnosis has been defined differently by different models, for example as an altered state of consciousness, (Fromm, 1992), dissociation (Bowers & Davidson, 1991), a special form of regression (Nash, 1992), a sociocognitive phenomenon (Spanos, 1991), a permissive state (Weitzenhoffer, 1989), role playing (Coe & Sarbin, 1991), and as an interactional outcome (Yapko, 1995; Zeig & Rennick, 1991).

In reaction to the continuing debate on the definition of hypnosis, the American Psychological Association's Division 30 (Division of Psychological Hypnosis) in 1994 adopted a definition that was developed from a dialogue among prominent clinicians and researchers in the field (Kirsch, 1994, p. 143): "Hypnosis is a procedure during which a health professional or researcher suggests that a client, patient or subject experiences changes in sensations, perceptions, thoughts, or behaviours. The hypnotic context is generally established by an induction procedure".

For the purpose of the current study, the APA definition will be accepted as definition of the phenomenon of hypnosis. However, the clinical application of hypnosis is usually embedded within a specific therapeutic approach, which consequentially influence the "working definition" of hypnosis. Yapko (1992, p. 37), for instance, defines hypnosis as :... a process of influential communication in which the clinician elicits and guides the inner associations of the client in order to establish or strengthen therapeutic associations in the context of a collaborative and mutually responsive goal-oriented relationship".

This definition is characteristic of the utilisation approach to hypnotherapy, which is one of the key principles of the Ericksonian perspective on hypnotherapy. This approach will be discussed in more detail in paragraph 5.1 in this chapter.

Although no common definition of hypnosis exists, there are areas of agreement on what Hilgard (1992) refers to as "the domain of hypnosis". This domain characterises the kind of phenomena that are included, such as muscular movements, sensory distortions, hallucinations, posthypnotic amnesia and hypnotic dreams. These phenomena will be discussed in more detail in paragraph 5.1.5 in this chapter. Firstly the most prominent explanatory models of hypnosis will be presented.

# 4. EXPLANATORY MODELS OF HYPNOSIS

## 4.1 Introduction

Different theories of hypnosis have been developed over the years but still there is no single unifying theory of hypnosis to account for all the various facets of hypnosis (Yapko, 1995). Both Hammond (2000) and Wickramasekera (2000) point out that hypnosis is multidimensional and cannot be effectively explained by a unifactorial model.

It is notable that there appears to be a polarisation of the field: some researchers – such as Hilgard (1977) – interpret hypnotic phenomena as reflecting processes unique to the hypnotic context and essentially unrelated to waking behaviour, while others such as the social psychological theorists maintain that there is nothing special about hypnotic phenomena and focus more on the demand characteristics of the hypnotic situation (Dixon & Laurence, 1992). This polarisation is often referred to as the state versus non-state debate and seems to continue despite attempts to find common ground (Kihlstrom, 1997).

This debate began in the 1960s with T.X. Barber's criticism against the popular conception of hypnosis as a unique state of consciousness (see Fellows, 1990, for a review). Briefly summarised, the state versus non-state debate refers to ongoing differences between scholars regarding the question whether hypnosis is a distinct state of consciousness or not. According to state theorists, hypnotic inductions

produce one or more distinct states of consciousness that are distinguishable from waking consciousness and from other altered states (Kirsch, 1992). Non-state theorists argue that hypnosis is not a particular experience, but could be defined only by the social context in which it is evident (Spanos, 1991).

In the following section the most prominent perspectives on hypnosis will briefly be presented. Since the conceptualisation of hypnosis will ultimately have implications for its application, the therapeutic perspectives from which the current study will be conceptualised, namely the Ericksonian approach and ego state therapy, will be evaluated in more detail.

## 4.2 The neodissociation perspective

The neodissociation perspective is one of the dominant contemporary hypnosis perspectives (Lynn & Rhue, 1991). Historically, this theory goes back to the work of Pierre Janet towards the end of the nineteenth century. He put forward the view that systems of ideas can become split off from the main personality and can exist as a subordinate personality that is capable of becoming conscious through hypnosis (Fellows, 1990). Hilgard (1977, 1991) reformulated the theory by integrating it with concepts from information processing, divided attention and brain functioning, calling it "neodissociation theory".

The underlying assumption in this theory is that there are multiple cognitive systems, which normally work synergistically under the control of a primary or executive control. During hypnosis, the normally integrated subsystems dissociate from one another to various degrees and are thus capable of independent and multi-level responses. Hilgard (1991) states that the neodissociation theory is intended to be more general than a theory of hypnosis, but its origin has been within hypnosis experimentation.

According to the neodissociation theory, both motoric and nonmotoric responses, such as amnesia and analgesia, are potentially mediated by dissociative processes. In this view, hypnotisability is also seen as generally stable, with trait-like properties (Hilgard, 1991). The neodissociation theory further proposes that hypnotically suggested behaviour is purposeful, in the sense that it is goal-directed – that is, it achieves the suggested state of affairs. However, behaviour can be non-volitional, in

the sense that it is not performed on purpose – that is, it does not flow from executive initiative and effort (Bowers & Davidson, 1991).

## 4.3 Hypnosis as psychological regression

According to this model, hypnosis is a special form of psychological regression. This regression is characterised by fundamental alterations in the experience of self, relationships and the way information is processed. (Nash, 1991). There is a shift to more primary-process thinking and increased transference to the hypnotherapist.

## 4.4 Hypnosis as relaxation

Edmonston (1991) mainly developed the theoretical stance that relaxation is the source from which all hypnotic phenomena are derived. He proposes to replace the term "hypnosis" with "anesis", the noun form of the Greek verb *anieses* - "to relax, to let go." Edmonston states that relaxation is such a basic process that other mechanisms, such as dissociation and psychological regression, are secondary to it.

## 4.5 The socio-cognitive perspective

The socio-cognitive view has developed strongly over the past decades and is often contrasted to more traditional conceptualisations of hypnosis such as the neodissociation theory (Lynn & Rhue, 1991). According to this perspective, hypnosis is not a particular or unique experience, but is defined only by the social context in which it is evident and through the manner in which responses are deemed hypnotic by participants who label it as such (Coe & Sarbin, 1991; Spanos, 1991; Spanos & Coe, 1992).

In a particular socio-cognitive perspective described as the social-psychological approach, hypnotic responding is viewed as fundamentally similar to other, more mundane forms of social interaction. A hypnotic subject is seen as being attuned to contextual demands and being able to guide his behaviour in terms of his understanding of those demands and in terms of the goals he wishes to achieve (Spanos & Coe, 1992). According to this view, it is suggested that hypnosis as a separate and unique entity of consciousness does not really exist and it only exists when someone is willing to role-play it. Hypnosis is therefore not seen as a state or

condition of the person, but as context-dependent (Spanos, 1991). In the socio-cognitive view it is further maintained that hypnotic responsiveness can be modified and that hypnotic subjects have control over their behaviour (Lynn & Rhue, 1991).

## 4.6 Hypnosis as an altered state of consciousness

One of the early and historically popular conceptualisations of hypnosis was that it is an altered state of consciousness (Yapko, 1995). In this perspective, the hypnotic state is considered to be a unique and separate state of consciousness relative to one's "normal" state of consciousness. According to the psychoanalytically based view of Fromm (1992), hypnosis is an altered state of consciousness in which the ego functions in a manner that is different from the way in which it functions in the waking state.

## 4.7 Interactive-phenomenological theories

Theories that place particular emphasis on interaction of multiple variables during hypnosis, and on understanding the subjects' experience, are seen as interactive-phenomenological theories (Lynn & Rhue, 1991). More emphasis is placed on the study of interactive processes and differences between hypnotic and waking behaviour, and cognitive activity, are underscored. Finally, subjects' personality traits, styles, and abilities are accorded a prominent role in shaping or facilitating hypnosis.

Nadon, Laurence and Perry (1991) propose a synergistic model where the multidimensional nature of hypnosis is addressed. According to this model, the interrelationship of personality, cognitive and social-psychological factors should be examined in the explanation of hypnotic performance.

Sheehan (1991) and McConkey (1991) emphasise subjects' cognitive commitment to co-operate with the hypnotist and to resolve conflicting role demands in a goal-directed manner. The subject's experience of hypnosis and the phenomenological meanings of suggested events are seen as important.

The social-psychobiological model of Banyai (1991) is a multidimensional approach. Hypnosis is seen as an altered state of consciousness, which may have a socially

and biologically adaptive value by eliciting meaningful cognitive and emotional experiences in both the hypnotist and the subject.

## 4.8 Conclusion

Hypnosis remains a complex phenomenon. It is clear that there are various views regarding the nature of hypnosis and that major differences still exist between researchers adhering to these schools of thought. Most workers, however, agree that a domain of hypnosis exists and that there are various hypnotic phenomena associated with hypnosis. For the purpose of the current study, it is sufficient to accept that hypnosis exists and that it has been proven to be a useful adjunct to psychotherapy (Kirsch et al., 1995; Schoenberger, 2000). This study deals mainly with the clinical application of hypnosis within a therapeutic context. Since hypnosis is usually applied within a specific therapeutic approach, the relevant therapeutic frameworks utilised in the current study will be explicated in the next section.

# 5. HYPNOTHERAPEUTIC APPROACHES UTILISED IN THE CURRENT STUDY

## 5.1 The Ericksonian approach

### 5.1.1 Introduction

The Ericksonian approach to hypnotherapy is based on the work of Milton H. Erickson. He is often seen as a person who pioneered the clinical use of hypnosis as no other person has done (Lankton & Lankton, 1983), and has been described as the best-known American practitioner of hypnosis in the twentieth century (Gravitz, 1991). Erickson founded the American Society of Clinical Hypnosis in 1957 and edited the *American Journal of Clinical Hypnosis* from 1958 to 1968. He published more than 100 scholarly articles primarily on the use of hypnosis. Erickson died in 1980. In the following section, the Ericksonian approach to hypnotherapy will be explicated and the main characteristics of the approach will be described.

### 5.1.2 Defining an Ericksonian approach to hypnotherapy

Defining an Ericksonian approach to hypnotherapy is a difficult task. Lankton (1994) points out that there is controversy and confusion about what "Ericksonian therapy" means. Erickson never developed a comprehensive, synthesised system of hypnosis (Gravitz, 1991) and he was often described as being atheoretical. The result was that several of his followers compiled their own models based on his approaches. Each has tended to emphasise one or another feature of his work (Zeig & Rennick, 1991), which makes it difficult to define an Ericksonian approach to hypnotherapy. Yapko (2000, personal communication) points out that Ericksonian hypnosis is not a therapy, but rather a certain style of doing hypnosis. Lankton (2001) goes as far as stating: "There is no Ericksonian hypnotherapy. Hypnosis is hypnosis. Erickson often used hypnosis in his problem solving approach." He continues to argue that Ericksonian therapy refers to a particular problem solving approach that Erickson pioneered. This approach concerns a unique view of people and problems, a paradigm for change, and is also associated with several techniques that Erickson popularised.

Erickson himself never compiled a comprehensive definition of hypnosis or hypnotherapy, but offered many definitions with the same theme (South, 1999). Some examples include the following: Erickson (1957/1980, p. 54) defined hypnosis as: "... a special but normal type of behaviour, encountered when attention and the thinking processes are directed to the body of experiential learnings acquired from, or achieved in the experiences of living". Another definition is that hypnosis is a special, inner-directed, altered state of functioning (Erickson, Rossi & Rossi, 1976, cited by Zeig & Rennick, 1991). Rosen (1982, p. 28) states that Erickson's own summary of hypnosis was:"... the evocation and utilisation of unconscious learnings". South (1999) concludes that the following definition, as presented in Haley (1973, 1986), is the most encompassing and functional: "Hypnosis is essentially a communication of ideas and understandings to an individual in such a fashion that he will be most receptive to the presented ideas and thereby be motivated to explore his body potentials for the control of his psychological and physiological responses and behavior".

It can be concluded that although there seems not to be a single definition of "Ericksonian hypnotherapy", there are certain principles that are characteristic of an Ericksonian approach. These principles, which form an integral part in the current

study aimed at promoting psychological well-being in the specific developmental phase of first-time motherhood, will be explicated in section 5.1.4. Firstly, however, it is necessary to briefly consider a general model of psychotherapy from an Ericksonian point of view.

### 5.1.3 A Metamodel of Psychotherapy: The Ericksonian Diamond (Zeig, 1994)

Zeig (1992, 1994) compiled a metamodel of therapeutic intervention, based on the principle of utilisation (see paragraph 5.1.4.2 in this chapter). It is based on five pivotal "choice points". The model is presented graphically in Figure 5.

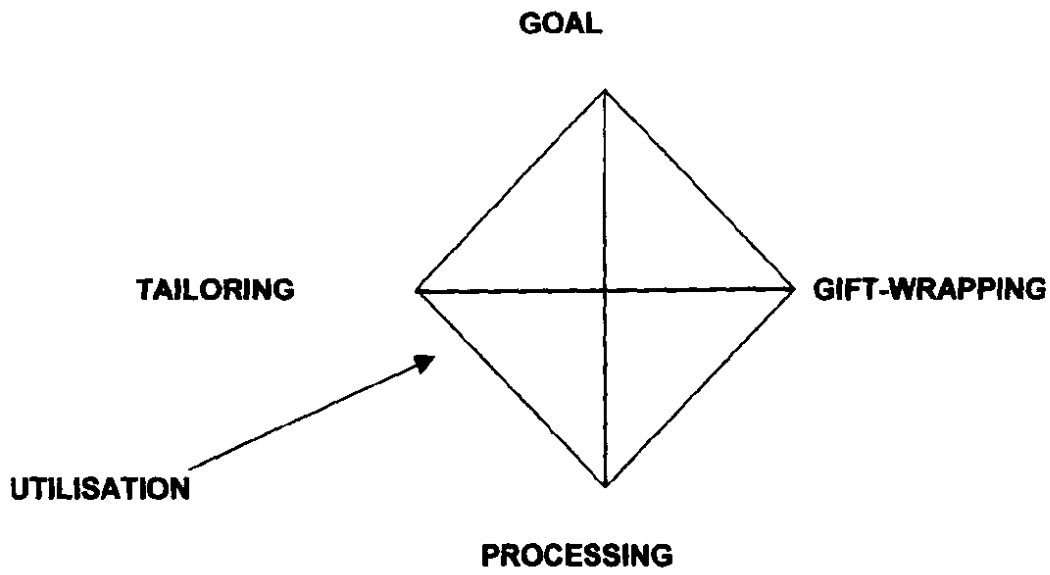



**FIGURE 5: THE ERICKSONIAN DIAMOND**

The basis of each facet of the diamond consists of a guiding question. The facets are "choice points", because if the therapists gets stuck, or encounters resistance from the client, a change can be made in one or a combination of facets.

The **goal** question that the therapist must answer is: "What do I want to communicate?" This goal could be, for example, to relax. Induction goals may differ from therapy goals, and goals may be divided into subparts. In an Ericksonian

approach to psychotherapy, the induction goal is often to elicit responsiveness, while therapy goals are focused on developing resources.

Once the goal is formulated, the therapist must decide how she wants to package the goal. This is referred to as "**gift-wrapping**". The goal could for example be presented within a story, a symbol or an anecdote, Techniques are seen as ways of gift-wrapping, rather than cures.

After considering the goals and the presentation, the therapist must decide how to individualise the treatment to the unique aspects of the client, that is, **tailoring**. The question to be answered is: "What is the position that the client takes?"

Having decided the first three choice points, the therapist has to consider the following question: "How do I present the tailored and gift-wrapped goal?" This is referred to as **processing**. Processing occurs in three stages: set-up, intervene, and follow-through, or the SIFT-method (Zeig, 1985). The set-up includes pre-hypnotic suggestions such as seeding and eliciting motivation, as well as the hypnotic induction. The main intervention is then presented, after which the therapist must follow through, using techniques such as induced amnesia or homework assignments, to name only a few.

The **position of the therapist** has to be carefully considered in both assessment and intervention, since it may be more influential on the outcome of treatment than any specific technique (Zeig, 1994). The therapist can choose to be kind, curious, or confronting, for example, considering the uniqueness of the client and the presenting problem.

According to Zeig (1994), the Ericksonian principle of **utilisation** is applied to establish any single or combination of choice points. The current author values this model as a dynamic model from which the principles of the Ericksonian approach to therapy can be applied.

### 5.1.4 Principles of an Ericksonian approach to hypnotherapy

#### 5.1.4.1 Introduction

Authors referring to an Ericksonian approach to hypnotherapy invariably refer to the principles that became the hallmark of Erickson's work. Lankton (1985) confirms that there are particular attitudes, techniques and values that are consistently identified as "Ericksonian", and that these could serve as a foundation upon which to build therapeutic relationships and interventions. Many of these principles will be included in the programme developed for the current study (see Chapter 4).

#### 5.1.4.2 Utilisation

Utilisation is often seen as the heart of Erickson's approach (Battino, 1999b, Yapko, 1986). Whatever the client presents is accepted and worked with. This includes verbal and non-verbal self-expressions, such as symptoms, background and anticipations (Frederick & McNeal, 1999). Symptoms are seen as resources and also utilised to facilitate change. According to this principle, the client's naturally occurring behaviour in the here and now is further used to absorb attention, redirect it inward and to induce trance (Edgette & Edgette, 1995). Zeig (1992, p. 256) describes utilisation further as the "readiness of the therapist to respond strategically to any and all aspects of the patient or the environment".

Within the utilisation approach each person is seen as unique (Gilligan, 1987), focusing on the client's unique resources, personal history and specific responses to the clinician (Yapko, 1986). Further implications of utilisation are the views that the client's experience is seen as being valid for her, that each person is seen as relating to experience from her own frame of reference, and that the client is joined at her frame of reference (Frederick & McNeal, 1999; Gilligan, 1987). It can be said that the principle of utilisation requires a client-centred approach where there is more than compliance from the client. Yapko (1992) refers to meaningful collaboration between client and therapist.

In summary, utilisation refers to accepting and working with everything the client presents. It also refers to recognising and utilising personal resources in a process unique to the individual.

#### 5.1.4.3 Every person is unique

It is well known that Erickson repeatedly emphasised the uniqueness of each individual. According to Frederick and McNeal (1999), this implies that each person is the dynamic expression of a particular combination of objective and subjective influences that cannot be duplicated. In practice it means that it is not possible to devise a single intervention that will be applicable to all clients. However, it is still possible to use process suggestions, rather than content suggestions, allowing for the client to attribute meaning to these suggestions in her own manner (Yapko, 2000, personal communication).

#### 5.1.4.4 Resourcefulness

In an Ericksonian approach to therapy it is assumed that individuals have far more abilities and resources than they are consciously aware of. Gilligan (1987, p. 16) states: "In fact, a person has resources to generate a happy and satisfying life." He argues that many resources are possibly dissociated from an individual's ongoing experience.

According to Zeig & Rennick (1991), the word "resources" can be seen as a function of the unconscious mind and each individual's lifelong learnings accumulated therein. The client is seen as "supersaturated" and the therapist serves as a catalyst, so that effective behaviour crystallises around stimulated ideas within the client. The role of the therapist is to guide associations to elicit previously dormant resources (Zeig & Rennick, 1991). Frederick and McNeal (1999) define resources as both conscious and unconscious processes within each human being, which can be accessed in many ways. Some resources are innate, while others are learned through normal development or as a response to stress. Resources can be natural resources, like intelligence, but can also be formed by training and life successes. The authors point out that learnings from life failures, such as divorce or job loss, could also be part of a person's resources.

Gilligan (1987) further explains that Ericksonian therapists do not attempt to add anything to the client, but rather assist her in learning to utilise the resources she already has. The conceptualisation of the client in an Ericksonian approach differs clearly from more traditional approaches. Traditional hypnotherapists tend to see themselves as putting something into the client from outside, while Ericksonian

therapists emphasise resourcefulness within clients and their inherent capacities for change (Edgette & Edgette, 1995; Gilligan, 1987; Zeig & Rennick, 1991).

In summary, the therapist working from an Ericksonian perspective assumes that the client already has the necessary resources to lead a satisfying life. The role of the therapist is to evoke and utilise these resources. In the proposed programme, emphasis will be placed on evoking resources related to self-efficacy, relaxation and calm.

#### 5.1.4.5 Hypnosis potentiates resources

According to Gilligan (1987, p. 17), trance has the benefit of offering an unbiased state of self-receptiveness. He states that trance can "deframe a person from rigid sets and thereby enable restructuring and reorganisation of self-systems". This means that the client might be more receptive to discovering resources when they are in hypnosis.

One of the reasons for applying hypnosis as therapeutic tool in the current study was this basic idea that it possibly offers a more powerful way to evoke and utilise client resources.

#### 5.1.4.6 Teleological orientation

Ericksonian approaches to therapy are geared towards the future (Zeig & Rennick, 1991) and are orientated to course-alignment, rather than error-correction (Gilligan, 1987). The focus of therapy is therefore on achieving the goals and the needs of the present self. Gilligan (1987) further states that the therapist focuses on the utilisation of present processes, and explores how they will naturally unfold to further developmental growth.

As part of this teleological orientation, the hypnotic phenomenon of age-progression is often used in Ericksonian hypnotherapy. This involves a hypnotic projection into an imagined future, followed by a review of how that future will be accomplished. It can be said that a self-fulfilling prophecy is being created within the client. This principle can be seen as especially important in the current study, where emphasis is being placed on creating possibilities for growth and well-being in the transition to motherhood.

#### 5.1.4.7 Permissiveness

In an Ericksonian approach, the therapist offers many possibilities for change, rather than definitely telling clients what they will or will not do. This can be referred to as a permissive approach to therapy. According to O'Hanlon (1987), a permissive approach does not require a particular response or pre-condition for successful trance, but allows for many possible responses. Yapko (1995) states that a permissive approach is more respectful of the client's ability to make choices about what she will and will not respond to. In essence, the therapist simply offers suggestions of what the client may experience if she chooses to. The client then has the responsibility to make use of the information provided by the therapist in her own way.

In a permissive approach, permissive language is often applied. Permissive verbs such as "can" and "may" are used in contrast to classical authoritarian verbs such as "will" and "must" (Edgette & Edgette, 1995). Many options are given for what the person might be experiencing, such as: "Your right hand might move up to your face, your left hand might move up, or both hands could remain comfortably on your lap." Yapko (1995) refers to this technique as "covering all possibilities", whereby any response can then be defined as the desired response.

Permissive approaches also validate any experience or response as appropriate and as an adequate link to the required response (O'Hanlon, 1987). It is important to mention that an Ericksonian approach does not exclude authoritarian language, and that a combination of both authoritarian and permissive language is common. Eventually it comes back to the main aim of tailoring therapy to the unique requirements of each individual.

In the current study, a permissive approach was extensively used to enable each client to experience hypnosis in her own way. This was seen as a method to guide the client on a certain path (i.e. discovering her inner resources on her journey to motherhood), but many options were given so that the individual could choose her own unique experience of this path.

5.1.4.8 Indirection

The use of indirection is another example of the hallmarks of an Ericksonian approach. Yapko (1995) describes indirect suggestions as those that relate to either the problem at hand or the specific desired approach in a covert or unobtrusive way. Direct suggestion refers to a proposal made in a straightforward, recognisable way (Edgette & Edgette, 1995) and includes specific statements such as "you will now go into a very deep trance", while indirect suggestion is more ambiguous and allows greater latitude for personal interpretation: "Sooner or later you'll be wondering about going into a very deep trance" (Lankton & Lankton, 1983).

Indirection serves as the basis for the therapeutic use of metaphors and stories, because it allows clients to make meaning relevant for them and to explore their potential to facilitate responses (Matthews, Lankton & Lankton, 1997). Although Rossi (1980) is of the opinion that indirect suggestions have the advantage that this can frequently bypass a client's learned limitations and thus better facilitate unconscious processes, Yapko (1992) states that the comparative benefits of direct versus indirect suggestions appear to be equal. Eventually it depends on the question of which approach is more likely to generate the desired result with a particular client at a particular time. In a later work, Yapko (1995) does however agree that the advantage of an indirect approach to suggestions is that there could be greater utilisation of the unconscious mind's resources on the client's own behalf, and that more of the person is involved in the therapy on multiple levels.

It should be noted that there are numerous references to cases where Erickson himself was extremely direct in his suggestions (Zeig & Rennick, 1991). O'Hanlon (1987) states that Erickson was very directive in dealing with symptoms and very indirect in matters pertaining to the way people would live their lives after the symptom was resolved, or even how, specifically, they would resolve the symptom.

The current author agrees with the view of Frederick and McNeal (1999, p. 32) about an indirect approach to suggestion: " It honours the inner world and only seeks to complement it." However, both direct and indirect suggestions were used to facilitate the hypnotic experience in the current programme, depending on the particular goals of the specific session.

5.1.4.9 Multilevel communication

This refers to a way of talking to people at multiple levels of meaning and influence, with the goal of indirectly causing some change in behaviour, feeling or attitude (Edgette & Edgette, 1995). Various types of suggestions are used to facilitate multilevel communication, such as anecdotes, metaphors and specific language forms. Battino (1999a) compiled a comprehensive chapter on hypnotic language forms, many of which are part of multilevel communication. For purpose of the current discussion, only the types of suggestions that will be extensively used in the hypnotherapeutic preparation programme will be included.

**Seeding** refers to when the therapist presents an idea to the client's unconscious mind by making statements that point to that idea (Frederick & McNeal, 1999). Statements are often interjected into the session in a casual and conversational manner. Geary (1994) is of the opinion that seeding "sets the table" for therapy, since it facilitates certain ideas being brought to mind. Frederick and McNeal (1999) also refer to the way that hope can be seeded early in treatment, by statements such as: "When you are better..." and "...you will be amazed at how your understanding will grow...". In the current programme seeding will be extensively used, both by means of direct and indirect suggestions. The basic ideas that will be seeded include references to inner resources, maintenance of current well-being, positive affect, optimism and self-efficacy.

**Interspersal** refers to a technique where therapeutic suggestions are made in such a way that they are hidden within more general suggestions (Frederick & McNeal, 1999). Most frequently, keywords or phrases are repeated within a series of suggestions. In the current study, interspersal will be used to complement the seeding that had already occurred. Keywords such as "naturally" (referring to natural childbirth) and "comfortably" (referring to comfort during labour) are some of the keywords to be used.

**Metaphors** are commonly associated with Ericksonian approaches. Frederick and McNeal (1999) describe it as a way of delivering a message in a less than direct way. It can be considered as one of the most powerful and gentle means of communicating relevant information to a client (Yapko, 1995). Frederick and McNeal (1999) as well as Gilligan (1987) believe that metaphors are powerful because they speak in the more primary process thinking of the unconscious mind. Several

metaphors will be used in the current programme, the central metaphor being the journey to motherhood.

#### 5.1.4.10 Positive and generative nature of the unconscious mind

From an Ericksonian perspective, the unconscious mind is seen as positive and generative in nature. It also contains the resources that clients need for resolving problems (Frederick & McNeal, 1999). Gilligan (1987) accordingly conceptualises trance as a process in which the client's conscious processes are set aside, thereby enabling unconscious processes to generate meaningful transformational experiences. In the current programme, reference will be made to the positive and wise nature of the unconscious mind.

#### 5.1.4.11 Summary

Despite Erickson's insistence that he does not hold a particular theory regarding personality or psychotherapy, it is evident that there are definite psychotherapeutic principles that form the foundation of an Ericksonian approach to psychotherapy. The manner in which these principles are applied in practice, will vary according to the uniqueness of both the therapist and the client. Classic hypnotic phenomena, however, are regularly utilised in the therapeutic application of hypnosis and this utilisation of hypnotic phenomena is often seen as one of the hallmarks of an Ericksonian approach. Zeig (1995) states that hypnotic phenomena are integral to Erickson's approach to hypnosis. In the context of the Ericksonian approach it is necessary to analyse these phenomena, but it is important to point out that the hypnotic phenomena are also extensively used in other approaches, including the ego state therapy approach (see paragraph 5.2 in this chapter).

### 5.1.5 The hypnotic phenomena

#### 5.1.5.1 Introduction

Battino and South (1999, p. 237) describe hypnotic phenomena as "...unusual or extraordinary behaviour elicited by individuals while in a trance state or as a result of being hypnotised". It includes both subjectively experienced psychological events and observable events (Edgette & Edgette, 1995). Hypnotic phenomena are not a recent discovery. Wickramasekera (1988) points out that hypnotic phenomena have

been reported in cultures across the world in all periods of recorded history and that they typically manifest in either religious or healing/medical contexts.

In this study, attention will be focused on hypnotic phenomena as they occur and are utilised in the trance state. Yapko (1995) states that the classic hypnotic phenomena are the basic ingredients for the therapeutic applications of hypnosis, while Lankton and Lankton (1983) compare trance phenomena to tools such as magnifying glasses, time machines and amplifiers, which are used to make previously unavailable worlds of unperceived experience perceivable.

Battino and South (1999) wisely point out that the behaviours associated with hypnotic phenomena are often experienced in our daily lives. It is also interesting to note that there are many similarities between clinical symptoms and trance phenomena. Edgette and Edgette (1995) refer to the work of Gilligan (1988) who views symptom phenomena as everyday versions of classical trance phenomena. Edgette and Edgette (1995, p. 17) describe symptom expression as "...hypnotic phenomena run amuck".

For purpose of the current study, the hypnotic phenomena that are most commonly experienced will be explicated. Where applicable, reference will be made to how the specific phenomenon could be utilised in a hypnotherapeutic approach aimed at promoting and maintaining psychological well-being in the transition to motherhood.

#### 5.1.5.2 Hypnotic phenomena related to memory functions

##### 5.1.5.2.1 Amnesia

Yapko (1995) describes amnesia as the experience of forgetting something. He views the classic defense mechanism of repression as the primary mechanism for hypnotic amnesia. It can be seen as a functional loss of the ability to recall or identify past experiences and can be induced in hypnosis either to ablate memories that occurred prior to trance or to ablate those being created in the trance experience itself (Battino & South, 1999; Edgette & Edgette, 1995).

In the current programme, suggested amnesia can be applied with regard to forgetting the experience of a contraction once it has passed.

#### 5.1.5.2.2 Hypermnesia

Hypermnesia refers to detailed or enhanced remembering. It allows the person to vividly remember earlier memories in all their sensory detail (Erickson, 1944/1980). The phenomenon differs from age regression, described in section 5.1.5.3.2. Hypermnesia can be effective when dealing with clients who have lost touch with certain aspects of themselves, or certain experiences that they have had. It could even be focused on remembering past successes (Edgette & Edgette, 1995).

#### 5.1.5.2.3 Posthypnotic suggestion

Posthypnotic suggestion refers to a person's ability to respond at a later time, to a suggestion given during trance (Edgette & Edgette, 1995). Such suggestions can involve the rapid re-induction of aspects of the trance state. It can be directed towards behaviours, attitudes or feelings. Erickson (1944/1980) views posthypnotic suggestion as one of the most significant of all hypnotic phenomena.

One of the indications for using posthypnotic suggestions is when the desired change is to take place after the therapeutic session (Edgette & Edgette, 1995). This is especially important in the current study of preparing women for coping with childbirth and the postpartum period. Edgette and Edgette (1995) state that this phenomenon allows the therapy to extend most naturally into the future. Examination of current hypnotic childbirth preparation practices show that posthypnotic suggestions have been used extensively, such as by Fuller (1990), Hilgard and Hilgard (1994), Leeb (1995) and Schauble, Werner, Rai and Martin (1998).

### 5.1.5.3 Hypnotic phenomena related to time perception

#### 5.1.5.3.1 Time distortion

Battino and South (1999) state that time distortion allows a person to distort objective "clock" time by shortening or lengthening a period of time. The experience of distortion of time is common in everyday life. According to Yapko (1995), the experience of time is subjective, meaning that each person experiences the passing of time in her own way at any given moment. The passing of time can thus seem

much longer (time expansion) or shorter (time contraction) than is objectively true. The phenomenon of time distortion can be induced by hypnotic suggestion.

The phenomenon of time distortion can be utilised to lessen discomfort associated with childbirth by making the time spent in labour and the experiencing of contractions seem much shorter than it actually is (time contraction), as will be suggested in the current programme.

5.1.5.3.2 Age regression

Age regression can be defined as an intense experiential utilisation of memory (Yapko, 1995), usually facilitating an experience of going back to a specific time (Battino & South, 1999). Techniques therefore usually involve taking the person back in time to some experience in order to re-experience it as if it were happening in the here and now. Age regression differs from hypermnesia in that the person relives rather than just remembers past events (Edgette & Edgette, 1995). According to Weitzenhoffer (1989) a person can sometimes in age regression even return to the psychological state as it existed at the regressed age.

Age regression is useful in areas such as reliving traumatic experiences and when a client needs to retrieve resources she had earlier in her life (Lankton & Lankton, 1983). When using the latter strategy, the hypnotherapist can help clients to rediscover in their own past personal experience the very abilities that will allow them to manage current difficulties in a more adaptive way. In their approach to ego-strengthening, Frederick and McNeal (1999) use what they refer to as projective/evocative age regression with the underlying Ericksonian principle that the unconscious mind is a vast reservoir of resources. The aim is to help the client locate inner resources by going back to previous successes. Age regression can be structured (e.g. the client can be guided to a specific event), or unstructured (e.g. the decision about what kinds of memories are accessed is left to the client's unconscious mind). Unstructured positive age regressions include generally pleasant experiences, revivification of positive memory and mastery experiences, and recalling nurturing figures from the past. In the current study, structured age regressions will be used to allow the client to return to previous positive experiences, such as calm and relaxation.

#### 5.1.5.3.3 Age progression

Age progression refers to the utilisation of projections of the future (Yapko, 1995). It involves guiding the client into the future where she may have the opportunity to imagine the consequences of current experiences and integrate meanings at deeper levels. This phenomenon is often referred to as "pseudo-orientation in time" (Battino & South, 1999) and could be seen as facilitating an altered framework by which a client can create experiences in a novel way (Lankton & Lankton, 1983). The use of age progression is one of the distinct qualities of an Ericksonian approach to hypnosis (Edgette & Edgette, 1995).

In ego-strengthening, structured age progression is a technique that is often used, as can be seen in mental rehearsal and end-result imagery (Frederick & McNeal, 1999). With mental rehearsal the therapist assists the client to mentally enact the steps for the accomplishment of a future activity, while with end-result imagery the client imagines herself in the future, after the goal has been achieved. Hammond (1990c) points out that it is not necessary to be in the trance state to apply end-result imagery, but that the experience has an intensity and quality of reality in trance, that a more consciously-willed experience does not possess. Ego-strengthening is explicated more detail in paragraph 5.2.5 in this chapter.

It is also possible to use unstructured age progressions, such as guiding the client to communicate with an imagined future self who may be healthier and wiser. Phillips and Frederick (1992, 1995) use future progressions with practically no structure. While it has definitive ego-strengthening properties, it can also be a prognostic tool regarding the therapy process.

In the proposed programme, both structured future progression, such as mental rehearsal and end-result imagery, and unstructured future progression, such as picturing oneself as a new mother, will be included.

### 5.1.5.4 Hypnotic phenomena related to dissociated movement

#### 5.1.5.4.1 Catalepsy

Catalepsy can be defined as the inhibition of voluntary movement associated with the intense focusing on a specific stimulus (Yapko, 1995). Signs of catalepsy, such

as a fixed gaze or general immobility, can be relied on to a large extent as indicator of hypnosis. It can be considered as one of the most basic features of hypnosis and is associated with most other hypnotic phenomena. Edgette and Edgette (1995) further describe it as a special state of muscle tone and balance that permits the person to sustain postures and positions for unusually long periods without fatigue.

Edgette and Edgette (1995, p. 177) suggest using the phenomenon of catalepsy to counteract the restlessness pregnant women experience late in the pregnancy: "...they can thwart the incessant urge to shift position by going into trance and developing a comfortable stillness, an effortless immobility".

5.1.5.4.2 Arm levitation

Ideomotor movement involves the body's motor system reacting and acting as if directed by the unconscious mind. The movement is then felt as being non-volitional. Arm levitation is an example of ideomotor movement (Edgette & Edgette, 1995) and is often used as a catalyst for change. It lets the client know that something different can happen in therapy.

5.1.5.4.3 Automatic writing and drawing

Automatic writing can be defined as a hypnotic phenomenon that is an outgrowth of a dissociation between conscious and unconscious mental functioning (Edgette & Edgette, 1995). It results in the client's writing with pen and paper but without conscious awareness. This material may apply to the problem currently being addressed.

5.1.5.5 Hypnotic phenomena related to the duality of reality

5.1.5.5.1 Dissociation

Edgette and Edgette (1995) state that dissociation is one of the more widely recognised and experienced hypnotic phenomena. Dissociation is the ability to break a global experience into its component parts, amplifying awareness of one part while diminishing awareness of the others (Battino & South, 1999; Yapko, 1995). This usually entails the person's mind dividing itself up in some way, such as visual images being distinct from emotions. It can also involve one part of the person's

body being experienced as separate from another part or a person feeling a sense of detachment from the immediate physical environment (Edgette & Edgette, 1995).

In clinical work, dissociation can be used for simple symptomatic relief, such as pain, where it can be used to separate a person from experiencing pain anywhere in the body. Edgette and Edgette (1995) mention that women giving birth can benefit from a dissociation of their pelvic region, referring to it as "psychogenic epidurals". The use of the phenomenon of dissociation has been mentioned in the hypnotic childbirth preparation techniques discussed by Hilgard and Hilgard (1994), McCarthy (1998, 2001) and Watkins (1987). In the current programme, dissociation will also be introduced as a means of coping with contractions during labour.

5.1.5.5.2 Hypnotic dreaming and daydreaming

Hypnotic dreaming refers to a person's capacity to have, either in the session or at home during sleep, a directed therapeutic dream that is an immediate by-product of the suggestion given in the session (Edgette & Edgette, 1995). One of the indications for using hypnotic dreaming in therapy is when it serves as a symbol, metaphor or idiom for the therapy. Edgette and Edgette (1995) suggest giving the suggestion that "you can have a dream for the future".

5.1.5.6 Hypnotic phenomena related to modified perception

5.1.5.6.1 Anaesthesia and analgesia

Hypnotically induced analgesia and anaesthesia can be seen as being on a continuum of diminishing bodily sensations. Yapko (1995) describes analgesia as a reduction in the sensation of pain, allowing associated sensations that orientate the client to her body, to remain. Anaesthesia refers to a complete or near complete elimination of sensation in all or part of the body (Battino & South, 1999). This hypnotic phenomenon has been used extensively in alleviating pain during childbirth, as indicated in the discussion by Hilgard and Hilgard (1994), the approach of Leeb (1995) and the research of Jenkins and Pritchard (1994). In the current study, this hypnotic phenomenon will not be utilised extensively, since the aim of the programme is wider than addressing discomfort during labour. Secondly, it is envisaged to include women who will deliver by means of epidural anaesthesia and

caesarean section as well, which makes the application of this hypnotic phenomenon less relevant.

#### 5.1.5.6.2 Hyperesthesia

Hyperesthesia is an enhanced sensitivity to physical sensations such as touch, warmth or coolness (Edgette & Edgette, 1995). It is not as commonly applied as other hypnotic phenomena, possibly because its application is limited. In the current study, it will be applied to facilitate the experience of bonding, by giving suggestions of touching and holding the baby after birth.

#### 5.1.5.6.3 Positive hallucination

Hallucinations created by hypnosis are suggested experiences the client can have, that are clearly removed from current, more objective realities (Yapko, 1995). Such suggestions can therefore be said to alter the subject's experience of sensory stimuli. Battino and South (1999) describe a positive hallucination as perceiving something that does not exist in objective reality. It could be an object, a person or a sound, for example. Lankton and Lankton (1983) state that utilising this phenomenon can be very rewarding when it facilitates a client's amplifying her experience of a new resource.

One example of utilising the phenomenon of positive hallucination in the proposed programme will be suggesting to the mother that she could have a conversation with her unborn baby.

#### 5.1.5.6.4 Negative hallucination

Negative hallucination denies the existence of phenomena that do exist in reality, like an object or a person or a sound (Battino & South, 1999). This phenomenon can be effectively applied in pain control, by suggesting that the person will not notice pain (Edgette & Edgette, 1995; Lankton & Lankton, 1983). Yapko (1995) suggests that indirect suggestions can effectively be used to create negative hallucination. In the current study, for example, it can be suggested that the mother be very aware of holding and experiencing her baby immediately after the birth, thereby not noticing the continuing medical procedures.

#### 5.1.5.7 The complements of the hypnotic phenomena

Hypnotic phenomena often come in complementary parts, and it is often useful to select the phenomenon that is the opposite of the one generating the problem when planning an intervention (Edgette & Edgette, 1995). The following is a list of the most common pairings or complements of phenomena:

| | | |
|---|---|---|
| Amnesia | - | Hypermnesia |
| Time contraction | - | Time expansion |
| Age regression | - | Future progression |
| Anaesthesia | - | Hyperesthesia |
| Negative hallucination | - | Positive hallucination |
| Catalepsy | - | Flexibility/movement |
| Dissociation | - | Association |
| Posthypnotic suggestion | - | Prehypnotic suggestion |

In the current programme, time contraction (suggesting contractions being short and quick) can for example be selected as a possible hypnotic phenomenon to utilise when dealing with the discomfort of labour, since time expansion (i.e., contractions and discomfort experienced as being extremely long) is often experienced during labour. Further, new mothers are often told by other mothers who have already given birth, how difficult labour can be (prehypnotic suggestion). Therefore, posthypnotic suggestions of an easy and comfortable labour need to be included.

#### 5.1.5.8 Summary

The different hypnotic phenomena associated with trance were described and it was pointed out how some of these phenomena can be applied in the current study. The utilisation of these phenomena presents the opportunity to initiate new ways of perception and experience for the client. It can be concluded that the appropriate utilisation of hypnotic phenomena could enhance the impact of hypnotherapeutic intervention in general, and the current programme specifically.

### 5.1.6 An Ericksonian approach in the promotion of psychological well-being

It has been mentioned that Erickson had a view of clients as being resourceful and that he placed great emphasis on helping clients discover and utilise their resources

in solving presenting problems. It is this view that makes an Ericksonian approach to therapy relevant in the promotion of psychological well-being.

There has been some interest regarding applying Ericksonian principles in the promotion of well-being. In a recent work, Jenkins and Forrest (1999) comment on the similarity between natural trance states and peak experiences or "flow" (Csikszentmihalyi, 1990). They further suggest that Ericksonian principles could be applied to utilise flow experiences in promoting the experience of skills, knowledge and abilities within the client. Earlier, Walters and Havens (1993, 1994) maintained that the Ericksonian approach could play an important role in the current wellness paradigm (see Chapter 2 for an explication of psychological well-being and the paradigm shift to wellness). They found several similarities between the focus of the wellness paradigm and the basic principles of Erickson's work. Walters and Havens (1993, 1994) also argue that research within this paradigm offers direct empirical evidence for Erickson's therapeutic goals and underlying assumptions, such as that people have all the resources they need to be healthy and happy, and that wellness, not illness, is the appropriate focus of intervention/psychotherapy.

Walters and Havens (1993) state that when hypnotherapy is expanded to include a focus on the ingredients necessary for wellness, it could lead to several benefits such as offering therapy clients a more comfortable way of looking at themselves and expanding therapeutic goals. It also offers an effective way to inoculate people against feelings such as self-doubt, depression and anxiety, thus not merely treating problems once they develop, but also preventing their development. They are of the opinion that people might be healthier and happier if they were taught how to use hypnosis to emphasise the attitudes and behaviours that research indicates to be conducive to psychological and physical wellness.

Walters and Havens (1994, p. 167) conclude that Erickson "recognised that optimism, altruism and self-efficacy are among the most fundamental ingredients of well-being and of healing, the essence of a life worth living and he used these recognitions to guide his interventions".

### 5.1.7 Conclusion

An Ericksonian approach to hypnotherapy seems to be difficult to define, since there exists no specific theoretical framework. In an overview of the literature it was,

however, evident that certain basic principles are associated with this style of therapy, and these principles were explicated. What is often emphasised in this approach is the resourcefulness of clients, utilisation of their inner resources and an orientation towards the present and future. These principles make an Ericksonian approach to hypnosis relevant to the current study of promoting psychological well-being and serve as the foundation on which the hypnotherapeutic programme was developed.

Like most therapeutic approaches, Ericksonian therapy is often applied once an individual presents with a specific problem, and little has been written how this approach could be used in a preventative manner or in the promotion of well-being. Further, there seems to be an absence of empirical research with regard to the efficacy of Ericksonian approaches (Matthews, 2000). The current study could therefore contribute to a wider application of Ericksonian hypnotherapy.

## 5.2 The ego state therapy approach

### 5.2.1 Introduction

Ego state therapy is a particular therapeutic approach that has grown from the amalgamation of psychotherapy and hypnosis, and is based on a theory that the psyche is not a homogeneous whole, but is composed of separate parts particular to the individual (Emmerson, 2000). It has been described as an ever-expanding system of psychological theory and practice that contributes to more effective methods for promoting health and wholeness in life (Morton, 2000). A specific technique within this approach, the ego-strengthening technique, has been applied in various therapeutic contexts, as was discussed in the work of Frederick and McNeal (1999). Since ego-strengthening can enhance self-esteem (Phillips & Frederick, 1995), it could be relevant in the promoting of general psychological well-being. In this section, the theoretical rationale regarding ego state therapy will be explicated and the applications of ego- strengthening within an ego state therapy model, will be described.

### 5.2.2 Theoretical rationale

Ego state therapy is a model that emphasises the complexity of the ego in terms of internal parts or subselves (Frederick & McNeal, 1999). This is not a new development, as various theoreticians have held the belief that the human personality is composed of parts. Frederick and McNeal (1999) refer to the work of Janet (1919/976), Morton Prince (1905/1978), Milton Erickson (1940s/1980), Jung (1969) and Berne (1961).

Federn (1952) is often cited as the first person to propose an energy model involving ego states within the ego. He regarded the ego as being composed of ego states formed in early childhood, existing together in a dynamic balance. Each ego state has its own origin, history, thoughts and feelings. Federn further believed that psychic energy could be cathected (harnessed) to the ego (ego cathexis) or to the object (object cathexis) (Frederick & McNeal, 1999).

Research done by Hilgard (1977) as well as Watkins and Watkins (1981) has led to theories of "multiplicity" and therapeutic techniques based upon them. The basic assumption is that multiplicity is a normal organisational principle of the human psyche (Hartman, 1995). Accordingly, there are many conscious part selves (multiplicities) in the human mind, outside the awareness of the overt self.

John and Helen Watkins (H.H. Watkins, 1993; J.G. Watkins, 1992) elaborated on the work of Federn and developed a theoretical basis for a form of therapy that involves working with ego states directly. This is a hypnoanalytic method called ego state therapy. According to this view, the ego consists of a dynamic family of subselves, which are separated from each other by what Phillips and Frederick (1995) describe as a semipermeable membrane. The ego state that carries the greatest energy cathexis is said to be "executive" at the time and is experienced as the "I" or the self.

Ego states can be formed in different ways, and according to Frederick and McNeal (1999) all ego states are adaptational. These authors also maintain that ego states can be formed at any time in life, although their formation is more common in childhood. Watkins and Watkins (1997) describe three ways in which ego states are formed:

- Ego states are formed by normal differentiation where children learn to discriminate and develop patterns of behaviour that are appropriate in particular situations;
- Ego states may be introjects of parents or significant others as well as significant events; and
- Ego states may be formed in an attempt to deal with overwhelming trauma.

Psychopathology develops when one or more ego states dealing with unresolved trauma become "walled off" from the others which prevents it from working in harmony with the other ego states (Frederick, 1993). However, in the current study, the focus is not on psychopathology, but rather on the possibility that there could be healthy, resrourceful and strong "parts" or ego states within an individual that could be activated or utilised to assist the new mother in her life transition.

### 5.2.3 Defining an ego state therapy approach

In order to conceptualise what is meant by an ego state therapy approach, it is first necessary to clarify certain related constructs.

Watkins and Watkins (1997) define an **ego state** as an organised system of behaviours and experiences, the elements of which are bound together by some common principle. They are, however, separated from each other by boundaries which Phillips and Frederick (1995) describe as semi-permeable. Phillips and Frederick (1995) further believe that ego states are energies within the greater personality, that they are adaptational and that they are there to help.

Phillips and Frederick (1995) introduced the **ego state therapy model** as a theoretical metaphor for understanding human behaviour. The authors describe it as a "parts" model of personality, where ego states are aspects of human personality that are totally unique within each person. Hartman (1995) concludes that ego states can range from minor moods to true dissociative identity disorder.

**Ego state therapy** can be defined as a combination of individual, group and family therapy techniques (Phillips & Frederick, 1995). The goal is the integration of the parts or subselves, which occurs when the parts are in communication with each other and are working together co-operatively. In ego state therapy, ego states are

activated with hypnosis and then worked with therapeutically using any therapeutic technique which could be applied to the greater personality (Frederick, 1993). It can therefore be seen as a treatment modality based on an eclectic-hypnoanalytic approach (Hartman, 1995).

In the current study, an ego state therapy approach is conceptualised as one that acknowledges the possible existence of various ego states within each individual, with the aim of evoking possibly helpful ego states to assist with ego strengthening in general, and to assist the new mother in her life transition. These possibly helpful ego states could be involved with ego strengthening, as will be explicated in paragraph 5.2.5, but first it is necessary to provide a brief outline of models of ego state therapy.

### 5.2.4 Models of ego state therapy

Phillips and Frederick (1995) proposed one of the first models of ego state therapy, referred to as the SARI model. Recently, Hartman (2002) proposed another model, that incorporates principles from an Ericksonian perspective with ego state therapy.

#### 5.2.4.1 The SARI Model (Phillips & Frederick, 1995)

The SARI model is a four-stage treatment model that was created for working with clients suffering from posttraumatic stress or dissociative identity disorder (Phillips & Frederick, 1995). It can be summarised as follows:

***Stage 1*** concerns the **stabilisation** of the client and the establishment of a sense of personal safety. This is an essential stage since no therapeutic work should be attempted before stabilisation has occurred. During this stage, the focus of the hypnotherapeutic intervention is often on ego-strengthening, mastery and empowerment.

***Stage 2*** of treatment is focused on **accessing trauma** and related resources that are currently dissociated from full experience, and are presumably related to the presenting symptoms of the client. According to Frederick and McNeal (1999), this can be done either in formal hypnosis or with nonhypnotic therapy. It is also suggested that sessions aimed at uncovering material be alternated with sessions in which ego-strengthening takes place.

***Stage 3*** involves **reassociating traumatic material**, so that the components of the traumatic material (e.g. sensory, visual, behavioural, affective and visual components) can become connected with the mainstream of thought. During this stage of treatment, it may be necessary to restabilise the client, and therefore return to stage 1.

***Stage 4*** concerns the integration of previously disassociated and reworked trauma material. The individual is helped to develop a new identity as ego states are integrated with one another. During this stage ego-strengthening is equally important.

The SARI model is a dynamic model, implying that if at any time the client feels unsafe or should destabilise, there is a return to stage 1 work. Similarly, should more uncovering be needed before integration (stage 4), there is a return to stage 2 (Frederick & McNeal, 1999).

In the current study, the focus is not on trauma or dissociation, and more emphasis will be placed on ego-strengthening (stage 1), since it is the current author's opinion that stage 1 work of the SARI model is crucial to any therapeutic intervention.

#### 5.2.4.2 A Utilisation Model of Ego State Therapy (Hartman, 2002)

Hartman (2002) proposed a model of ego state therapy that involves integrating Erickson's (1958/1980, 1959/1980, cited by Hartman, 2002) utilisation approach with the ego state therapy theory and methods of Watkins and Watkins (1997). This model is presented in Figure 6. Hartman (2002) notes that there are some similarities between the utilisation approach, as explicated earlier, and ego state therapy, such as the fact that both conceptualise hypnosis to be an inner focus, and access the inner resources of an individual. He further argues that ego state therapy reflects the principle of utilisation, since a client's internal reality and patterns of ego state self-expression are accepted and worked with. Accordingly, Hartman (2002) propose an utilisation model of ego state therapy based on ten pivotal points:

- **Goals:** Since utilisation is directed towards a specific end when working with ego state pathology, it is important that therapists define specific goals during therapy. Therapy goals can for example be aimed at processing information on a more

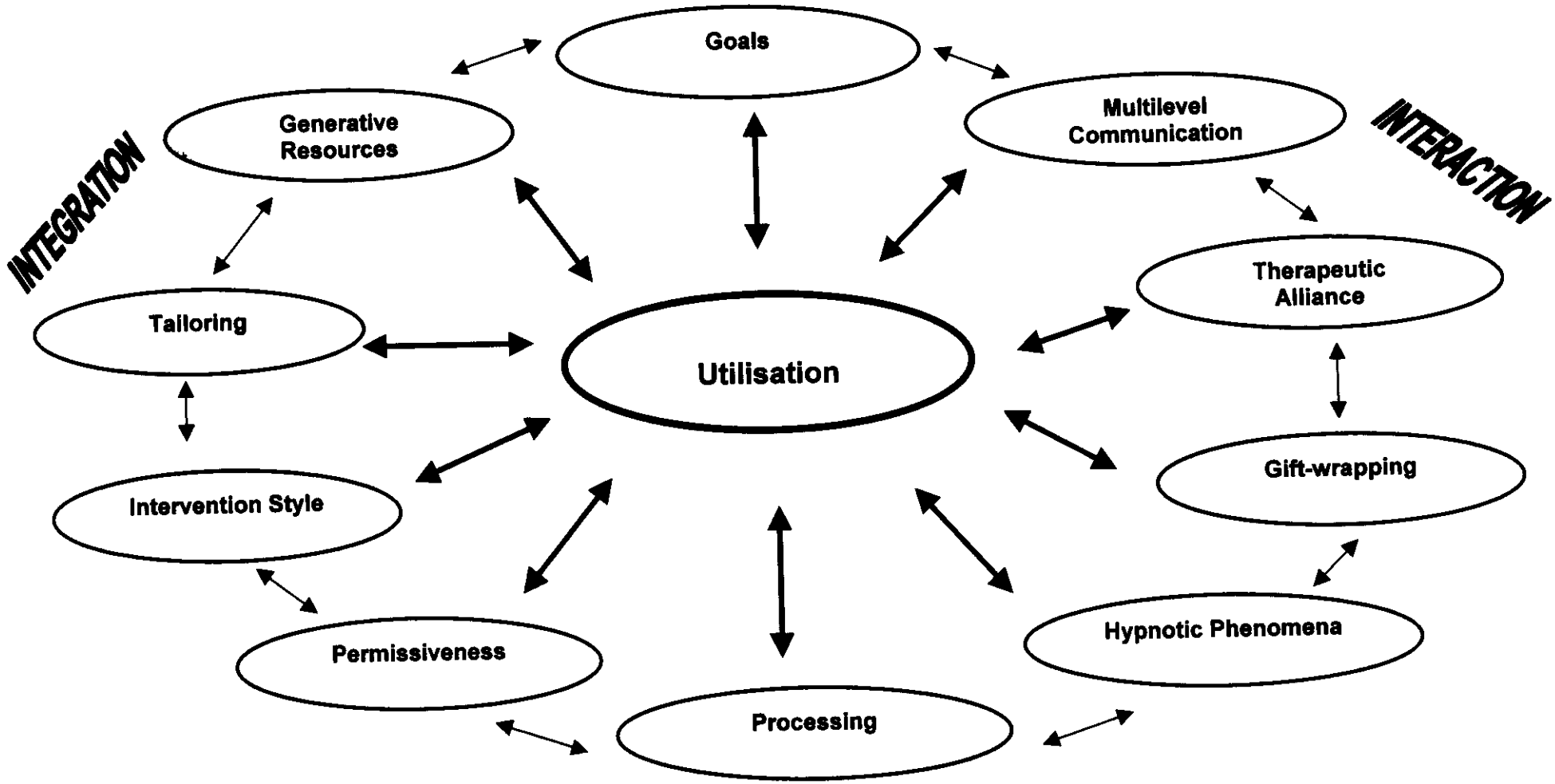



FIGURE 6: A UTILIZATION MODEL OF EGO STATE THERAPY (HARTMAN, 2002)

experiential level, as well as at stabilising the client, ego-strengthening and accessing ego states and inner resources.

- **Gift-wrapping** relates to the packaging of the goal within a metaphor, a story or an anecdote. It can also be presented within an age regression, age progression or an internal dialogue between ego states.

- **Tailoring** suggests that the therapist must decide how to individualise treatment for the needs, values and unique characteristics of the client andher individual ego states. Tailoring can be done by methods of intervention, language patterns and word choices, to name a few.

- **Processing** the intended goals can be achieved by seeding ideas, eliciting ego state responsiveness and reframing experiences, among others. Processing can be done by either direct or indirect methods.

- The **intervention style** chosen by the therapist influences the outcome of treatment. A therapist can, for example, choose to be kind, confrontational or motivational, depending on the goals set for treatment.

- The **therapeutic alliance** between the therapist and the client, as well as between the therapist and individual ego states, is important.

- **Generative resources** and strengths of each client and ego state should be elicited. In this sense, a utilisation approach in ego state therapy implies that ego states' inherent capacities for productive change are enhanced.

- **Permissiveness,** referring to a permissive rather than an authoritarian communication style, is desirable in ego state therapy since it is more respectful of the client's ability to make choices on her own behalf. It is especially useful when working with oppositional or immature ego states.

- **Multilevel communication** is used when the goal is to indirectly stimulate and guide multiple associations, causing some change in behaviour, feelings and attitudes. These communications are not always evident in the overt content of the communication and are designed to elicit responses without conscious

awareness. In this regard metaphors, word plays and figures of speech are often used.

- **Hypnotic phenomena** can effectively be utilised in ego state therapy, for instance as part of gift-wrapping. An example would be to use age regression to make the client aware of previous successes.

In the current study, Hartman's model will be applied, as the envisaged intervention programme (see Chapter 4) will entail aspects from both the Ericksonian and ego state therapy approaches. Goals will be set for each session, will be gift-wrapped within metaphors, and emphasis will be placed on tailoring the treatment to each woman's own experience. The goals can be processed by seeding and eliciting ego state responsiveness, with the therapist adopting a supportive and motivational intervention style. Time will also be spent on developing a sound therapeutic alliance. There will be a continuous emphasis on the woman's own generative resources, a permissive communication style will be adopted and multilevel communication will be applied by means of metaphors and word usage. Finally, hypnotic phenomena such as age progression and dissociation, to name a few, will be employed.

### 5.2.5 Ego state therapy and ego-strengthening

One of the topics that often come into focus during the course of ego state therapy, is that of ego-strengthening. It has long been considered important in the process of psychotherapy (Phillips, 2001), and according to Phillips and Frederick (1995), ego-strengthening is required by most clients. They argue that this technique may enhance self-esteem, lead to increased clarity of thinking and better problem solving abilities. Frederick and McNeal (1999, p. 136) describe ego-strengthening as "...the process of extending the scope and influence of the ego and increasing the effectiveness of ego functions". According to these authors, the self is experienced as stronger, more adequate and more effective in coping with both the internal and external world when ego-strengthening has occurred.

Ego-strengthening is not a new technique. Hartland (1965, 1971) was the first to mention that most clients need to feel strong enough to do without their symptoms before they could give them up. On an empirical level, both Stanton (1979) and Calnan (1977) demonstrated that ego-strengthening increased internal control.

The role of ego-strengthening has been acknowledged by various theoretical frameworks such as psychodynamic, cognitive-behavioural and self-psychology theories (Phillips and Frederick, 1995). More recently, Barber (2000) referred to ego-strengthening as "suggestions-for-effective-living". These suggestions are intended to help individuals cope more effectively and live more happily by enhancing their awareness of the positive aspects of life, by increasing self-confidence and by reducing worry and anxiety. It was also evident in the work of Milton Erickson, who was of the opinion that the unconscious mind contained all the resources to help an individual to resolve difficulties (Gilligan, 1987; Matthews, Lankton & Lankton, 1997; Zeig & Rennick, 1991).

When viewed from the perspective of ego state theory, ego-strengthening techniques increase the interplay between positive, helpful aspects of the personality (McNeal & Frederick, 1993). Although ego-strengthening has been applied in various therapeutic approaches, its use within the framework of an ego state model has only been elaborated on more recently, as will be presented in the next section.

### 5.2.6 Ego states as internal resources

McNeal and Frederick (1993) first reported the formal use of ego-strengthening techniques with ego states and stressed the importance of integrating ego-strengthening with the rest of therapy. In their later work (Frederick & McNeal, 1999), the authors describe various ways in which ego states can serve as internal resources, namely:

- The **activation of positive or helpful ego states** can be an efficient ego-strengthener because it evokes or activates inner resources and gives the client evidence of the presence of a benign personality part within the subconscious mind.

- **Conflict-free ego states** can be used as internal resources. Frederick and McNeal (1999) refer to the work of Hartmann (1961) who theorised that the ego is a group of functions that include healthy and adaptive mechanisms which exist apart from frustration and conflict. This was called the conflict-free ego-sphere. McNeal and Frederick (1993) introduce the concept of "Inner Strength" as a possible conflict-free ego state. According to the authors, this aspect of the personality is connected to a person's deepest survival instincts. Frederick and

McNeal (1999) later mention other possible conflict-free inner resources, such as "The Inner Advisor", the "Safe Place" and "Inner Love".

- **Conflict-laden ego states** can also serve as inner resources. According to Frederick and McNeal (1999), it is possible that ego states that were formed at the time of trauma hold negative traumatic material, but also frequently contain resources that were previously available and continued to be available after the trauma.

- **Integration of ego states** that previously were in conflict could also be ego-strengthening when these ego states begin to communicate and co-operate.

The possible use of these resources for ego-strengthening in the current study seems to lie in the activation of helpful ego states and of conflict-free ego states. The manner in which these resources could be accessed and applied in ego-strengthening will now be explicated.

### 5.2.7 General approaches to ego-strengthening

Frederick and McNeal (1999) describe ego-strengthening as existing on a spectrum, with direct, structured suggestions being at one end of the spectrum. Imagery and mastery techniques are placed in the centre, while projective/evocative techniques are placed at the other end. Each of these will briefly be discussed.

#### 5.2.7.1 Direct structured suggestions

Hartland (1965, 1971) introduced ego-strengthening by using direct suggestions that were authoritarian, directive and future-orientated. The goal was to strengthen ego functions such as concentration and memory, self-confidence and energy. Phillips and Frederick (1995) state that direct suggestions can be useful to stabilise individuals who have a great need for structure.

#### 5.2.7.2 Imagery and mastery

The centre of the spectrum of ego-strengthening can be conceptualised as the adding of imagery and mastery techniques to direct suggestions (Frederick & McNeal, 1999). According to Phillips and Frederick (1995), direct suggestions that

are modified by adding imagery are well suited to use in self-hypnosis. Frederick and McNeal (1999) claim that imagery is an important feature in trance and that there are many advantages of adding imagery to ego-strengthening procedures, such as that positive associations could be expanded through the use of imagery.

Frederick and McNeal (1999) also mention that ego-strengthening can develop from a sense of efficacy, which in turn can evolve during experiences of mastery. They refer to the work of Gardner (1976, cited in Frederick & McNeal, 1999) who believes that enhanced effectiveness could be seen in the client's ability to maintain hypnotherapeutic gains. Gardner further emphasises the active involvement of the client in her therapy as well as the importance of self-hypnosis as a mastery tool. Mental rehearsal and end result imagery as described by Hammond (1990c) could also be seen as ego-strengthening techniques residing in the centre of the spectrum. Mental rehearsal and self-hypnosis are two of the techniques that will be applied in the proposed programme.

#### 5.2.7.3 Projective ego-strengthening

Phillips and Frederick (1995) describe this as a "newer" projective/evocative approach that can evoke unconscious material relevant to the client's ego strength. It can also be applied to activate inner resources and to place the client in contact with information from the unconscious mind. Frederick and McNeal (1999, p. 48) state that "...it helps the client's ego to extend its realm by developing a better working relationship with her unconscious mind". The authors maintain that this is an embodiment of the concept of client centred therapy.

Techniques used in this approach include age regression to positive events, such as previous achievements, getting in touch with one's "inner strength", internal self-soothing and hypnotic age progression. Frederick and McNeal (1999 p. 53) claim that the knowledge that there are significant resources within people lies at the heart of projective/evocative ego-strengthening: "The purpose of these techniques is to activate internal resources."

In developing the current programme, several of these projective/evocative techniques will be applied.

### 5.2.8 Specific ego-strengthening techniques utilised in the current study

#### 5.2.8.1 The Inner Strength

Frederick and McNeal (1999) and McNeal and Frederick (1993) describe inner strength as a psychic structure created through normal development and maturation. It is also seen as a conflict-free aspect of the personality that is often dormant and that has always been there from the moment of birth. According to McNeal and Frederick (1993), the therapist can suggestively connect this aspect of personality with the client's deepest unconscious resources.

McNeal and Frederick (1993) have developed a projective/evocative technique for what they refer to as "Meeting Inner Strength". This script will be incorporated in the current programme (see Chapter 4), since the concept of "inner strength" can possibly play an integral part in equipping new mothers with resources to deal with the transition to motherhood. It is the current author's opinion that an increase in a woman's awareness of her inner resources could increase her sense of self-efficacy and her psychological well-being in general.

#### 5.2.8.2 The Inner Advisor

According to Frederick and McNeal (1999), the concept of inner guidance is not new, and they believe that it is part of human nature to desire a source of guidance. The authors refer to the work of Rossman (Rossman 1987, cited in Frederick & McNeal, 1999) where the inner advisor is conceptualised as a source of understanding, comfort and support. Frederick and McNeal (1999) further describe the inner advisor as compassionate, with the client's best interests in mind.

The inner advisor technique can be used to access and develop a part of the personality that can become an ever-present guide in a person's life. It could therefore be regarded as a resourceful part of the personality (Frederick & McNeal, 1999). Meeting with the inner advisor can be ego-strengthening in the sense that the experience could validate a wise and loving inner part that is there to provide support and wisdom. According to Frederick and McNeal, it is encouraging to feel that the part is available and can be called upon for guidance when needed. It can also become a self-object for calming and an expression of objective thinking.

The script of Rossman (1987, cited in Frederick & McNeal, 1999) is intended to facilitate meeting with the inner advisor. This script will be incorporated in the current programme (see Chapter 4). In the current study, it could be expected that access to such a guiding and wise part could contribute to the woman's sense of self-efficacy and coping during the transition she is experiencing.

#### 5.2.8.3 Inner Love

Inner love is a hypnotically activated, conflict-free internal structure that, according to Frederick and McNeal (1999, p. 193) "...is something like an ego state, can profoundly affect clients in a positive way, providing the particular kind of self-esteem enhancement that comes with knowing one is loved". Inner love requires some prior experience with loving interpersonal relationships. It moves beyond elemental survival to the realm of a person's relationships, self-worth, meaning and significance in the world.

The technique described by Frederick and McNeal (1999) can be seen as one that put the client in contact with these inner resources of unconditional love. When a pregnant women is assisted to get in touch with the part called inner love, it could possibly enhance her confidence in herself as a potentially loving, caring and capable mother. It is also possible that this part could contribute to maternal-child attachment. The script developed by Frederick and McNeal (1999) will be included in the current programme (see Chapter 4).

#### 5.2.8.4 Mental rehearsal by means of age progression

Age progression is a hypnotic phenomenon that has been used extensively in ego-strengthening. It refers to future-orientated work and was discussed in more detail in the section dealing with hypnotic phenomena (see paragraph 5.1.5.3.3 in this chapter). Age progressions can be structured, such as techniques for mental rehearsal, goal imagery and success imagery. Hammond (1990c) views structured hypnotic age progressions as "goal-directed hypnotherapy techniques". Phillips and Frederick (1992) developed a model for unstructured age progressions which they believe is both ego-strengthening and diagnostic.

Both structured and unstructured techniques of age progression could enhance a pregnant woman's experience and concept of herself as a strong and capable

mother. Lederman (1996) maintains that being able to visualise oneself as a mother is important in the development of a maternal identity; this technique could therefore be seen as contributing to this developmental task. Mental rehearsal will be included in the current programme (see Chapter 4), regarding the experience of labour and the postpartum period.

#### 5.2.8.5 Self-hypnosis

Wickramasekera (1988) defines self-hypnosis as giving suggestions to one's self to induce an altered state of consciousness characterised by alterations in perception, mood and memory. Sanders (1997) points out that hetero-hypnosis and self-hypnosis are similar in the sense that both are thought to facilitate access to the unconscious, and are associated with imagery, fantasy production and alteration in subjective experience. However, hetero-hypnosis can be distinguished from self-hypnosis on a contextual basis. Sanders (1997) refers to the work of Fromm et al. (1981) who describe self-hypnosis as a self-directed, self-induced state, whereas hetero-hypnosis is a dyadic situation in which the therapist provides the client's induction.

Self-hypnotic procedures can be presented to the client in many different ways. According to Sanders (1997), the selection of specific techniques will depend on the needs of the client, the style of the therapist and the nature of the problem. She suggests that the therapist begin working with the client by administering suggestions in the dyadic situation, and then continue to progressively transfer the responsibility for self-induction and self-direction to the client. Hall and Lynn (2000) maintain that self-hypnosis is to some extent a skill that can be practised and that most clients can be taught the fundamentals of self-hypnosis in one to two sessions.

Various authors have mentioned the therapeutic value of self-hypnosis. Hall and Lynn (2000, p. 145) state: "At a minimum, self-hypnosis is a coping skill that increases the individual's sense of self-control." Frederick and McNeal (1999) regard clinical self-hypnosis as ego-strengthening since it contributes to a sense of mastery and control. They state that clinical self-hypnosis is valuable in promoting self-care since clients know what they can do to relax and calm themselves. Sanders (1997) argues that the purpose of teaching a client self-hypnosis is threefold: it provides a vehicle for the client to actively participate in the treatment process, it is a way to improve self-mastery and it extends hypnotherapy beyond the consultation room.

She also believes that self-hypnosis can be used in conjunction with and to reinforce the therapist's posthypnotic suggestions designed to spur personal growth.

In the proposed programme, self-hypnosis will be facilitated in the first session and in all subsequent sessions clients will be requested to enter trance by means of self-hypnosis before the session content is delivered (see Chapter 4). Clients are encouraged to view self-hypnosis as a self-help technique for themselves, something she could do for herself that is self-directed and self-controlled (cf. Hall & Lynn, 2000).

### 5.2.9 Conclusion

Ego state therapy was described as a therapeutic approach that provides a "parts" model of personality. One of the assumptions of this approach is that the psyche consists of several distinguishable parts, referred to as ego states. While pathology is often the result of conflict within the "family' of ego states, it is also evident that there are possibly several conflict-free and helpful ego states. The utilisation of these helpful ego states in ego-strengthening was described.

Since ego-strengthening refers to strengthening the self or the ego, it can be concluded that the ego state therapy model provides a wealth of possibilities for enhancing psychological well-being. However, there still exists a need for knowledge regarding the application of these techniques in populations without obvious pathology. The current study could therefore contribute to a broadening of the application of ego state therapy and ego-strengthening.

## 5.3 Summary

Two approaches to hypnotherapy, namely the Ericksonian and ego state therapy approaches, were explicated as the foundation on which the proposed programme was developed. It was argued that an Ericksonian approach acknowledges the possible existence of innate resources in all individuals, while the ego state therapy model provides various techniques to evoke these resources. Since the focus of the current study is on promoting the psychological well-being of pregnant women, it is relevant to review the literature regarding the use of hypnosis in obstetrics before explicating the proposed programme.

# 6. CLINICAL APPLICATIONS OF HYPNOSIS IN OBSTETRICS

## 6.1 Introduction

Hornyak and Green (2000) state that the largest and earliest body of scientific and clinical literature on hypnosis and women's health has been in the area of obstetrics. The most common use of hypnosis in obstetrics has been in childbirth training focusing on the relief of labour pain and on delivery itself. More recently, attention has been given to the use of hypnotic interventions to address anxiety related to medical procedures, stress, fears, or conflicts about childbirth and negative perceptions and beliefs (e.g. Mairs, 1995; Mantle, 2000). In this section, the different applications of hypnosis in obstetrics will be considered.

## 6.2 The use of hypnosis as a childbirth preparation method

### 6.2.1 Introduction

Hypnosis training as preparation for childbirth has been used for many decades. Hammond (1990a) includes a whole chapter of suggestions and metaphors that can be applied in obstetrics and gynaecology. Several approaches to hypnotic childbirth preparation can be found in the literature, such as those suggested by Hilgard and Hilgard (1994), Leeb (1995), McCarthy (1998, 2001), Oster (1994), Oster and Sauer (2000) and Schauble et al. (1998). Most of these approaches have the same aim, namely to prepare pregnant mother for coping with labour. They differ, however, regarding the format of the sessions (group or individual sessions), timing (early or later in pregnancy), duration and number of sessions, and different types of hypnotic interventions applied.

A few recent approaches to childbirth preparation by means of hypnosis will be analysed in the next section.

### 6.2.2 The approach of Hilgard and Hilgard (1994)

Hilgard and Hilgard (1994) recommend that preparation for childbirth be started in the last two months of pregnancy because anticipation and participation are then at their greatest. They are of the opinion that the purpose of the preparation should not only be to reduce pain, but to make birth a rewarding, participative experience.

However, many of the suggestions in their approach focus mainly on the relief of pain in labour. According to Hilgard and Hilgard (1994), obstetric pains are located in specific regions of the body, therefore it is possible to apply uniform procedures to assist in pain relief. They describe eight such procedures:

- **Training rehearsals** for actual labour are extensively employed, which are similar to the Dick-Read and Lamaze methods (see Chapter 2 for an explication of these methods). This reduces the anxiety produced by facing an unknown and potentially frightening experience. The rehearsals may be given greater reality by being carried out under hypnosis. Hypnotic rehearsal is also applied in the techniques described by Kroger (1990), Leeb (1995), Oster (1994), Stoler (1990) and Waxman (1990).

- **Relaxation** is an element in most hypnotic procedures and can be applied to combat tension that often builds up during confinement (Hilgard & Hilgard, 1994). This view is supported by Watkins (1987), while Waxman (1990) emphasises in his hypnotic training sessions that the mother has to be conditioned to become completely relaxed, mentally and physically, whenever she enters the trance state. He believes that this can be more effective if the mother is taught self-hypnosis and practices it regularly. Waxman further combines relaxation with deep breathing.

- **Substituting** a minor symptom for the pain can be effective, with the secondary symptom being felt in the same location where the pain was originally found. Hilgard and Hilgard (1994) describe a case study where a "light tingling" was substituted for the pain of a contraction. It is also possible to displace the symptom to another part of the body. The rhythmic contractions of the abdomen can for example be displaced to rhythmic contractions felt elsewhere in the body, like the hands. In some instances, direct suggestion of symptom relief may be satisfactory, such as telling the client that she can be numb from the waist down. This approach is also utilised in the protocol of Leeb (1995) and Fuller (1990).

- **Indirect suggestions** of pain relief can be used, such as using the well-known glove-anaesthesia method. After anaesthesia has been produced in the hand by stroking and suggestion of numbness, the client can transfer the numbness from the palm of the hand to other areas. This is a common procedure also recommended by Leeb (1995), Kroger (1990) and Watkins (1987).

- The practice of **imaginative separation** from the present scene can be used, by imagining being at another place, in other circumstances, such as taking a trip. Rodger (1990) suggests that the mother can "sit over there and watch" the birth process. Watkins (1987) refers to utilising the hypnotic phenomenon of general **dissociation** to manage contractions during labour.

- Finally, Hilgard and Hilgard (1994) mention that **posthypnotic suggestions** can be given. These suggestions are intended to reduce postoperative pain and discomfort, to make the whole experience satisfying and to provide a confident and positive attitude carrying into the postpartum period. Fuller (1990) gives direct suggestions of the mother experiencing the post-delivery hospital stay as "a pleasant vacation".

The focus of the model presented by Hilgard and Hilgard (1994) is clearly more on addressing discomfort and pain during labour, although some posthypnotic suggestions are made regarding general well-being. It is also evident that many other writers apply some of the same principles as the Hilgards in their approach to childbirth preparations by means of hypnosis.

### 6.2.3 Leeb's protocol for training in self-hypnosis (Leeb, 1995)

Leeb (1995), an obstetrician and gynaecologist, describes a protocol for training clients in the use of self-hypnosis for labour. It consists of five to six individual sessions, lasting an hour each. Attention is given to the teaching of rapid techniques for inducing self-hypnosis and producing glove-anaesthesia. Leeb (1995) also gives direct suggestions for the experience of "epidural anaesthesia" and provides methods for achieving graded analgesia. Positive suggestions are used during all sessions. Homework assignments regarding the use of self-hypnosis are seen as very important, and the client also receives a pre-recorded tape with suggestions for self-hypnosis. Leeb's (1995) protocol deals mainly with reducing pain and discomfort during labour, without directly addressing psychological concerns.

### 6.2.4 The Hypnoreflexogenous Protocol (Schauble et al., 1998)

The purpose of Schauble et al.'s (1998) hypnoreflexogenous protocol is to provide a "conditioned reflex" which is aimed at enhancing the client's sense of readiness and control. An attempt is made to "exalt maternity and enliven the emotions" (Schauble et al., 1998, p. 274). The protocol is based on the premise that, if the client is sufficiently educated and prepared regarding the birth process, anxiety will be reduced. Schauble et al. maintain that the preparation takes on the quality of a posthypnotic suggestion, where the preparation information may be incorporated as a suggestion for what will occur during labour and delivery. Information is given regarding the muscular nature of the uterus and alternate ways of producing hypno-analgesia and anaesthesia are taught. Suggestions are given to maintain a positive emotional state during labour and also into the postpartum phase.

The protocol consists of six group sessions of approximately two hours. Shauble et al. are of the opinion that it is not necessary for the mother to apply hypnosis during her actual labour, as their protocol prepares her for delivery rather than require that she be in a hypnotic state during childbirth.

In the proposed programme, the principle of giving information regarding labour while the client is in trance, will be similarly applied. The proposed programme can further be seen as a preparation programme, where the client can choose whether she wants to apply self-hypnosis during labour or not.

### 6.2.5 Oster's individualised model (Oster, 1994; Oster & Sauer, 2000)

Oster (1994) as well as Oster and Sauer (2000) discuss another model, which they believe offers the mother a sense of involvement in the birth process, control, awareness and some anxiety relief. According to Oster and Sauer (2000), it emphasises the empowerment of the woman by adequately preparing her for labour and delivery. Because self-hypnosis is taught, it also provides her with a tool that she can apply at any point. Oster (1994) prefers to work with individual clients, using the following elements:

- An opportunity for the mother to tailor the protocol to address her needs along with her husband;
- Utilisation of a "parts model" for induction, deepening and imagery; and

- Incorporation of "hypnotic rehearsal", dissociation, time distortion and cognitive reframing, as well as continued application of the hypnotic procedure after the delivery and into the recovery period.

Oster (1994) maintains that this six-session, individual approach adequately prepares the mother for labour and delivery and that it enables her to use self-hypnosis as needed. He further emphasises the empowerment of the expectant mother and reframes the birth process from "what is being done to me" to "what are we doing together".

Oster (1994) acknowledges that his "parts model" is similar to Watkins and Watkins' (1997) notion of ego states. This model is the only model to date that addresses psychological concerns during labour and delivery extensively. By teaching self-hypnosis, it also provides a self-help tool that could enhance coping (Hall & Lynn, 2000), and therefore psychological well-being in the postpartum period.

### 6.2.6 The technique of McCarthy (1998, 2001)

McCarthy (1998, 2001) developed an individual approach of four to five individual sessions, which lasts 30 minutes each. He worked primarily within an Ericksonian framework, utilising hypnotic phenomena such as catalepsy, age progression, dissociation and anaesthesia. McCarthy (1998) argues that there are no specific sets of words that are to be used, but that the hypnotic phenomena should be utilised according to the needs of each individual pregnant woman.

In a general outline of his approach, McCarthy (1998) describes possible session content as follows:

- Session one is seen as the introduction to hypnosis and teaching of self-hypnosis;
- Session two consists of the client putting herself in trance. The therapist deepens trance and then uses imagery and suggestions for the first and second stages of labour. McCarthy (1998) also refers to prenatal bonding, where the mother can imagine that she already has given birth and suggestions of love and joy can be given;
- Session three focuses on teaching the client the phenomena of dissociation and anaesthesia;

- Session four is seen as an opportunity to refresh and clarify misunderstandings. At this stage, simple posthypnotic suggestions regarding a quick recovery, establishing a good milk supply and making a strong bond with the baby may also be given.

McCarthy (1998), being a medical practitioner, claims that he had used this approach with over 600 women and that none of these women developed postnatal depression. He admits, however, that he cannot make any definite statements since no formal research was conducted.

In the proposed programme, as explicated in Chapter 4, some principles used by McCarthy (1998) will be utilised, such as the application of hypnotic phenomena, the use of specific imagery for labour, suggestions for prenatal bonding and for postnatal well-being.

### 6.2.7 Conclusion

Although there are several different approaches to hypnotic childbirth preparation, they often have several features in common, as summarised by Oster and Sauer (2000):

- Listening to the woman's (and often also her partner's) beliefs about pregnancy, labour and delivery;
- Providing factual educational information about the childbirth process and correcting erroneous beliefs;
- Discussing the role of hypnosis in labour and delivery;
- Assessing hypnotic talents and hypnosis training;
- Enhancing expectancy that this new skill can make a difference in her experience of childbirth; and
- Developing rapport and encouraging a collaborative approach.

Regardless of the specific approach, it is generally accepted that the inclusion of hypnosis in preparation for childbirth can be beneficial to both mother and baby (e.g. Kroger, 1977, cited in Watkins, 1987; Oster & Sauer, 1997).

In most hypnotherapeutic childbirth preparation programmes, however, there is still a lack of emphasis on the psychological experience of labour and of the transition from

pregnancy to motherhood. The approach of Oster and Sauer (2000) seems to be the only one to date that acknowledges these factors, but it still places more emphasis on labour than on general postpartum psychological well-being. It could be argued that there is a need for a more holistic approach that will enable the client to have a comfortable and satisfying birth experience, but also prepare her for her new role and identity of a mother. The current programme was developed to address these limitations in previous hypnotic preparation programmes.

## 6.3 Other applications of hypnosis during pregnancy, labour and the postpartum period

### 6.3.1 Hypnosis during pregnancy

Hypnosis has already been used to manage problems that occur during pregnancy such as hyperemesis gravidarum (Morton, 2000; Simon & Schwartz, 1999; Torem, 1994), nausea and vomiting, insomnia, backache, headache, fatigue and regulation of appetite (Watkins, 1987). Hammond (1990a) mentions the application of hypnosis with patients who experienced threatened premature labour, while Mehl (1994) reports on the value of hypnosis reverting breech presentation. More recently, Mantle (2000) points out that hypnosis could be a valuable tool in the treatment of prenatal stress and anxiety.

### 6.3.2 The use of hypnosis during labour and delivery

Although less common than in childbirth preparation, there have been accounts of women receiving hypnosis for the first time only by the time they are in active labour (Rock, Shipley & Campbell, 1969), where the focus was on direct suggestions for immediate pain relief.

### 6.3.3 The use of hypnosis in the case of caesarean section

Chiasson (1984) describes how hypnotically induced anaesthesia can be applied even when the mother is having a caesarean section, but stresses that the phenomenon of glove anaesthesia should be induced several times before the actual delivery. It is the current author's opinion that hypnosis could also be used to prepare the mother for caesarean section, since hypnosis has been found to promote the

physical recovery of patients from other types of surgery, as well as promoting the emotional response of patients following surgery (Blankfield, 1991; Pinnell & Covino, 2000).

### 6.3.4 The effect of hypnosis in the postpartum period

Hypnotically prepared mothers may be influenced via suggestion to lactate more promptly (Hilgard & Hilgard, 1994; Waxman, 1990). Since tension may inhibit lactation via the pituitary gland, the relaxation that the prepared mother experiences may result in prompter flow of milk. Oster and Sauer (1997) use an individualised approach to ease the transition to breastfeeding. Chiasson (1984) mentions the use of posthypnotic suggestions for a quick recovery and relaxation after caesarean section.

Although it is generally accepted that hypnosis can be a useful adjunct in obstetric care, and although there is a wealth of anecdotal evidence regarding the value of hypnosis in labour, it is necessary to evaluate relevant empirical findings.

## 6.4 Empirical studies regarding the use of hypnosis in obstetrics

### 6.4.1 Introduction

According to Watkins (1987), hypnosis has been used in some form or other for over a hundred years to relieve labour pain. An overview of the literature confirms that this kind of intervention is indeed the most common application of hypnosis in obstetrics as was discussed in the previous section. Although it is occasionally implied that the use of hypnosis to alleviate pain during labour, could contribute to the mother's postnatal psychological well-being, very little empirical research has been done regarding the use of hypnosis during pregnancy to enhance general psychological well-being and adjustment after the birth. In the following section relevant empirical research will be discussed.

### 6.4.2 The effect of hypnosis on various aspects of labour

Experimental studies of the use of hypnosis during labour were more abundant during the 1950's and 1960's than in recent decades. This is possibly due to the fact

that results were conflicting and hypnosis was seen as being more trouble than it was worth (Jenkins & Pritchard, 1994). In some of the early studies it was found that hypnosis, with the emphasis on relaxation, shortened both the first and second stages of labour (Abramson & Heron, 1950). Davidson (1962) reports that hypnotic preparation was more successful in the relief of labour pain than the Read method (see Chapter 2). The benefit of hypnosis for relief of labour pain was is also reported in a study by Rock, Shipley and Campbell (1969).

Later studies seem to contradict these findings. Freeman, Macaulay, Eve, Chamberlain and Bhat (1986) found that self-hypnosis seems not to be an effective form of analgesia though it may help to make childbirth a more satisfying experience. Venn (1987) found no evidence that hypnosis was more effective in reducing pain and enhancing satisfaction during childbirth when compared with Lamaze classes (see Chapter 2). This study, however, suffered a number of methodological problems, which could have affected the results.

A significant study was done by Harmon, Hynan and Tyre (1990). They studied the benefits of hypnotic analgesia as an adjunct to childbirth education and found that women who had been hypnotically prepared for birth experienced reduced pain, shorter stage one labours, had less medication and more frequent normal deliveries. The babies also had higher Apgar scores than those of mothers who did not receive hypnosis as part of birth preparation. These authors conclude that there could be substantial benefits when hypnosis training is incorporated into childbirth education.

In another study, Jenkins and Pritchard (1994) assessed the effects of hypnotherapy on the first and second stages of labour in a group of pregnant women. The study involved 126 primigravid and 136 parous women, both with control groups. Individual hypnotherapy of six sessions was applied, and the focus was on teaching the women auto-relaxation and auto-analgesia. They found that all forms of analgesia were used by fewer women in the research groups than in the control groups. It was further found that the duration of the first stage of labour was shortened for primigravid women, but the second stage of labour was not affected by hypnotherapy.

Mairs (1995) conducted a study to evaluate perceived levels of pain and anxiety. She found that women who were taught self-hypnosis in a series of four classes reported significantly lower ratings of pain and anxiety after delivery than did a

control group. Mairs concluded that self-hypnosis may have served as a coping tool for the hypnotically prepared group, affecting perceptions of pain by altering perceptions of control. The study is, however, limited by the fact that women were not randomly selected. The control group also consisted of women who were given the choice of taking part in the hypnosis programme, but who declined it.

A study worth mentioning is that of McCarthy (1998), who specifically focused on the prevalence of postpartum depression in a sample of more than 600 women. He administered an individual hypnosis programme consisting of five 30-minute sessions, based on Ericksonian principles. McCarthy reported a virtual absence of postpartum depression in this sample, which is significant as the prevalence of postpartum depression is usually estimated to be between 10% and 15% (O'Hara, 1995). McCarthy's study is unfortunately limited by the fact that no control group was used and no formal psychometric evaluations were done, but it points to the possible effectiveness of utilising hypnosis in preventing postpartum depression.

Finally, in a recent study by Martin, Schauble, Rai and Curry (2001), hypnotic preparation for childbirth was found to be effective in reducing the number of complications, reducing surgical interventions and reducing the length of postpartum hospital stay of pregnant teenage mothers. This is one of the few empirical studies related to the effectiveness of hypnosis, but it is limited by the fact that the experimental group only consisted of adolescent mothers. However, it does give some support for the use of hypnosis in childbirth preparation.

### 6.4.3 Conclusion

There seems to be reasonably strong evidence that obstetric hypnosis for the relief of pain can be effective for a number of women. Hypnotherapeutic preparation for childbirth further seems to reduce complications during delivery and to reduce surgical intervention. Finally, there is some evidence for the role of hypnosis in preventing postpartum depression, but it needs to be further explored.

According to Hilgard and Hilgard (1994), many studies regarding the effect of hypnosis in reducing labour pain are unsatisfactory for two reasons. Firstly, the studies lack precise information regarding the hypnotisability of successful and unsuccessful clients, with the result that it is not known whether preliminary screening would improve the effectiveness of the method. Secondly, the studies

commonly lack a satisfactory index of the pain. Oster and Sauer (2000) further point out that many studies regarding the use of hypnosis for childbirth preparation do not include pre- and post-measures of anxiety, lack a verbatim script of the hypnotic protocol and do not adequately detail the hypnotic intervention to permit replication of treatment. The authors also state that the efficiency and effectiveness of hypnotic childbirth preparation would benefit from both empirical research studies and increased publication of specific protocols and suggestions used clinically. In a recent review of existing literature, Irving and Pope (2002) conclude that more research is needed to confirm that hypnosis during childbirth preparation could have a beneficial effect on mothers' postnatal physical and psychological well-being.

It is evident that there is a lack of empirical data regarding the effectiveness of hypnotic childbirth preparation in general and that there exists a need for more rigorous empirical investigation. Further, there is a virtual absence of data regarding the effect of prenatal hypnotherapy on postpartum psychological functioning. The current study could possibly address some of these issues.

## 7. EVALUATION AND INTEGRATION

In this chapter, hypnosis was considered as a phenomenon that is generally viewed as a useful adjunct to psychotherapy. Two therapeutic approaches, namely the Ericksonian approach and the ego state therapy approach, were explicated as frameworks from which hypnotherapy was conceptualised in this study. This is also in correspondence with the therapeutic approach suggested by Hartman (2002), who explicates the combination of these two approaches in hypnotherapy.

It has become evident that an approach based on the principles of Ericksonian psychotherapy could provide a foundation for the current programme, since it strongly emphasises aspects such as client resourcefulness and is orientated towards both the present and the future. In addition, from the ego state therapy model it is assumed that there are several healthy and positive "parts" or ego states that exist within the personality. This provides many possibilities for ego-strengthening that eventually could lead to the enhancement and maintenance of psychological well-being. However, to date the empirical research regarding the application of these two models for the purpose of the promotion of psychological well-being is limited.

A survey of literature has indicated that hypnosis has been used extensively in obstetric care, but the focus has mainly been on the relief of pain and discomfort during labour. Only recently did authors such as McCarthy (1998, 2001) and Oster and Sauer (2000) begin to focus on psychological processes during pregnancy and birth, but their accounts are mainly based on clinical case studies. Empirical studies of the effects of hypnosis on pregnant women are mainly limited to studying birth outcomes such as amount of analgesia required, duration of labour and the Apgar scores of the baby. There is no empirical evidence regarding the effect of hypnosis on aspects such as mood, satisfaction with delivery, the mother's experience of her baby and general psychological well-being. Another interesting aspect is that all outcome studies to date have focused on the immediate postpartum period, resulting in limited knowledge regarding the time frame in which hypnosis might still have an effect after birth. Finally, many studies regarding the effects of hypnosis on labour were methodically flawed, for example, hypnotisability were often not established, which led to limitations in generalising data.

It is clear that hypnosis, applied within the frameworks of Ericksonian and ego state therapy, could be effective in enhancing psychological well-being. There also exists a need for more empirical research regarding the joint application of these two approaches to hypnosis, but also regarding the application of hypnosis during pregnancy and the effects of hypnosis on the psychological experience of this life transition. The current study was devised to empirically investigate these possibilities. In the next chapter the protocol that was developed to facilitate psychological well-being is presented.

# CHAPTER 4

# A PRENATAL HYPNOTHERAPEUTIC PROGRAMME

## 1. INTRODUCTION

In this section the hypnotherapeutic programme utilised in this study will be presented. The actual script is presented on the left-hand side of the page, with notes regarding hypnotic phenomena, Ericksonian principles and application of ego state therapy techniques presented on the right-hand side of the page. Words in uppercase are woven through the whole of the programme as significant "markers" that could be heard by the unconscious mind (cf. Battino & South, 1999).

## 2. AIM OF THE PROGRAMME

The programme is aimed at preparing women who are pregnant for the first time psychologically for the experience of birth and the early postpartum phase. The programme specifically focuses on activating and utilising inner resources that could contribute to helping the new mother cope with this life transition. Each session has a specific focus, but the threads that are woven into all the sessions are utilising inner resources, seeding hope and optimism, maintaining health and well-being, and preparing for change and growth. Although the programme is structured, later sessions are shorter to allow for tailoring for specific concerns or requests that could arise.

## 3. GENERAL PROCEDURE

At the beginning of each session, some time will be spent to address any questions that the client may have before commencing with the actual programme content. The script for the specific session will then be delivered. After terminating trance the client has the opportunity to share her experience of the session. This will provide valuable information, for example, how the ego states were experienced. These specific images could be applied again in further sessions to reinforce ego-strengthening.

# 4. DESCRIPTION OF PROGRAMME CONTENT

## 4.1. Session 1: Guiding towards self-hypnosis and commencing ego-strengthening

### 4.1.1 Objectives

The objectives of the first session were:

- To invite the client to experience hypnosis as naturalistic trance;
- To guide the client to get in touch with some of her inner resources, referred to as "Inner Strength" (adapted from Frederick and McNeal, 1999);
- To assist the client in finding her own, personalised way of entering trance and finding her inner resources, and to utilise self-hypnosis (adapted from Hunter, 1994).

### 4.1.2 Expected outcomes

After experiencing this session, the client should be able to apply self-hypnosis and should have become aware of a sense of Inner Strength as a potential inner resource. She will also feel more prepared for further hypnotherapeutic work.

### 4.1.3 Session content

**(Facilitating trance)**

| | |
|---|---|
| I wonder whether you would like to make yourself COMFORTABLE and PREPARE yourself for a journey inside yourself.... a journey that you could perhaps find INTERESTING or ENLIGHTENING, or maybe even COMFORTING...and perhaps you can realise...that there are MANY WAYS...to PREPARE yourself for a journey...LOOKING FORWARD to the actual experience...picturing yourself on the journey, WORKING OUT the most interesting and REWARDING way to get to your destination...and right now you can... simply allow | **Permissive approach**<br>**Seeding**<br>**Metaphor**<br><br>**Interspersal**<br><br>**Seeding / interspersal** |

yourself to become absorbed in this experience...absorbed in yourself.... Maybe focus on your breathing...and notice that with every breath you take, you are taking in something and letting out something...such a NATURAL CYCLE... of taking in and letting go. That's right. Taking in peace, letting out tension...taking in courage... letting out worries...that's right...

**Pacing and leading**

And perhaps you would like to take a few moments to make your body as comfortable as you would like to be today...that's right... and maybe you will be aware of your baby also getting comfortably prepared for this experience...just enjoy the feeling of being comfortably in control...in choosing just how you would like to experience your hypnosis today... Good... You know it is quite possible that your conscious mind is busy with thoughts...analysing...learning... thinking...while your unconscious mind is exploring on another level...deep inside yourself...and it's perfectly OK ...just allow your conscious mind to do whatever it wants to...while your unconscious mind knows what is to be fulfilled today...in many WONDERFUL and UNEXPECTED ways...

**Ericksonian language use**

**Seeding internal locus of control**
**Tailoring**

**Multilevel communication**

**Conscious / unconscious dissociation**

**Seeding**

**(Intensification of trance experience)**

You know...I would like to invite you to experience something that you might find very INTERESTING. ..it is possible that there have been many places... or situations...or times in your life...where you have felt so comfortable...and safe... strong... confident...calm...happy... and perhaps you would like to allow your unconscious mind to guide you to such a place or time or situation ...of such comfort, and peace...and safety...and strength...that's right. And I'm not sure where your journey is taking you ...just allow your unconscious mind to

**Ericksonian language use**

guide you...perhaps you go back to a time very long ago, when you were little...or maybe you explore a more recent time...you could even journey into the future to a time that is still to come, a time you have been dreaming of...and I know you can go and explore this wonderful place or time...perhaps you would like to use all your senses in doing so...picturing images...hearing sounds... experiencing certain bodily sensations ...whichever way you experience it is fine...just allow yourself to absorb this sense of peace and comfort...and STRENGTH...WISDOM...HOPE... JOY...and you may be surprised to know that you can achieve this sense of well-being whenever you choose, by using self-hypnosis, which I will explain to you in a little while...

**Age regression**

**Age progression**

**Accessing bodily resources**

**Covering all possibilities**

**Posthypnotic suggestion**

**(Ego-strengthening)**

And while you are involved in exploring these experiences...I would like to invite you to focus really deep inside yourself, and perhaps it is possible to have a sense of finding a part of... yourself ... a part that I will refer to as your Inner Strength... This is a part of you that has most probably been there since the moment of your birth...even though at times it may have been difficult for you to feel.... it is with you now... It's that part of yourself that has allowed you to survive and to GROW...to overcome many obstacles...just as it helps you now to overcome obstacles and to GROW STRONGER and more MATURE...it is that part that has enabled you to remain psychologically HEALTHY AND BALANCED...maybe you would like to take a few moments to get in touch with that part of yourself ...and you can notice what images...or feelings...what thoughts...what bodily sensations are associated with being in touch with your Inner Strength...and when those images, or thoughts, or feelings, or bodily sensations, or whatever it is, are coming to you...

**(Adapted from Frederick and McNeal, 1999)**

**A possible conflict-free ego state**

**Activation of resourceful ego state**

**Stimulation of association**

when they are clear to you in your inner mind... and when you have a sense that the experience is completed for you...in your own way...you could just indicate by a nod of the head.

**Ideomotor response**

In the future...when you wish to get in touch with Inner Strength... you will find that you can anytime do so by calling forth these images, thoughts, feelings, bodily sensations, or however *they are coming to you, and* by doing so you will be in touch with Inner Strength again...and when you are in touch with this part of yourself, you will be pleasantly surprised to find that you are feeling more CONFIDENT.... confident in the knowledge that you have, within yourself, all the RESOURCES you really need to make the TRANSITION to being a mother...to be able to experience your labour and delivery in a COMFORTABLE AND SATISFYING WAY, to EASE into your role as mother NATURALLY and efficiently... to have the experience that dreams can come true. When you are in touch with this part of yourself, it is also possible to feel more calm... more OPTIMISTIC...to look forward to the future and to realise...you can COPE with and GROW through all the exciting changes that occur during your journey to motherhood. When you are in touch with this part of yourself, you could perhaps realise that you have experienced an inner sense of well-being in your life before... therefore you can easily *GLIDE through this life transition you* are experiencing. You can anticipate the JOY and the MIRACLE of life....

**Posthypnotic suggestion**

**Seeding confidence and internal locus of control as well as ease in labour**

**Guiding associations towards the future**
**Seeding possibility of experiencing positive affect**

**Seeding ease of experiencing life *transition***

And in the next days and weeks to come, you may find yourself becoming CALMER and more OPTIMISTIC about yourself and the CHANGES you are experiencing, about labour and becoming a mother, about your

**Posthypnotic suggestion**

**Seeding positive affect and ability to cope with change**

general WELL-BEING...and you will find that you can get in touch with Inner Strength by simply closing your eyes for a moment and evoking these images in your own special way... reminding yourself that you have within... all the RESOURCES you really need...you are HEALTHY and STRONG...

**Posthypnotic suggestion**

**Ego-strengthening**

**(Facilitate learning of self-hypnosis)**

**(Adapted from Hunter, 1994)**

And now... I would like to teach you something else that you could find interesting and beneficial, something you could use to strengthen and reinforce what we do here. You can arrange with yourself your own, personal approach to hypnosis... some little pattern or pathway that can take you into hypnosis...a pattern you can feel comfortable with.... as you know, everyone experiences hypnosis in her own, special way...It is very, very personal...

There are some general patterns of self-hypnosis that I would like to mention to you...as I describe them, perhaps one of them will seem just right for you...with some modifications to suit you personally... like changing a phrase, or an image, or a word...or perhaps something I say will remind you of something. ..in your own experience that you would like to adapt as a self-hypnosis approach... so in one of these ways... it will be possible for you to create your own, special self-hypnosis technique.

It is best to keep it simple...in hypnosis, the best techniques are always very simple... like counting yourself down into hypnosis... getting yourself into a comfortable position with your head supported, like sitting in a comfortable chair or lying on your bed...closing your eyes with the intention of going into hypnosis, and simply, count.... some people just

continue to count slowly and steadily until they reach a level that's just right for them at that time. Others decide beforehand on a certain number, like "when I've reached 15, I'll have a more profound experience of my internal world...20, I can have a curious sense of my experiencing my own self-hypnosis...and when I reach 25...I can just relax...", that sort of thing. Some people recite a few numbers over and over, like 1...2...3...4...5...

It is also possible to use a variation of those, like to see yourself or feel yourself going down a beautiful stairway...or perhaps down a terrace in a beautiful garden, where each step takes you further into your own internal experience, and you can take as many steps, as many terraces as are just right for you at that particular time...that's right...so simple and easy just to allow yourself to experience your own hypnosis.

**Covering all possibilities**

Perhaps you would like to use more imagery: some people like to imagine that they are floating on a cloud...or going out to explore the galaxies, or just have their favourite daydream ...some people use colour...if you close your eyes and see a lovely kaleidoscope of colour, you might like to adapt it as a self-hypnosis technique...or see a pinpoint of colour in the distance...as you watch it come closer and closer.... it gets bigger and bigger, until you are enveloped with that gorgeous colour, and that colour takes you into hypnosis.

Some people prefer the comfortable, familiar things: the ticking of a clock, the sound of waves on a beach, a favourite piece of music, or perhaps the rhythm of their own breathing...in...and out...

And you can choose for yourself now, some little pattern that is just right for you...and really focus on it inside for a few moments...go over it several times in your mind.... imagine yourself taking yourself into your own inner hypnotic experience, using that approach ...think about getting ready to do your hypnosis, taking yourself in imagination to the place where you are going to do it, settling yourself down, close the eyes with the intention of going into hypnosis, perhaps notice a change in the fluttering of the eyelids...as you take yourself inward with your own induction...and you may just enjoy your hypnosis within your hypnosis...you can just rehearse the whole scenario. That's right...and when you are experiencing being in your own hypnosis, you could just indicate by a nod of the head.

**Immediacy**

**Ideomotor response**

**(Preparing for termination of trance)**

In a little while I am going to ask you to bring yourself out of your hypnosis and shortly after that to allow yourself again to enter trance in your own way to practice it a little...but first I want to tell you that it is very important to do your self-hypnosis at least once a day, setting aside a specific time as hypnosis time...you know how much you would like to be PREPARED to experience your baby's birth in a COMFORTABLE and SATISFYING way...and to MAINTAIN and ENJOY your INNER WELL-BEING...by allowing yourself to practise your own self-hypnosis, you are doing just that, even if you only have five minutes... take five minutes of clock time...the more you do it, the better you get at it...the better you get at it, the more useful it becomes...you know, everybody deserves at least five minutes of their own time every day. You do. You can allow yourself to

**Seeding / interspersal technique**

**Posthypnotic suggestion**

**Universal qualifier (Ericksonian word usage)**

invest that time in your own hypnosis. After all, it is a talent that comes from within you...it is part of your own rich inner resources...

**(Intensifying experience of self-hypnosis)**

(Allow client to come out of trance at her own time and then immediately suggest that she take herself back into hypnosis).

**Fractionation**

Good...you can just allow yourself to become absorbed in your hypnosis again in your own way...your pattern that you established a little while ago...take your time...it is a very personal experience... and when you experience being in trance... you could just indicate by a nod of the head....

**Tailoring**

**Ideomotor response**

That's good...you can just enjoy the feeling of what you have accomplished today: getting in touch with some of your inner resources...establishing your own way of entering trance... that's right.... and now you can start to bring yourself back to the real world on this (mention day) here in the room with me and when you know exactly where you are you can open your eyes and you will feel refreshed and comfortable.

**Ego-strengthening**

**Terminating trance**

### 4.1.4 Duration

The duration of this session is approximately 30 minutes.

## 4.2 Session 2 : Further facilitation of inner resources by means of ego-strengthening

### 4.2.1 Objectives

The following are the objectives in session 2:

- To enhance the client's experience of her inner resources by means of activating ego-states referred to as "Inner Advisor" and "Inner Love" (adapted from Frederick and McNeal, 1999);
- Establishing the metaphor of an "Inner Team" as inner resource to draw upon during labour, delivery and the postpartum phase;
- Continuous seeding of the possibility of growth and maintenance of well- being.

### 4.2.2 Expected outcomes

The client will have experienced the additional resources of the Inner Advisor and Inner Love; she will own the metaphor of an "Inner Team" to draw upon during labour, if so wished, and she will be aware of the possibility of growth and psychological well-being.

### 4.2.3 Session content

**(Facilitating trance)**

Once again you can allow yourself to become more COMFORTABLE and relaxed, knowing that you were able to do so easily and EFFORTLESSLY during your previous experience.... that's right...using your own special technique of guiding yourself into your own hypnosis...and isn't it WONDERFUL to realise how one can GROW AND LEARN from oneself... DISCOVERING that there are so many possibilities of EXPERIENCING LIFE ... just going inside yourself ...on your special JOURNEY...your special road of discovery...and wonder...and I'm going to remain quiet

**Seeding comfort**

**Utilising previous trance experience**

for a few moments so that you can experience going into your trance in your own special way... and when you feel as comfortable as feels right for you to continue working today, you could indicate by a nod of the head.

**Dissociative statement**

**(Facilitating ego-strengthening)**

Good... and I wonder whether you would like to allow yourself to continue on your JOURNEY OF DISCOVERY.... perhaps you can remember vividly your previous encounter with your Inner Strength... and perhaps you were surprised at the extent to which you felt its presence in your life after your previous experience ...perhaps you experienced it in other indirect ways...feeling calmer...coping well...feeling stronger.... experiencing a sense of meaningfulness...it really doesn't matter just how you experienced it and if you experienced it, as your unconscious mind already knows how to apply the knowledge and the strength coming from your Inner Strength...

**Permissive language**

**Conscious / unconscious dissociation**

**(Facilitating ego state work with the Inner Advisor)**

And perhaps you would like to allow yourself to relax even more, maybe absorbing yourself again in your own internal experience, a world of INNER SAFETY and COMFORT, a special place, like you did before.... experiencing the serenity and the peace...and when you are ready... I would like to invite you to discover yet another interesting part of yourself...a part I will refer to as your Inner Advisor. I don't know... just how it will come to you...but I do know you can allow an image to form, that can represent your Inner Advisor ...you can just allow an image to evolve in your inner mind...an image that is COMFORTABLE for you...an image that represents your Inner Advisor...a wise, kind figure who knows you

**Seeding idea of comfort**
**Utilising previous trance experience to ratify trance**

**(Adapted from Frederick and McNeal, 1999)**

**A possible conflict-free ego state**

**Presupposition of process**

well...let it appear in any way that comes and accept it as it is for now...it may come in many forms...a wise old man or a woman, a friendly animal or a bird...a ball of light, a friend or a relative, a religious figure...you may perhaps not experience a visual image, but have a sense of peacefulness and kindness... it really does not matter as everyone has her own unique way of meeting this internal part...maybe you would like to call it something that you are COMFORTABLE with...

And you can accept your Inner Advisor as it appears ...as long as it seems wise, kind and compassionate... you will most probably be able to sense its caring for you and its WISDOM...you can even invite it to be comfortable there with you...accept what comes...and perhaps, when you are ready...you might want to talk to your advisor about the FASCINATING TRANSITION that awaits you... ask any questions you might have concerning your current condition ...your coming labour...the actual birth experience...the first few weeks after the baby is born...take all the time in the world in the next minute to do this.

**Seeding change as positive**

**Time distortion**

NOW listen carefully to your advisor's response...as you would to a wise and respected teacher... you may imagine your advisor talking with you...or perhaps you simply have an indirect sense of its message in some other way...allow it to communicate with you in whatever way seems natural... and you can continue the conversation until you feel you have learned all you can at this time... be open to the responses from your advisor...and consider them carefully...

**More forceful for more impact**

As you consider what your advisor has told you, you might want to imagine what the rest of your pregnancy, your

**Age progression**

labour, the birth of your baby, and your new role as a mother would be like if you took the advice and put it into action...perhaps you are surprised at how MEANINGFUL and FASCINATING it could be to make TRANSITIONS...perhaps your advisor assures you about your INNER WELL-BEING...that has existed for most of your life... maybe you need to clarify a few thoughts with your advisor...take your time to LEARN AND TO GROW....you have all the time you need...and when this experience of meeting you inner advisor is completed for you, you could just indicate by a nod of the head. Good...and when it seems right...you might want to thank your advisor for meeting with you...and you can ask your advisor what the easiest way could be to get in touch with it again in the future.... realise that you can meet your advisor whenever you feel the need...now and in the future...and isn't it wonderful and COMFORTING to know that you know more than you think you know...there is so much WISDOM AND KNOWLEDGE inside yourself that you perhaps haven't realised before...that's right...just say goodbye for now to your Inner Advisor, and when this experience is completed for you, you could simply indicate by a nod of the head again.

**Seeding that change could be meaningful**

**Seeding maintenance of well-being**

**Seeding possibility for growth**

**Posthypnotic suggestion**

**Seeding self-efficacy**

**(Facilitating ego state work with "Inner Love")**

**(Adapted from Frederick and McNeal, 1999)**

Good...while you remain comfortable and relaxed in your own internal world you might be interested to know that there is possibly yet another part inside yourself that you could meet...if you wish...it is possible to have another experience...that could be special for you...even more so at this WONDERFUL AND FULFILLING TIME of your life... an opportunity to

**Permissive approach**

meet all the LOVE... that resides within.... within you...and asks for nothing in return...all the love... that will never impose any conditions upon you...this is your Inner Love...it is all the unconditional love you have experienced...just because you are you...and I'm going to remain silent for a few moments just to allow you to experience your Inner Love... that's right...perhaps you would like to imagine this Inner Love as a special cocoon, safely embracing you and your baby...warm... nurturing... soft...yet supportive...

**Seeding ability for love and attachment**

**Metaphor**

**Seeding ability to nurture**

But perhaps you would like to remember that you could encounter your Inner Love in many different ways...perhaps as visual images...or thoughts...or emotions.... feelings...or even bodily sensations...whatever comes natural to you...is the correct way for you to experience your Inner Love...and when you are aware of experiencing this Inner Love, you could just indicate by a nod of the head again.

You can also get in touch with your Inner Love again, if you want to, by simply making yourself comfortable like this...and allowing yourself to focus on the images...or thoughts...or emotions...or bodily sensations that you have today...and you will be in touch with your Inner Love again ...and you may be SURPRISED at what you can LEARN ABOUT LOVING...being a mother...all this you can also learn from your Inner Love.... in MANY UNSUSPECTED WAYS...and you can now allow your experience of Inner Love to be completed and to let it go where it needs to go to continue its work inside...

**Posthypnotic suggestion**

**Seeding possibility of gradual development and growth**

**(Establishing co-operation of inner resources, functioning as an internal team)**

And now...I would like to invite you to experience something you might find really INTERESTING AND ENLIGHTENING...if you were to allow yourself...to experience the presence of these parts within yourself again... your Inner Strength...strong and supporting... your Inner Advisor, wise and compassionate...your Inner Love...warm and accepting... Perhaps you would like to invite all of them... or one of them... to join you for a short while...just accept their presence as it comes...and now... you might want to experience the knowledge...that you have INSIDE YOURSELF ALL THE RESOURCES YOU NEED to make a transition to a new phase in your life...you have inside an INNER TEAM...a team that has possibly been with you for many years, enabling you to remain BALANCED and EMOTIONALLY HEALTHY... a team that can work with you now and later... here and there.....and work together with the medical staff during your delivery...to ensure that you can experience the birth in a most COMFORTABLE and SATISFYING way.... and later...when you have crossed the bridge to being a mother both physically and psychologically...the Inner Team will still be there, guiding you...advising you...strengthening you...enabling you to love and be loved...You have inside everything you need for your journey to motherhood and it is a wonderful reassurance, isn't it?

**Seeding possibility of a positive experience**

**Seeding internal locus of control**

**Metaphor**

**Ericksonian word usage**

**Posthypnotic suggestion**

**Ericksonian use of tag questions**

Good... and when you are ready... you can let the Inner Team go where they need to go to continue their preparation and anticipation within you...knowing that they are there all the time.... you can get in contact with any one or all of them whenever you need to...and even without

**Seeding preparation for motherhood**

consciously thinking about it, you may be aware of these sources of strength and health within...in many unsuspected ways you may become more aware of an inner sense of FULFILMENT...JOY... MEANINGFULNESS...and WELL-BEING...

**(Preparing to terminate trance)**

You can just enjoy this special experience for a few moments... and now I would like to ask you to start coming back to the present again and you may want to bring with you all these wonderful feelings of well-being... (terminate trance as in previous session).

**Posthypnotic suggestion**

### 4.2.4 Duration

The second session has a duration of approximately 25 minutes.

## 4.3 Session 3: Facilitating the experience of labour and delivery

### 4.3.1 Objective

The objective of this session is preparation for the experience of labour and delivery, by applying various hypnotic phenomena and suggestions adapted from the scripts by Hunter (1994), McCarthy (1998, 2001), Peterson (1993) and Schauble et al. (1998).

### 4.3.2 Expected outcomes

In this session the woman will experience a "mental rehearsal" of the actual labour and delivery. Hereafter the mother will know more what to expect and be more aware of her inner resources that could contribute to her coping with labour and delivery.

### 4.3.3 Session content

**(Facilitating trance)**

While you are making yourself COMFORTABLE, you can again allow yourself to become absorbed in your own internal experience, as deeply as is necessary for the JOURNEY you might want to continue today...and you know you can do so by using your own special approach of experiencing trance, it could be the same as before... or you might have altered it slightly...you can just experience it in a RELAXED AND COMFORTABLE way... and while you are doing that, you might want to use the opportunity to thank yourself and your Inner Team for the good work you have been doing so far.... you know, if someone else had been working so hard at preparing for the birth of her baby, and for her journey to motherhood, you would have congratulated her .... so you can also be kind to yourself...congratulate yourself internally...that's right...

**Seeding comfort**
**Permissive approach**

**Metaphor**

**Tailoring**

**Seeding idea of further ego state work**

**Ego-strengthening**

**(Ego-strengthening)**

Good...you have been PREPARING yourself for many weeks for the birth of your baby...you have noticed many FASCINATING changes... and perhaps you have even started to ANTICIPATE THE WONDERFUL MEMORIES OF THE FUTURE... you have perhaps practised breathing exercises you could use in labour... you have collected information from various sources...you have learned how to experience trance by means of your own pattern of self-hypnosis... you have truly learned a lot ...and it is wonderful to realise how much you can learn from yourself, isn't it?

**Utilising past experience to seed and reinforce self-efficacy**

**Seeding possible positive affect**

**Ericksonian use of tag question**

**(Utilising changes that have already occurred to reinforce awareness of inner resources)**

Now, just as you have CHANGED AND ADJUSTED over the past few

**Seeding that positive change has already occurred**

months...your body has also adjusted...grown...TRANSFORMED into a special place for your baby .... and as you are breathing now... in and out...you are perhaps aware of the rise and fall of your chest...the natural cycle ... breathing... in...and out...and perhaps the movement or stillness of your baby...maybe you would like to imagine your baby relaxing...floating inside your uterus ... and isn't it surprising to realise .... that your baby has been growing and changing inside you, without your even thinking about it...NATURALLY .... EFFORTLESSLY... and in the same way...your body is PREPARING itself for the birth of your baby... without you even having to think about it. ...that's right...NATURALLY your body knows what to do...your baby knows what to do... your inner team knows what to do...you can just follow and experience your journey throughout labour and delivery EFFORTLESSLY in the way that is most COMFORTABLE AND SATISFYING for you.

**Focusing**

**Positive hallucination**

**Seeding idea of birth as a natural process**

**Ego-strengthening**

**(Establishing metaphor for preparing for labour)**

As the date of your baby's birth draws closer, your cervix are getting softer, riper, like a pear, ripening on a tree...it becomes heavier and heavier...but it waits until exactly the right time to fall down all the time becoming fuller, softer...ripening...and your body ripens and adjusts... and the time will come when the pear will be ripe, and fall down, down... at the right time and place...when your baby will know that it is the right time to be born...

**Metaphor: natural process to prepare for labour**

**(Facilitating age progression)**

Now, I would like to invite you to an experience that you might find ENLIGHTENING AND INTERESTING...even EXCITING... I call it a kind of dress rehearsal...a dress rehearsal for your baby's birth,

**Seeding positive affect associated with labour experience**

but it is only an exercise...you will always know that it is not really the time for your baby to be born... good...you can...take yourself forward in time...COMFORTABLY, EASILY...if you wish.... to a date a few weeks from now....just imagining the future...or just experiencing it in your own special way...and I do not know exactly which date you are going to.... and perhaps your conscious mind does not know, but your unconscious mind knows.....and will lead you there .... just allow your unconscious mind to take you forward, to the date of your baby's birth...take all the time you need in the next few minutes of clock time...and when you get there, you can just indicate by a nod of the head.

**Age progression**

**Tailoring**

**Multilevel communication**

**Age progression**

**Time distortion**

**Dissociative statement**

Good...you might want to take yourself to the point where you have already gone to the hospital and your contractions are getting closer and closer to one another...each one lasting longer and longer...perhaps your partner is there with you...it is a very EXCITING TIME...and this excitement could be a very positive experience for you because it can be part of your inner resources as you GRADUALLY EASE through labour and delivery. It is a wonderful experience to have a baby...and it requires a lot of energy to have your baby in a POSITIVE AND SATISFYING WAY...so you might choose to allow your excitement to be part of your experience from the very beginning...to use it as a resource during your labour...and perhaps.... you might find it REASSURING to realise.... that whatever UNEXPECTED AND WONDROUS EXPERIENCES lie ahead.... you have all the internal resources... to have your baby in a COMFORTABLE and SATISFYING way...

**Age progression**

**Reframing**

**Seeding ease of labour**

**Incorporation**

**Seeding self-efficacy**

**(Suggestions for phase one of labour)**

Now, it might help you to understand

| | |
|---|---|
| the goal of each phase of labour... and isn't it interesting to realise how many natural phases we find in life...like the seasons ...each there for only a specific time.... each with a special charm...each with a goal in the cycle of life...growing...harvesting ...resting...a continuous journey...and perhaps you know...that labour is divided in various phases...during the first phase your cervix widens, opens up...and that is the reason for your contractions...it is like a beautiful flower...opening in the summer sun.... basking in the warmth and comfort...and when you have a contraction again...you might want to remind yourself of the aim of the contraction...it opens up your cervix, more and more.... wider and wider... PREPARING the passage... for your baby to GLIDE THROUGH...and sometimes you could perhaps even imagine...that each contraction is like a hug you give to your baby...a gentle massage.... stimulating your baby...preparing your baby for the STIMULATING AND WONDERFUL WORLD that awaits...Your baby knows what to do.... during this EXCITING AND FASCINATING TIME...you might choose to help by preserving your energy...by taking yourself away from the situation.... should your contractions become too uncomfortable...allowing your body to continue its work...You can even practice it now... you can imagine that a contraction is coming...like a wave building up...until it finally crashes onto the shore...and recedes again .... and you can choose to experience each wave...or to take yourself away to another place, another experience ...just the way you did when practising your own hypnosis...you might want to become absorbed in your own internal experience every time you feel a contraction...coming out of the experience after it is finished...or you might want to remain comfortably inside all the time, relaxing more and more every time you feel a | **Metaphor: labour can be predictable and there is a definite end to each phase**<br><br>**Metaphor: natural ability of the cervix to dilate**<br><br>**Seeding ease of delivery**<br><br>**Metaphor**<br><br>**Seeding positive affect**<br><br>**Dissociative technique**<br><br>**Metaphor: contractions as waves Adapted from McCarthy (1998)**<br><br>**Seeding idea of choice and internal locus of control** |

contraction...it's up to you....and it is amazing to think about just how easily you CAN MAKE A CHOICE during your labour.... after every contraction you can allow yourself plenty of time to rest...STRENGTHENING yourself ...PREPARING yourself to continue your journey...knowing that you have within you an Inner Team to assist you .... your Inner Strength, Inner Advisor and your Inner Love... and we all know that teamwork makes any work so much LIGHTER and more BEARABLE, don't we?

**Seeding idea of choice and control**

**Time expansion**

**Ericksonian language use: tag question**

**(Suggestions for phase 2 labour)**

And as your contractions are getting STRONGER AND STRONGER, you might want to wonder about just how STRONG a muscle your uterus is... that's right...your uterus is a very STRONG muscle and your body needs that strength...and you know...your body is used to the contraction of your muscles...since you were born your muscles contracted...to move an arm or a leg...and it happened without discomfort...and your heart is a muscle.... it contracts every day to pump blood, without causing discomfort...and your uterus can contract without unnecessary discomfort...

**Seeding idea of strength**

And NOW...when the flower has opened completely...your cervix is fully dilated.... your uterus starts to practice to push...this is the next phase of labour...your body is practising to push your baby down the birth channel...STRONGLY BUT EASILY, COMFORTABLY.... pushing your baby downwards towards being born...channelling your baby.... channelling your love...channelling your STRENGTH and RESOURCES towards your goal.... towards meeting your baby...

**Immediacy**

**Seeding strength and ability to remain comfortable during labour**

**(Suggestions for delivery)**

That's right...and you are there now... now things can change rapidly... because the aim of each contraction is to push...push really strongly... guiding your baby...through the birth channel...and now you can play a different part in your baby's birth...you and your Inner Team can work with the medical team to channel your baby into the world... the world of warmth and love... so that it can SLIDE EASILY AND COMFORTABLY INTO THE WORLD... Now...with every contraction... you can go deep inside yourself...adding your energy and strength to the strength of every contraction...and you can enjoy being such a part of your baby's journey ... as your baby glides further and further down...you can go deep inside yourself...being part of the power and strength...just as you are a part of your Inner Team...and as every contraction fades away...you can let go of the memory of that contraction ... and use the time to really relax... collecting your energy...preparing yourself for the next contraction...and you may be surprised to find that the periods between your contractions seem long and refreshing...while each contraction can pass like a flash, utilising all the energy you and your body ...and your Inner Team...have combined. When the next contraction arrives...you can again move deeper inside yourself, be part of the strength, guiding your baby in to the world...like when you push a child gently down a slide...

**Immediacy**

**Affirming mother's active participation in labour**

**Seeding possibility of ease during delivery**

**Seeding idea of mother being in control of labour**

**Suggesting amnesia**

**Time distortion**

And your baby is coming closer and closer to its birth...you can listen intently to what the medical team says, but only when they address you directly...listen with your conscious and unconscious mind...your Inner Team and medical team will assist you in the process of guiding your baby to be born...that 's right...you have SO MANY RESOURCES to experience this special occasion in your own unique way....

**Multilevel communication**

**Emphasising inner resources**

**Tailoring**

| | |
|---|---|
| NOW...your baby's head has been born...you can stop pushing so that the medical team can SOFTLY EASE the baby's head into the world...and with the next contraction...you can push with all you energy and strength.... let your baby slide into the world with excitement and joy.... and your baby's body is being born...very quickly NOW...there's your baby...there's your baby...and perhaps you'd like to reach down ...holding your baby... looking, listening, touching...using all your senses...and you can enjoy the experience of really meeting your baby for the first time...and perhaps feel your Inner Love in a more direct and pronounced way...being aware of being a mother...perhaps being aware of the meaningfulness and joy of this experience on a very deep and personal level...you know just how... and in the same way your baby is getting to know you...feeling, listening...and he /she might be aware of many sounds, but your baby is more aware of you, your voice, your touch...this is a very special moment ...and when you are experiencing this moment in your inner mind, you can just indicate by a nod of the head... | **Immediacy**<br><br>**Seeding ease of delivery**<br><br>**Seeding positive experience of birth**<br><br>**Facilitating bonding**<br><br>**Facilitating awareness of well-being**<br><br>**Tailoring**<br><br>**Utilising the senses/Hyperesthesia**<br><br>**Ideomotor response** |
| **(Suggestions for phase 3 labour)**<br><br>In a little while it will be time for the last phase of labour...time for the placenta to be delivered.... but perhaps you are so involved with your baby that you do not even notice it...but you can give a little push...and feel how the placenta is slipping out easily... | |
| **(Posthypnotic suggestions for well-being after delivery)**<br><br>If it is perhaps necessary for the nurse to take away your baby for a little while to do the necessary medical procedures, you can remain comfortable with the knowledge that soon you will hold your baby again. | **Dissociation** |

You can let the outer team...the medical team...go about their work...and inside your Inner Team is working too...preparing to heal your body...preparing your body to nurse your baby...preparing you for holding your baby again...perhaps your Inner Love is preparing you for being a mother in every way...maybe it is necessary for the doctor to insert a few sutures, and to examine your body to make sure everything is OK...without causing you discomfort...because deep inside yourself you know, both consciously and unconsciously, that your body is strong and will heal quickly and easily...you know now that your body knows what to do...your body knows how to heal...and you also have the assistance of your Inner Team...YOU HAVE INSIDE yourself ALL THE RESOURCES YOU NEED to HEAL...to recover...to be ready to ENJOY the new experience of being a mother and caring for your baby... perhaps you have even discovered NEW STRENGTHS on a very deep and personal level...

**Utilisation of conflict-free ego states**

**Multilevel communication**

**Seeding experience of self-efficacy**

You can allow yourself to sense your inner resources...knowing that you will be able to breastfeed easily and comfortably...you are ready for a new phase in you life...you have given birth to your baby...but also to a new identity...you are now truly a mother... and it feels good to hold your baby and relish the special teamwork you have been doing together. You might even wonder at how easily and naturally you have made the transition to becoming a mother...and when this experience is completed for you in your inner mind you could just indicate by a nod of the head.

**Ideomotor response**

**(Prepare to terminate trance)**

That's right.... everything is OK...and you can just enjoy your baby for a few moments...and then let go of this experience, knowing you did well in the dress-rehearsal, and then you can start coming back to the real world.

**Terminating trance as in previous sessions**

### 4.3.4 Duration

The session has a duration of approximately 35 minutes.

## 4.4 Session 4 : Facilitating bonding and development of motherhood identity

### 4.4.1 Objectives

The objectives for session 4 were:

- To facilitate bonding and attachment while the baby is in the womb;
- To facilitate the development of motherhood identity by means of ego state therapy techniques.

### 4.4.2 Expected outcomes

The client will experience a sense of having a bond with her baby, which may promote postnatal attachment. The expectant mother will experience a sense of confidence that she has the necessary competencies to fulfil her role as a mother.

### 4.4.3 Session content

**(Facilitating trance)**

| | |
|---|---|
| As you are settling yourself comfortably you might ANTICIPATE the interesting experiences you are going to explore today...by now you have experienced your hypnosis in various ways...you can wonder...about the DISCOVERIES you can still make in your JOURNEY TO MOTHERHOOD...you can again use your own unique way of becoming absorbed internally...going into trance...and when you have reached the level of trance that you are comfortable with, you could just indicate by a nod of the head. | **Permissive approach**<br>**Seeding positive expectancy**<br><br>**Metaphor**<br><br>**Tailoring**<br><br>**Ideomotor response** |

**(Facilitating possible positive experience of relationship with baby)**

Today you might find it fascinating to know that you can have an experience of meeting your baby...meeting him/her while she is still in your womb...and you know...you and your baby have come a long way on your JOURNEY...you have already experienced highlights...like feeling it kicking for the first time...perhaps finding out whether it's a boy or a girl...and now, with you baby's birth just a few weeks away...you can enjoy this time with a calm, relaxed frame of mind...reminding yourself that you have ALL THE RESOURCES INSIDE...to experience the birth in a COMFORTABLE AND SATISFYING WAY...and to ENJOY THE EVOLVING OF A NEW IDENTITY AS A MOTHER...which might be a new experience for you...

**Ego-strengthening**

**Facilitating development of motherhood identity**

**(Focusing inward on experiencing baby and own ability to love baby)**

And I wonder whether you would like to allow yourself to focus inward...first on your breathing, in...and out...and then deeper still...focusing on your womb...and your baby in your womb ...and you can choose to experience your baby in your own, unique way... maybe you can picture it...floating peacefully, relaxed, or moving around a bit.... maybe you can see your baby's features.... you might even like to touch your stomach...getting in touch with your baby...perhaps you just have a sense of being in contact with your baby in another, unique way...and while you are experiencing your baby in your own special way...you might be surprised at how HEALTHY...STRONG...AND HAPPY YOUR BABY is...WITHOUT YOU CONSCIOUSLY THINKING about it, your baby is growing stronger...waiting to meet you...

**Focusing attention to ratify trance**

**Positive hallucination**

**Tailoring**

**Seeding positive expectancy**
**Conscious / unconscious dissociation**

| | |
|---|---|
| And sometimes babies can look so loveable...and I wonder whether A PART OF YOU can realise that it might be so easy to be a LOVING MOTHER and perhaps... if you go back...you can find times where you have loved unconditionally before...a favourite pet...or a special doll...it CAN BE SO EASY TO LOVE AND NURTURE...and perhaps you would like to remind yourself of that part of yourself...Inner Love...and maybe it tells you that YOU HAVE INSIDE ALL THE LOVE YOU NEED TO MOTHER a baby...and perhaps you might find it pleasing to become absorbed in this unique, loving experience of your baby...that's right... | **Ericksonian language use: universal qualifier**<br>**Preparing for ego state work**<br><br>**Age regression**<br><br>**Ego-strengthening** |
| And perhaps you might find it interesting to DISCOVER...that you can communicate with your baby today...you have possibly done this many times before...you can send a message to your baby today...while it is peacefully floating or moving around inside your womb...and you know that your Inner Strength.... and your Inner Advisor...and your Inner Love... knows what you want to communicate to your baby today...and I don't know what it is ...that you want to share... perhaps your conscious mind does not either...but your unconscious mind... and your Inner Team knows...maybe you want to tell your baby of your love...or your excitement as you look forward to his/her birth ...you can just allow your Inner Team to guide you in sending a special message to your baby...and I'm going to remain silent for a while to allow you to experience this in your own way... and when this experience is completed for you, you could just indicate by a nod of the head. | **Permissive language**<br><br>**Conscious / unconscious dissociation**<br><br>**Tailoring** |
| **(Facilitating positive relationship with baby)** | |
| Good.... and perhaps you'll be amazed to discover that your baby also has something to communicate to you...perhaps that she is happily | **Positive hallucination** |

GROWING AND PREPARING to be born...that she is STRONG AND HEALTHY...I do not know what your baby is communicating to you...but I do know that your unconscious mind knows and can help you to understand the message...even if it comes in a non-verbal way...you can just experience this message in your own special way...and when it is completed for you, you could just indicate by a nod of the head. Good... and now you can say goodbye to your baby for the moment, knowing that he / she is preparing and anticipating for that special day in her own way...without you even having to think about it...and you can get in touch with him/her any time you wish in the weeks to come...by just drawing upon your INNER RESOURCES...

**Seeding idea that baby is strong and healthy**
**Presupposition of process**

**Tailoring**

**Posthypnotic suggestion**
**Ego-strengthening**

**(Facilitating development of identity as mother)**

And there is something else that you might find very interesting today ...something that might be meaningful to you in a very DEEP AND SPECIAL way...something you might find valuable now...after your baby's birth and for many years to come...While you continue to relax and remain comfortably in your own internal experience, perhaps you would be interested in meeting another possible part inside yourself...a part that could still be developing... a part that could perhaps be called... the evolving mother...or the budding mother...that part that enables you to fulfil the role of a mother...to nurture, to care for someone... you can just focus deeply inside yourself...and when you find that part inside yourself...you can just indicate by a nod of the head.

**Seeding sense of meaningfulness**

**Posthypnotic suggestion**

**Permissive language**

**Preparing for ego state work**

| | |
|---|---|
| Good...it could actually be fascinating to realise that this mother-part could have been developing since the moment you found out that you were pregnant...you have started to watch what you eat...looking after your health...started to build your life around your baby's birth...that's right...you have been practising hard to become a mother...both consciously...and unconsciously... perhaps your internal resources...your Inner Team...has assisted without your realising it.... and it is good to know that you have SO MUCH KNOWLEDGE AND STRENGTH INSIDE to assist you in being a mother, isn't it? | **Affirming gradual development of motherhood identity**<br><br>**Multilevel communication**<br><br>**Ego-strengthening**<br><br>**Tag question** |
| And you can just allow yourself to experience this evolving mother-part inside of you...finding comfort and confidence, knowing that it could continue to GROW AND EXPAND... TO LEARN AND TO UNDERSTAND ...and it reminds me of a special plant...developing buds...gradually and NATURALLY OPENING...and it has inside everything it needs...to become a strikingly beautiful flower.... perhaps you are even a little surprised at how NATURALLY you will be able to grow into the role of being a mother ...with JOY and WISDOM and HOPE ...and since you know that you have inside you ALL THE RESOURCES YOU NEED to give birth and become a mother, you can look forward to the birth of you baby, with calm, courage and excitement...and in the weeks to come, you might be surprised to find yourself becoming more and more aware of these inner resources...you know how to love... you know how to be a mother.... you are carrying a very special baby. You can look forward...to the times when you can look back...and realise how much you've changed and grown. | **Seeding growth**<br><br>**Metaphor**<br><br>**Ego-strengthening**<br><br>**Seeding positive expectancy**<br><br>**Posthypnotic suggestion**<br><br>**Ericksonian word usage: implied directive** |

**(Preparing to terminate trance)**

You can continue to absorb the meaningfulness and the confidence from this experience for the next few moments...let it flow really deep inside your inner mind... and when you come back to the real world in a short while, you can bring with you all these positive feelings ... all the hope and courage that you became aware of...and now...you can start to bring yourself out of your internal experience...and when you are completely aware of where you are, you can open your eyes.

**Posthypnotic suggestion**

### 4.4.4 Duration

The session lasts about 25 minutes.

## 4.5 Session 5: Facilitating postpartum well-being

### 4.5.1 Objectives

The objectives of this session are:

- To prepare the mother for the demands of the postpartum period;
- To facilitate the idea of general psychological well-being in the postpartum period.

### 4.5.2 Expected outcomes

The client will develop a positive expectancy of the postpartum period, an enhanced sense of self-efficacy, and will anticipate personal growth during early motherhood.

### 4.5.3 Session content

**(Facilitating trance)**

Perhaps you would find it STIMULATING to allow yourself to a preview of the first few weeks after your baby's birth...the not so distant future...you have been travelling on a JOURNEY...through your pregnancy... experienced many INTERESTING CHANGES... discovered many UNEXPECTED WONDERS along the way...and now...you might want to have a look at the final destination...the final discovery...the ultimate prize...your new identity as an evolving mother...and the special baby you have been nurturing within...

**Seeding positive expectancy**

**(Facilitating positive postpartum experience)**

You can ...just allow yourself to go forward...and imagine what it will be like ...to actually be a mother... perhaps you notice what an EASY BABY you have...how NATURALLY you are able to breastfeed your baby...and because you know that you have an Inner Team ...you have all the inner resources you need...you can attend to all the diverse things you need to, as a mother...you can stay calm, and confident...allowing yourself TO ENJOY YOUR BABY...you can allow your body TO REST WELL, even if you have only a few minutes to spare...you can FEEL PROUD of all the experience you have gained on your JOURNEY OF TRANSFORMATION. It might even be amazing to discover...how this experience enables you to relate to the people around you in a warm and MEANINGFUL way...it is possible that you can sense how your journey has enabled you to GROW...to experience an enhanced sense of WELL-BEING...I'm not sure how and when you get this sense of

**(Adapted from Torem, 1992)**
**Age progression**

**Posthypnotic suggestion**

**Ego-strengthening**

**Posthypnotic suggestion**
**Ego-strengthening**

**Seeding sense of psychological well-being**

| | |
|---|---|
| meaningfulness and growth...but your unconscious mind will...Perhaps you would like to get in touch with your Inner Strength, or your Inner Advisor again...ask them all you need to at this time...about being a mother... developing a new identity... MATURING and growing into a CONFIDENT, LOVING and FULFILLED woman...and if you do ask their advice...listen carefully... absorbing it...and when this experience is completed for you, you could just indicate by a nod of the head. | **Conscious / unconscious dissociation**<br><br>**Ego-strengthening through utilisation of ego states**<br><br>**Ideomotor response** |
| And allowing yourself to look into the future makes you feel COMFORTABLE AND OPTIMISTIC about your capabilities in fulfilling the role of a mother. You might even be surprised to realise that you have GAINED A NEW DIMENSION of being...which amplifies all your other dimensions... a wife...an individual...a total woman...almost like discovering the many different facets of a brilliant diamond...all of which contribute to the uniqueness of the diamond...and maybe you know that diamonds are all unique...all different and special... developing over millions of years... such a special gem...and only through lots of effort and hard work does its true beauty become visible...and perhaps you can later bring with you...your own gem...that you can discover deep inside yourself... | **Seeding positive expectancy**<br><br>**Seeding idea of growth**<br><br>**Metaphor** |
| And I wonder whether you are aware of a sense of HEALTH and STRENGTH inside...aware of your INNER RESOURCEFULNESS...your ability to experience this transformation in a positive way... and you can choose to store all these positive experiences and feelings...the knowledge of your INNER HEALTH and WELL-BEING...now and later...it can truly become a part of yourself... And when you come back to the present, you can bring with you a special gift...you can bring with you all | **Ego-strengthening**<br><br>**Time distortion** |

the positive images, sensations and feelings...back from the future...to help guide you on your journey now and later...perhaps you can bring with you all the gems that have been waiting to be discovered...and you can also realise...that just as your Inner Team has been working together through your pregnancy and delivery...they are part of you ...part of a whole...part of your INNER WELL-BEING...they will always be there to guide you through your journey of life....

**Metaphor**

**Ego-strengthening**

**(Preparing to terminate trance)**

Now you can just comfortably and effortlessly bring yourself back to the present and when you are completely aware of where you are, you can just open your eyes.

### 4.5.4 Duration

The session lasts about 20 minutes.

## 4.6 Session 6: Addressing individual needs

### 4.6.1 Objectives

The following are the objectives for session 6:

- To meet individual needs that could possibly arise during the course of the programme;
- To reinforce aspects of the programme as requested by the client.

### 4.6.2 Expected outcomes

Specific needs of clients will be met to allow for tailoring of suggestions.

### 4.6.3 Session content

Session content was developed according to the needs mentioned by the client. Most often it was found that clients requested a repetition of sessions 3 and 5. If a caesarean section was going to be done, the following suggestions were used (in the place of session 3 if it was a planned caesarean, otherwise as a last session if it only became apparent towards the end of the pregnancy).

| | |
|---|---|
| You have recently LEARNED that you are going to have your baby by means of a caesarean section...perhaps it came as a surprise...but then there are often surprises when one undertakes an interesting journey. Perhaps you would like to remind yourself of the purpose of your journey... the ultimate destination...is having your baby...holding it...loving it...and even if you reach your destination via an unexpected route, you are still travelling there... DISCOVERING WONDERFUL THINGS...and you know you have INSIDE all the RESOURCES you need to travel this last part of your journey. | **Seeding: possibility to gain something from this experience**<br><br>**Metaphor**<br><br>**Ego-strengthening** |
| **(Preparing for age progression)** NOW, you can again allow yourself to focus deeply inside...allowing yourself to become aware of your Inner Team... your INNER RESOURCES...and perhaps it might be useful to do another dress rehearsal today...practising for the day of your baby's birth...and perhaps you know by now exactly when your baby is going to be born...it could give you such a sense of inner calm to know that you are PREPARING exactly for this specific day...getting everything ready...you can go forward to that day...just imagining it in your own way. Perhaps you are going to the time where you are just waking up in hospital on your special day...allowing yourself to sense the anticipation...and | **Focusing attention**<br><br>**Age progression** |

excitement...sensing your INNER RESOURCES and you can choose... to focus only on your inner experience, letting the medical team tend to the necessary medical procedures...while you and your Inner Team are awaiting your baby's birth...and you can remain CALM...COMFORTABLE...knowing that you will soon be holding your baby.

**Ego-strengthening**
**Seeding idea of choice**

**Dissociation**

And when you are being wheeled to the theatre you may be aware of your partner being there with you...and it gives you such courage and CONFIDENCE...knowing that you are going to share a SPECIAL EXPERIENCE. While the wheels of the trolley are moving, you know that you are swiftly moving on your JOURNEY to that special moment...all the time only focusing on your baby... and your Inner Team...your INNER RESOURCES...

**Ego-strengthening**

**Metaphor**

Perhaps you are in the operating theatre by now...you might be aware of lights and sounds...medical staff...and you can choose to be assured about the fact that there are so many competent people around you...to share the birth of your baby...and the more you are aware of the lights...the sounds...the monitors...the more you can RELAX ...allowing the medical team to continue their work, while you and your Inner Team are ANTICIPATING ...PREPARING inside...for that special moment that is almost here. That's right...you can experience all the medical procedures in a CALM, RELAXED frame of mind, because you want to have your baby in a COMFORTABLE and SATISFYING way...all the time focusing on your special gift...

**Ego-strengthening**

**Dissociation**

And while the doctor performs the procedure, you might be surprised at how swiftly he works...how quickly time seems to pass...and he is telling you that your baby is almost ready to be born...there it is...there's your baby

***Time distortion***

...and you can look at its precious little body...there's your baby...STRONG and HEALTHY...perhaps you can hold him/her for a few moments...just sensing his/her presence...and RELAX...knowing that all is well...and you know it will be necessary for the medical staff to take away your baby for a while to be examined...you can remain CALM...and CONFIDENT... knowing that your partner is there with the baby...soon you will all be together...you can RELAX while your doctor completes the medical procedures...and you can use this time to PREPARE for meeting your baby again...being aware of your INNER RESOURCES...being aware that you are HEALTHY...that your body will HEAL QUICKLY...that you will be able to experience the JOY and the WONDER of being a mother in many unsuspected ways in the days to come...

**Seeding positive expectancy of baby**

**Ego-strengthening**

**Posthypnotic suggestion**

**Seeding**

And because you know that you will be able to experience the caesarean in a COMFORTABLE and SATISFYING way, you can ENJOY the last few days before the birth in a CALM and RELAXED frame of mind...

**Posthypnotic suggestion**

**(Preparing to terminate trance)**
You can now start to bring yourself back to the present and you might choose to bring with you all the positive feelings that you have just had.

### 4.6.4 Duration

This session lasts about 20 minutes.

## 5. SUMMARY

This chapter focused on the actual programme that was utilised with clients in the experimental group. Each session was described in terms of objective, expected outcomes, session content and duration.

# CHAPTER 5

# EMPIRICAL STUDY

## 1. INTRODUCTION

This chapter describes the empirical study, with reference to a pilot and main study. As part of the main study quantitative and qualitative data were gathered and analysed. The design, participants, measuring instruments, procedure and analysis of data are described in this chapter.

## 2. PILOT STUDY

Before embarking on the actual research, a preliminary study was done with seven women who volunteered. The preliminary study was done to address problems that could arise during application of the programme or the administration of the measuring instruments. All of the measuring instruments used in the final study were used, with the exception of the Maternal Self-efficacy Scale (Teti & Gelfand, 1991), which was included later. Time was spent to ensure that the instructions and contents of the questionnaires were clear. After completion of the preliminary study, the content of the programme was slightly adapted, and the procedure changed from a group format to an individual programme. Since the uniqueness of each person is an important principle in the Ericksonian approach (cf. Frederick & McNeal, 1999), an individual programme provided the opportunity to address individual issues. In the developed programme the last session was utilised to address such issues, if necessary.

## 3. MAIN STUDY

The main study consisted of a quantitative as well as a qualitative component.

## 3.1 Quantitative study

### 3.1.1 Design

A pretest-posttest-follow-up control group design was implemented. Random selection within the limits of equal sample size was utilised.

### 3.1.2 Participants

**Women in their first pregnancy** were recruited by means of introducing the study at childbirth preparation classes in three geographical locations (in two large towns in Mpumalanga, as well as in Pretoria, Gauteng). Volunteers were requested to complete the prenatal evaluation questionnaire.

Participants were selected according to the following criteria:

- They had to be between 20 and 40 years old;
- They had to be involved in a stable relationship (married or cohabiting);
- It had to be a first, medically uncomplicated pregnancy;
- The pregnancy had to be no less than 24 weeks and no more than 38 weeks in duration;
- Participants in the experimental group had to obtain a minimum score of at least 2 on the Stanford Clinical Hypnotizability Scale. All participants met this criterion.

Eligible participants were as far as possible randomly assigned to either the experimental or the control group. The researcher telephonically contacted each participant to inform her regarding which group she was assigned to. Participants in the control group were given the opportunity to contact the researcher for hypnotherapy after the last of the questionnaires had been completed.

The experimental group finally consisted of 23 women, of which 21 were randomly assigned to the experimental group. Two women specifically requested to be included in the experimental group, since they were quite anxious about their coming labour. The control group also consisted of 23 women, of which 15 were randomly assigned to the control group. The remaining 8 women in the control group consisted of participants who had indicated beforehand that, due to practical considerations such as time constraints and geographical locations they would only be able to

participate as part of the control group. During the course of the study, some women in the control group failed to return the questionnaires, which resulted in 22 women participating in the control group during the first postnatal evaluation, and 18 women during the follow-up postnatal evaluation.

The **researcher** is a psychologist with 13 years' experience in private practice and in applying hypnotherapy. I have trained with the South African Society for Clinical Hypnosis and completed Phase III (advanced) training. I have attended workshops both locally and internationally, including workshops presented by John and Helen Watkins and Michael Yapko.

### 3.1.3 Measuring instruments

3.1.3.1 Measurement of hypnotic responsiveness

3.1.3.1.1 The Stanford Hypnotic Clinical Scale: Adult (SHCS: Adult) (Morgan & Hilgard, 1978)

*(i) Rationale*

The Stanford Hypnotic Clinical Scale (SHCS) was developed to measure hypnotic responsiveness in clients and to assist in the selection of particular procedures that may be used in therapy (Hilgard & Hilgard, 1994).

*(ii) Nature and administration*

The SHCS consists of five items:

1. **Moving hands** (an easy motor item to introduce the client to respond to suggestions).
2. A dream within hypnosis (often useful to interpret the client's attitude towards hypnosis).
3. Age regression (commonly useful in therapy).
4. A posthypnotic suggestion (possibly related to a capacity for continuation of the hypnotic experience).
5. Posthypnotic amnesia (useful in relation to the experience of pain).

The SHCS consists of a standard protocol that is administered individually by the hypnotherapist. It requires approximately 20 minutes.

*(iii) Scoring and interpretation*

The SHCS is scored in terms of how many of the tasks the client were able to perform. Items are scored on a scoring booklet. A maximum score of 5 can be obtained. A person who passes four or five of the items can be placed in the upper third of responsiveness, one who passes two or three is in the middle third, and one who passes one or none, in the lowest third (Hilgard & Hilgard, 1994). In the current study a score of at least 2 (middle third) is required.

*(iv) Reliability and validity*

The SHCS was derived from the longer Stanford Hypnotic Susceptibility Scales, forms A, B, and C, which were developed for research purposes. These scales were very lengthy, which made them less practical for clinical use. A reliability estimate of 0.72 for the SHCS was obtained from the productmoment correlation between the total score on this scale and the total score on SHSS: C (Hilgard & Hilgard, 1994). The authors state that the SHCS appears to be a reliable estimate of hypnotic responsiveness.

*(v) Motivation for use*

Hypnosis can be seen as a matter of degree (Watkins, 1987), and it is generally accepted that people differ considerably in their responses to hypnosis (Kirsch & Council, 1992). Holroyd (1992) states that in any research employing hypnosis, it is important to measure hypnotisability, while Barabasz (1999, personal communication) states that little can be said about the specificity of hypnosis in treatment, unless a relationship between hypnotisability and outcome can be demonstrated. Recently Lynn and Shindler (2002) again confirmed the importance of hypnotisability assessment in treatment. In the current study, a measure of hypnotic responsiveness was included to establish the women in the research group's hypnotic responsiveness.

### 3.1.3.2 Measurement of aspects of psychological well-being related to pregnancy, labour and early motherhood

#### 3.1.3.2.1 Perception of labour and delivery scale (PLD)

*(i) Rationale*

This scale was compiled especially for this study and was adapted from the existing Childbirth Perceptions Questionnaire developed by Padawer et al., 1988. The original questionnaire was developed to compare possible differences in psychological adjustment and satisfaction between women delivering vaginally and those delivering by emergency caesarean section. In the current study, only certain items dealing specifically with perception of delivery were selected. An extra item was added, dealing with the mother's perception of her coping with labour and delivery. The purpose of this scale is to determine the mothers' perception of labour and delivery. It can be seen as a subjective account of the perception and experience of labour.

*(ii) Nature and administration*

The PLD consists of 4 items, scaled on a 4-point Likert-type scale. The mother has to indicate how much she agrees with each item, ranging form "Strongly disagree" to "Strongly agree". Items were formulated differently during the prenatal testing and postnatal testing, for example: "I expect to feel satisfied with the way I delivered" (prenatal questionnaire) and "I am satisfied with the way I delivered" (postnatal questionnaire).

*(iii) Scoring and interpretation*

A total score is calculated by adding the response scoring to each item, with possible scores ranging from 4 to 16. Higher scores indicate a more positive perception of labour and delivery.

*(iv) Reliability and validity*

In the study of Padawer et al. (1988), a Cronbach alpha coefficient of 0.82 was found for the subscale measuring satisfaction with childbirth. The authors did not provide data regarding validity of the instrument. In the current study, the Cronbach alpha coefficient was found to be 0.83. A panel of psychologists supported content validity of the current scale.

*(v) Motivation for use*

A review of the literature shows conflicting results regarding the effect of the actual experience of labour and delivery on later psychological well-being. Ball (1987) found no relationship between type of delivery and emotional well-being. According to the study by Padawer et al. (1988) there were no differences between women delivering vaginally and those who had emergency caesarean sections on three levels of psychological adjustment.

However, Affonso and Arizmendi (1986) as well as Thune-Larsen and Moller-Pedersen (1988) found that the actual birth experience could influence postpartum adaptation. McCarthy (1998) states that some of the women he has treated exhibited symptoms of Posttraumatic Stress Disorder (PTSD) after a traumatic birth experience. Maclean, McDermott and May (2000), found that women who gave birth assisted by instrumental delivery reported the childbirth event to have been distinctly more distressing than women delivering vaginally or by emergency caesarean section. Earlier Tulman and Fawcett (1991) found that the nature of the delivery experience could become a major hindrance in postpartum emotional recovery. This scale was therefore included to determine the women's perception of the birth experience and to establish whether the hypnotherapeutic programme could influence the experience. A positive experience of labour could also possibly be related to a stronger sense of psychological well-being.

3.1.3.2.2 Feelings about baby and relationship with baby (FRB)

*(i) Rationale*

This scale was compiled for the purpose of the current study and was adapted from the research done by Woollett and Parr (1997). The authors identified certain tasks for women in the postpartum period, one being getting to know the baby and becoming attracted to the baby. Drawing on the work of Oakley, Rajan and Grant (1990), they devised a series of questions that gives a subjective indication of the mother's feelings towards her baby and relationship with her baby. Four of these questions were used in the current study.

*(ii) Nature and administration*

The scale consists of 4 items. The respondent has to choose between three possible alternatives, e.g.

"How do you experience having your baby around?"

Easier than expected / as expected / harder than expected

The scale is very brief and can be administered in less than 5 minutes. In the current study, the scale was administered during pregnancy and in the postpartum period, with items formulated accordingly.

*(iii) Scoring and interpretation*

Woollett and Parr (1997) used descriptive statistical methods regarding the overall pattern of responses. They described responses to each item in terms of percentages. In the current study, the responses were scored on a scale from one to three, with higher scores indicating positive feelings about the baby and the relationship with the baby.

*(iv) Reliability and validity*

Woollett and Parr (1997) gave no indication of the scale's reliability and validity. In the current study, face validity has been established. A Cronbach alpha coefficient of 0.75 has been determined in the current study.

*(v) Motivation for use*

Getting to know the baby and developing a bond with the baby is seen as a major psychological task during the postpartum period (Affonso, 1987; Woollett & Parr, 1997). The FRB scale gives an indication of the mother's subjective experience of her baby and her relationship with her baby. The scale was included because theoretically one could expect that a positive subjective experience of the baby could be related to a stronger sense of psychological well-being.

3.1.3.2.3 Maternal Self-Confidence Scale (MSC)

*(i) Rationale*

The Maternal Self-confidence Scale was adapted from a subscale of the Childbirth Attitudes Questionnaire (Ruble et al., 1990). This 19-item questionnaire was developed to conceptualise and measure changes in attitude during the transition to motherhood. In the current study, only the scale dealing with maternal self-confidence was selected. An extra item was added to the scale taken from the work of Terry (1991), and indicates the mother's perception of her coping with early motherhood.

*(ii) Nature and administration*

The MSC consists of 5 statements, and the mother has to indicate to what extent she agrees with each statement, ranging on a scale from 1 to 7 (Strongly disagree to Strongly agree). The last item was originally part of a subscale indicating subjective view of coping effectiveness, devised by Terry (1991). The scale is easy to administer and takes less than 5 minutes to complete.

*(iii) Scoring and interpretation*

A total score is calculated by adding response scores of individual items. Higher scores indicate a stronger sense of maternal self-confidence.

*(iv) Reliability and validity*

Ruble et al. (1990) report alpha coefficients for the Maternal Self-confidence subscale to be 0.74 during the pregnant phase and 0.72 during the postpartum phase. They also state that the original scales show good short-term stability. The last item, taken from Terry (1991), was part of a subscale where an alpha coefficient of 0.75 was reported. The authors did not mention data regarding the validity of the subscale. In the current study, content validity is accepted. A Cronbach alpha value of 0.89 was found in the current study.

*(v) Motivation for use*

The MSC scale was included to obtain a subjective measure of self-confidence in the maternal role. Theoretically one could expect that a higher level of self-confidence could be related to a stronger sense of psychological well-being.

3.1.3.2.4 Maternal Self-Efficacy Scale (MSE) (Teti & Gelfand, 1991)

*(i) Rationale*

The MSE was developed by Teti and Gelfand (1991) for a specific study aimed at determining the effects of self-efficacy beliefs on parenting behaviour. The measure is domain-specific and focuses on the experience of self-efficacy regarding specific parenting behaviours. In the current study, only 4 of the 10 subscales were included, as they were the most relevant to the baby's age.

*(ii) Nature and administration*

The MSE consists of ten 4-point maternal self-efficacy items. In the current research, eight items were selected to assess the mothers' feelings of efficacy in relation to the following four domains of infant care:

- ability to soothe the baby;
- understanding what the baby wants;
- performing daily routine tasks;
- global feeling of efficacy in mothering.

*(iii) Scoring and interpretation*

Item scores were summed to yield a maternal self-efficacy score. Possible scores ranged from 8 to 32, with higher scores indicating a higher level of maternal self-efficacy.

*(iv) Reliability and validity*

According to Teti and Gelfand (1991), a Cronbach alpha of 0.79 was calculated in a pilot study and 0.86 in the formal study. They reported that maternal self-efficacy scores were strongly related to the reverse scored PSI Sense of Competence Scale (Abidin, 1986), with $r = -0.75$, $p < 0.001$. This confirms the concurrent validity of the MSE. In the current study, face validity was accepted. The Cronbach alpha coefficient in the current study was 0.49.

*(v) Motivation for use*

Perceived self-efficacy beliefs concern judgements of one's ability to perform competently and effectively in a particular task or setting (Teti & Gelfand, 1991). The MSE specifically addresses self-efficacy beliefs regarding parenting behaviours, and theoretically one could expect that higher measures of maternal self-efficacy might be related to higher levels of psychological well-being. The study of Teti and Gelfand (1991) confirmed a negative relation between maternal depression and maternal self-efficacy, which also indicates a possible relationship between maternal self-efficacy and maternal psychological well-being.

3.1.3.3 Measuring instruments related to possible pathology

3.1.3.3.1 The Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987)

*(i) Rationale*

The EPDS was developed by Cox et al. (1987) as a means to screen for postnatal depression. It was designed to counter the limitations of other scales that detect clinical depression when used on childbearing women. The scale focuses on the

cognitive and affective features of depression, rather than on somatic symptoms. It is not a diagnostic tool, but rather a screening measure to identify women who need further evaluation. The EPDS has been used extensively in research on depression in postnatal women, such as in studies by Green (1998), Lussier, David, Saucier and Borgeat (1996), Murray, Cox, Chapman and Jones (1995) and Okano, Nagata, Hasegawa, Nomura and Kumar (1998). Recently, Evans et al. (2001) also used the EPDS to investigate the prevalence of depression during pregnancy.

*(ii) Nature and administration*

The EPDS consists of ten statements about feelings in the past week. Women are asked to underline one of four possible responses, which are scored from 0 to 3. The EPDS is very easy to complete and this can be done in less than five minutes.

*(iii) Scoring and interpretation*

A total score is calculated, with possible scores from 0 to 30. Higher scores indicate more negative feelings. A study by Elliot et al. (2000) reports a mean score of 5.9 in women as measured at three months postpartum. Women who score above a total score of 12 are seen as possibly suffering from postnatal depression, and requiring clinical intervention. In some studies, a cut-off point of 9-10 was selected to increase sensitivity of the measure (e.g. Zelkowitz & Milet, 1996). The following seven items are reversely scored: 3, 5, 6, 8, 9, 10.

*(iv) Reliability and validity*

The psychometric properties of the EPDS was originally established by Cox et al. (1987), on 84 mothers considered by health visitors to be clinically depressed. A threshold of 13 identified all 21 with major depression, and 6 out of 14 with probable major depression. There were 11 false positives. The sensitivity for detecting minor depression was established at 0.77 and 1.0 for major depression, and the specificity 0.8 and 0.76 respectively.

In a later study Harris, Huckle, Thomas, Johns and Fung (1989) found the sensitivity of the EPDS to be 95% and its specificity 93%. Murray and Carothers (1990) carried out a further validation. In their research in a community sample they found the EPDS to have a sensitivity of 95.7% above the threshold of 12.5, and its sensitivity to

be 81%. Although the EPDS was initially aimed at detecting postpartum depression, it has been validated for use during pregnancy (Murray & Cox, 1990). In a recent study, Green (1998) concluded that the EPDS has face validity as a continuous measure of emotional well-being both during pregnancy and the postpartum period. It can be accepted that the EPDS has satisfactory psychometric properties. In the current study, reliability of the EPDS was determined by means of a Cronbach alpha coefficient ($\alpha = 0.83$).

*(v) Motivation for use*

The phenomenon of postnatal depression has received much attention over the past three decades. In the current study of postnatal well-being, it is important to screen for the presence of postnatal depression since it could indicate a lower level of psychological well-being. Indices of pathology are expected to correlate negatively with indices of well-being, and could thus indirectly validate findings from these measures. Similarly, Green (1993) previously used the EPDS in exploring emotional well-being in postpartum women, arguing that lower scores on the EPDS could be indicative of higher levels of well-being.

3.1.3.3.2 The General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979)

*(i) Rationale*

The General Health Questionnaire (GHQ) focuses on symptomatology in the "hinterland" of physical and mental illness. It indicates the individual's ability to carry out normal, healthy functions, and identifies the appearance of new phenomena of a distressing nature (Goldberg & Hillier, 1979).

*(ii) Nature and administration*

The original questionnaire consisted of 140 items and was later shortened to 28 items by means of factor analysis. The GHQ-28 consists of four subscales, each having seven items. These subscales are:

- A: Somatic symptoms
- B: Anxiety and insomnia

- C: Social Dysfunction
- D: Severe depression

The questionnaire can be administered either individually or in a group. The individual is requested to respond to items on a four-point scale. The possible responses differ for the various items. The GHQ takes about 10-15 minutes to complete.

*(iii) Scoring and interpretation*

All responses are scored in the same direction, with possible scores of zero (0), zero (0), one (1) and one (1). According to Goldberg and Hillier (1979), this method gives better results than the Likert method.

The scores on items for subscales are added. The scores of the four subscales are then added to reach a total score out of 28. A low score (0 to 4) is an indication of more positive mental health, while higher scores (5 to 28) increasingly suggests the presence of psychopathology.

*(iv) Reliability and validity*

The concurrent validity of the GHQ-28 was determined by correlating the scores of the four subscales with the Clinical Interview Schedule, which is a psychiatric evaluation. The correlations found were: 0.32 for Scale A (Somatic symptoms); 0.70 for scale B (Anxiety and insomnia); 0.56 for scale C (Social dysfunction), 0.56 for Scale D (Severe depression) and 0.76 for the total score.

According to Goldberg and Hillier (1979), the low correlation for Scale A was due to differences in the operational definition of the somatic complaints. However, the correlation between the subscale scores and the total score (Scale A = 0.79, Scale B = 0.90, Scale C = 0.75 and Scale D = 0.69) indicates a reasonable level of internal consistency. In a later study, Goldberg, Gater, Sartorius, Ustun, Piccinelli, Gureje, et al. (1997) reported high validity coefficients for the GHQ-28, and also reported that the instrument is as sufficient in developing countries as in the developed world.

Ayers (1999, cited by Ayers, 2001) investigated the psychometric properties of the GHQ as applied to obstetric populations. He found an internal consistency of 0.91

and a test-retest reliability of 0.61 over 4.5 months with postpartum women. Ayers (2001) concluded that the GHQ might be useful to ascertain cases of clinical depression in pregnant and postpartum women.

More recently, Lee et al. (2001) evaluated the utility of the GHQ in screening for depression among Chinese women who had recently delivered a baby. They found ROC curves comparable to that of the EPDS, and concluded that the GHQ may be useful for detecting postnatal depression.

In a South African study, Wissing and Fourie (2000) report the following Cronbach alpha indices: Scale A = 0.65, Scale B = 0.71, Scale C= 0.56 and Scale D = 0.65. In the current study, a Cronbach alpha coefficient of 0.63 was obtained for the total scale.

*(v) Motivation for use*

Low scores on the GHQ-28 are expected to correlate with higher scores on psychological well-being. With the use of the GHQ-28 (that measures pathology), the spectrum of evaluation of mental health is broadened, and findings regarding the absence of symptoms of pathology could increase knowledge regarding the presence of psychological well-being.

3.1.3.4 Measuring instruments related to general psychological well-being

3.1.3.4.1 The Satisfaction with Life Scale (SWL) (Diener, Emmons, Larson & Griffen, 1985)

*(i) Rationale*

The Satisfaction with Life Scale was developed to assess the respondent's satisfaction with her life as a whole (Pavot & Diener, 1993). It does not measure constructs such as positive affect, but is rather aimed at measuring life satisfaction as a cognitive judgement of an individual's life. This judgement occurs according to the individual's own criteria (Diener et al., 1985). According to Diener (2000), the SWLS provides one approach of assessing subjective well-being.

*(ii) Nature and administration*

The SWLS consists of five items. The items are responded to on a scale of 1 to 7, where 1 represents "strongly disagree" and 7 represents "strongly agree". Since it consists of 5 items only, the scale can be administered in two to five minutes.

*(iii) Scoring and interpretation*

The SWLS is scored by awarding a score from 1 to 7, in accordance with the given response. Possible scores vary from 5 (low satisfaction) to 35 (high satisfaction). Wissing and Van Eeden (1997) reported a mean score of 23.45 in a large South African sample.

*(iv) Reliability and validity*

According to Van Eeden (1996), the SWL exhibits favourable psychometric properties, including high internal consistency and high temporal reliability. Diener et al. report a two-month test-retest correlation coefficient of 0.82 and an alpha-coefficient of 0.87. The test was later revised by Pavot and Diener (1993), where test-retest reliability coefficients of 0.50 to 0.84 were found and alpha coefficients of 0.79 to 0.89. In a South African sample, a Cronbach alpha index of 0.71 was reported by Wissing and Fourie (2000), and an index of 0.79 by Wissing and Van Eeden (1997). In the current study, a Cronbach alpha index of 0.87 was determined.

Both Diener et al. (1985) and Pavot and Diener (1993) state that the SWLS has satisfactory construct validity.

*(v) Motivation for use*

Van Eeden (1996) found that the SWLS is one of the best indices of general psychological well-being. Diener (2000) describes satisfaction of life as a separate component of subjective well-being, which in turn can be described as people's evaluation of their lives. The scale was included in the current study to get an indication of this cognitive evaluation of the women's satisfaction with their current life situation. Theoretically these women are going through a life transition which brings opportunity for growth and possibly a change in their experience of psychological well-being and life satisfaction.

3.1.3.4.2 Affectometer 2 (AFM) (Short form) (Kammann & Flett, 1983)

*(i) Rationale*

This scale, developed by Kammann and Flett (1983), aims at the establishment of a general level of well-being, based on the measurement of the balance between positive and negative feelings that the individual has recently experienced. The individual is asked to indicate her feelings "over the past few weeks", which, according to these authors, reflects a compromise between measuring well-being in a global sense and the choice of a specific time period which enables the individual to reasonably accurately recall her feelings.

*(ii) Nature and administration*

The AFM 2 was adapted from the longer AFM. It consists of 20 sentence items. The individual is requested to indicate how often a feeling was present on a graded response scale. The possible responses are:
Not at all (1); occasionally (2); some of the time (3); often (4); all the time (5).
The scale takes only about five minutes to complete.

*(iii) Scoring and interpretation*

The AFM consists of ten items measuring positive affect (PA) and ten items measuring negative affect (NA). The overall level of well-being is conceptualised as the extent to which good feelings predominate over bad feelings, as reflected in the balance formula for calculating the total score: PNB = PA - NA.

The total score is obtained by subtracting the subtotal for negative affect (NA) from the subtotal for positive affect (PA) to get an indication of the affect balance. A high total score indicates positive affective well-being while a low score indicates a negative affective experience. In South African studies, mean scores for a Setswana-speaking sample of 738 respondents were reported to be PA = 36.04, NA = 27.42 and PNB = 8.62 (Wissing et al., 1999). Fourie (1999) reported mean scores of 37.59 for PA, 20.76 for NA and 11.09 for PNB in a group of 384 adults.

*(iv) Reliability and validity*

According to Kammann and Flett (1983), the AFM2 gave an alpha coefficient of 0.95 in a random sample of 110 adults. There is also a high correlation coefficient between the two subscales (0.87), and a significant curvilinear relationship was found between the total score of the AFM and scores on the Beck Depression Inventory (eta = -0.84). In research done on a South African sample, Wissing and Van Eeden (1997) report Cronbach alpha indices for PA, NA and PNB of 0.86, 0.90 and 0.92 respectively. In the current study, a Cronbach alpha index of 0.81 for PA and 0.83 for NA was determined. It can thus be said that the AFM possesses satisfactory psychometric properties.

*(v) Motivation for use*

The AFM was included to measure the affective dimension of psychological well-being. During this life transition, pregnant mothers' affective experiences are often very prominent, and it would be valuable to establish whether the affect balance are influenced by a therapeutic intervention such as the current programme. Van Eeden (1996) found that the AFM is a good indicator of a general psychological well-being factor.

3.1.3.4.3 Sense of Coherence Scale (SOC) (Antonovsky, 1987)

*(i) Rationale*

The sense of coherence-construct refers to:
"...a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) the stimuli from one's internal and external environments in the course of living are structured, predictable and explicable [comprehensibility]; (b) the resources are available to meet the demands of these stimuli [manageability]; and (c) these demands are challenges, worthy of investment and engagement [meaningfulness]." (Antonovsky, 1987, p. 19). (parentheses added). The SOC scale aims to measure the construct of the sense of coherence.

*(ii) Nature and administration*

The SOC consists of 29 items which are divided into three components, namely comprehensibility, manageability and meaningfulness. The items are to be answered on a seven-point Likert-scale with two anchoring phrases. The questionnaire takes about 10 to 15 minutes to complete.

*(iii) Scoring and interpretation*

The following thirteen items are reversely scored: 1, 4, 5, 6, 7, 11, 13, 14, 16, 20, 23, 25, 27.

Item scores are then added to reach a total score. Possible scores range from 29 to 203. Higher scores indicate a stronger sense of coherence. Mean scores of 117-152 have been reported by Antonovsky (1987, 1993). In a review of South African data, Strümpfer and Wissing (1998) reported a mean score of 137 from 27 different studies.

*(iv) Reliability and validity*

According to Antonovsky (1993), a Cronbach alpha coefficient for internal consistency was calculated in 26 studies, and was found to range from 0.78 to 0.93. Test-retest reliability in eight studies indicate correlations of 0.56 to 0.97. In a review of South African data, Strümpfer and Wissing (1998) report a mean value of 0.87 in various studies for coefficient alpha. In the current study, a Cronbach alpha coefficient of 0.91 was determined.

In another study Frenz, Carey, and Jorgensen (1993) also found the SOC to be internally consistent and stable at brief intervals. Antonovsky (1993) describes the content, operational and criterion validity of the SOC as favourable. Strümpfer and Wissing (1998) reviewed several South African studies where scores on the SOC were correlated with criterion measures. They concluded that the validity of the SOC is supported.

*(v) Motivation for use*

Antonovsky (1979, 1987) argued that individuals differ in their sense of coherence, and that this personal variable is intimately related to adaptive functioning in stressful situations. The transition period of pregnancy and motherhood can be seen as a possible stressful situation. It is therefore relevant in the current study to assess the pregnant women's sense of coherence both during pregnancy and early motherhood, and to assess the possible effect of the therapeutic intervention on their sense of coherence. Wissing and Van Eeden (1997) further argue that the sense of coherence construct, as measured by the SOC, gives a good indication of general psychological well-being.

3.1.3.4.4 The Generalized Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995)

*(i) Rationale*

The Generalized Self-Efficacy Scale (GSE), a 10-item scale, was developed by Schwarzer and Jerusalem (1995). The scale was developed to assess a general sense of perceived self-efficacy, with the aim to predict coping with daily hassles as well as adaptation after experiencing stressful life events

Self-efficacy refers to global confidence in one's coping ability across a wide range of situations, and reflects an optimistic self-belief. According to Schwarzer (1993), self-efficacy reflects the belief of being able to control challenging demands by taking adaptive action. The Generalized Self-Efficacy Scale aims at measuring this general sense of competency, rather than competency in specific domains of functioning.

*(ii) Nature and administration*

The Generalized Self-Efficacy Scale consists of 10 items. It is answered on a 4 point Likert-type scale, where the individual has to indicate to what extent she agrees with these 10 items. Possible responses are:
Not at all true (1); Barely true (2); Moderately true (3) and Exactly true (4).

The scale is short and easy to complete, and takes about 5 minutes to complete.

*(iii) Scoring and interpretation*

Possible raw scores range from 10 to 40, which can be converted to a standardised score ranging from 12 to 71, with a mean score of 29. A higher score indicates a higher sense of self-efficacy. In this study raw scores are used.

*(iv) Reliability and validity*

According to Schwarzer (1993), the Self-Efficacy Scale has been used in numerous research projects where it yielded internal consistencies between alpha = 0.75 and 0.90. In more recent studies, the reliability of the scale was confirmed as seen in the findings of alpha values ranging from 0.74 to 0.92. In the current study, a Cronbach alpha value of 0.91 has been found.

Schwarzer (1993) states that the scale is valid in terms of convergent and discriminant validity. It correlates positively with self-esteem and optimism, and negatively with anxiety, depression and physical symptoms.

It can be concluded that the Generalised Self-Efficacy Scale has favourable psychometric properties.

*(v) Motivation for use*

The birth of a first baby can be seen as an event that brings about a major life change (Ball, 1987), which may provoke some degree of stress. The way in which individuals react to such changes has been referred to as a coping process (Lazarus, 1969). This scale was included to get an indication of self-efficacy expectations in coping abilities before and after the therapeutic intervention.

### 3.1.4 Procedure

#### 3.1.4.1 Obtaining participants

Participants were obtained by means of introducing the study at childbirth education classes (see paragraph 3.1.2 in this chapter). All participants signed an informed consent form. Ethical implications such as anonymous use of data were explained and adhered to. Participants were randomly placed in the experimental and control

groups within limits of practicalities, as indicated in paragraph 3.1.2 above. The lack of a complete randomization of participants is a shortcoming of this research, which should be taken into account in the interpretation of findings.

#### 3.1.4.2 Prenatal evaluation

All participants in the experimental and control groups completed the first set of measuring instruments (referred to as the prenatal evaluation) before the programme was implemented.

#### 3.1.4.3 Programme

Participants in the experimental group were contacted telephonically to arrange a suitable time for implementing the programme. All sessions were individual sessions. During the first session, time was spent to gather relevant personal information and to build rapport necessary for further therapeutic work. The Stanford Hypnotic Clinical Scale (SHCS) was also administered during this session. All participants met the minimum score of 2 on the SCHS. After the first contact, 6 further sessions were scheduled with each client. The programme content, as described in Chapter 4, was delivered during these sessions.

The control group did not receive any intervention other than attending childbirth education classes.

#### 3.1.4.4 Postnatal evaluation

After completion of the programme, participants in the experimental group were followed up telephonically, close to the time of their expected date of delivery. They were also requested to contact me as soon as possible after the baby had been born. Where possible, I went to visit them either at home or in hospital, to complete the qualitative evaluation. At this stage the second set of questionnaires (referred to as the postnatal evaluation) was given to them. They were requested to complete those within the next two weeks and mail it back to me (stamped envelopes were included). I followed them up telephonically to ensure that the questionnaires were completed in the specified time.

Participants in the control group were also followed up telephonically at a time close to their expected date of delivery. Where possible, the questionnaires were given to them personally while still in hospital, otherwise it was mailed to them. Further follow-up was the same as with the research group.

#### 3.1.4.5 Follow-up postnatal evaluation

Two months after the participants had given birth, they were contacted again telephonically to remind them about the study. Some of the participants in the experimental group were seen individually for the qualitative evaluation, and the last questionnaires (referred to as the follow-up-postnatal evaluation) were given to all participants or mailed to them to complete. They were again followed up telephonically to ensure completion of the questionnaires within the specified time.

Participants in the control group received the questionnaires by mail and were followed up in the same way as the experimental group.

### 3.1.5 Data analysis

Cronbach alpha reliability indices were determined for all scales, using data of both groups. Significance of differences within and between the experimental and control groups were determined by means of paired t-tests and two-sample t-tests.

## 3.2 Qualitative study

### 3.2.1 Participants

Participants in the experimental group were requested to participate in the qualitative component of the programme. Due to the fact that the participants came from different locations, the majority of the women were asked to complete open-ended questions in writing, on their experience of the programme and what it meant to them. Six women were interviewed individually, while the other 17 gave written responses in essay format to the same questions, and mailed them back together with the questionnaires of the quantitative component.

### 3.2.2 Aim of the qualitative study

The aim of this component was to gather information regarding mothers' experience of the impact of the hypnotherapeutic programme, as described in their own words. This information can supplement the information obtained in the quantitative component and provides the opportunity for new facets to emerge.

### 3.2.3 Interviews

The format followed in both interviews was a standardised, open-ended interview pattern (Patton, 1990).

#### 3.2.3.1 Postnatal interview/essay

This interview took place within the first two weeks postpartum. The question asked was:
"What impact did the programme have for you in your present situation?"

#### 3.2.3.2 Follow-up postnatal interview/essay

These interviews were held approximately 8 to 10 weeks postpartum. The following question was asked:
"What did participation in the programme mean to you at this time of your life?"

### 3.2.4 Procedure for gathering data

Interviews were audiotaped and transcribed. Written responses were collected from the other 17 participants.

### 3.2.5 Data analysis

A content analysis (cf. Patton, 1990) was performed on the transcribed responses as well as the written responses of participants, keeping in mind the question that was put to the participants. Words and phrases that were thematically linked together, were grouped to indicate main themes.

## 4. SUMMARY

In this chapter the research design, measuring instruments, procedure and analysis of data were described. The results of the research are presented and discussed in the next chapter.

# CHAPTER 6

# RESULTS AND INTERPRETATION

## 1. INTRODUCTION

In this chapter the results of the empirical study will be described and interpreted. Mothers in the experimental group's comment regarding the impact of the programme will also briefly be reported.

## 2. DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

As indicated in Table 1, the experimental and control groups were more or less similar with regard to age, marital status and whether the pregnancy was planned.

The majority of women in both groups indicated that they expected to have a normal delivery. Data regarding actual delivery shows that most women in the *experimental group* eventually had normal deliveries (56.51%). Of these normal deliveries, 26% took place without administering epidural anaesthesia. The incidence of caesarean section in the experimental group was 43.47%. In the *control group* most women eventually had a caesarean section (54.55%). The incidence of normal deliveries in the control group was 45.46%. However, none of these women had a natural childbirth without any medication, while 13.64% received some medication and 31.82% received epidural anaesthesia.

Although caution should be applied in attributing causality, these results suggest that the hypnotherapeutic intervention could have contributed to a higher incidence of normal deliveries. It is possible that the programme prepared the mothers psychologically for the actual birth experience by strengthening their perceived self-efficacy in coping with a normal delivery. This finding is similar to the finding of Saisto, Salmela-Aro, Nurmi, Kononen and Halmesmaki (2001a), who evaluated an intervention with anxious women who requested a caesarean section. The intervention consisted of three 45-minute sessions of cognitive therapy with a trained obstetrician, a 90-minute session with a midwife and a visit to the maternity ward.

Saisto et al. (2001a) reported that 62 percent of the women who initially requested caesarean section, chose to deliver vaginally after the intervention.

**TABLE 1: Demographic characteristics of participants**

| Variable | Experimental group (n=23) % | Control group (n=23) % |
|---|---|---|
| **Age** | | |
| 20-29 | 78.26 | 82.61 |
| 30-34 | 13.04 | 8.70 |
| 35-39 | 8.70 | 8.70 |
| **Marital status** | | |
| Married | 95.65 | 86.36 |
| Cohabiting | 4.35 | 13.64 |
| **Planned pregnancy** | | |
| Yes | 73.91 | 60.87 |
| No | 26.09 | 39.13 |
| **Type of expected delivery** | | |
| Normal | 60.87 | 52.17 |
| Normal with epidural | 30.43 | 30.43 |
| Epidural caesarean | 4.35 | 0.00 |
| Caesarean with full anaesthetic | 4.35 | 17.39 |
| **Type of actual delivery** | | |
| Normal (no medication) | 13.04 | 0.00 |
| Normal (some medication) | 13.04 | 13.64 |
| Normal with epidural | 30.43 | 31.82 |
| Epidural caesarean | 30.43 | 50.00 |
| Caesarean with full anaesthetic | 13.04 | 4.55 |

# 3. RESULTS OF THE QUANTITATIVE COMPONENT

## 3.1. Reliability of the measuring scales

Cronbach alpha values were calculated for all measuring instruments. The reliability indices of all measures were satisfactory (see Table 2).

**TABLE 2: Reliability indices for all measuring scales**

| Measuring instrument | Cronbach alpha |
|---|---|
| Perception of Labour and Delivery (PLD) | 0.83 |
| Feelings about baby and relationship with baby (FRB) | 0.75 |
| Maternal Self-Confidence Scale (MSC) | 0.89 |
| Edinburg Postnatal Depression Scale (EPDS) | 0.83 |
| General Health Questionnaire (GHQ) | 0.63 |
| Satisfaction with Life Scale (SWLS) | 0.87 |
| Affectometer 2 : PA (AFM) | 0.81 |
| Affectometer 2 : NA (AFM) | 0.83 |
| Sense of Coherence Scale (SOC) | 0.91 |
| General Self-Efficacy Scale (GSE) | 0.91 |

## 3.2 Comparison of pre-test scores of the experimental and control groups

In view of the fact that a complete random assignment of participants to the experimental and control groups was not possible, a comparison of their initial pre-test score is necessary. The two groups were compared by means of two-sample t-tests on the research measures during the prenatal evaluation phase (see Table 3 for results). Although the participants were randomly assigned to a large extent, the experimental group scored significantly higher on depression, general symptoms of psychopathology and negative affect. The experimental group thus seemed to be significantly more vulnerable in comparison to the control group before the intervention started. This is also evident in the levels of their mean scores compared to normative data. Firstly, the experimental group's mean score on the EPDS was 10.87. Generally a cut-off point of 12 is seen as an indication of possible depression

**TABLE 3: Significance of differences between experimental and control group during prenatal evaluation on all measures**

| Measures | Experimental Group Mean (sd) | Control Group Mean (sd) | p |
|---|---|---|---|
| PLD | 12.47 (1.72) | 13.21 (1.59) | 0.13 |
| FRB | 10.41 (1.44) | 10.68 (1.28) | 0.11 |
| MSC | 25.65 (6.17) | 28.78 (5.14) | 0.06 |
| EPDS | 10.87 (4.95) | 8.30 (3.58) | 0.05* |
| GHQ | 6.78 (5.17) | 4.04 (3.56) | 0.04* |
| SWLS | 25.53 (5.65) | 28.21 (5.16) | 0.08 |
| AFM (PA) | 35.56 (5.74) | 37.26 (6.32) | 0.34 |
| AFM (NA) | 21.60 (5.46) | 17.08 (6.10) | 0.01** |
| AFM (PNB) | 13.95 (10.59) | 20.17 (11.04) | 0.05* |
| SOC | 132.84 (22.93) | 145.13 (22.90) | 0.07 |
| GSE | 15.10 (2.41) | 15.93 (2.38) | 0.24 |

**Note:** PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

* $p = < 0.05$ ** $p = < 0.01$

in childbearing women (Elliot et al., 2000), but in some studies a cut-off point of 9 to 10 has been used to increase sensitivity to the possibility of depression (Zelkowitz & Milet, 1996). As Evans et al. (2001) reported, prenatal depression is more common than previously acknowledged, and self-reported scores for depression scores are likely to be higher in pregnancy than in the postnatal period. However, the mean prenatal score of the experimental group was still significantly higher than the mean score of the control group.

Secondly, the experimental group obtained a total score of 6.87 on the GHQ, where scores of below 4 are usually associated with more positive mental health (Goldberg & Hillier, 1979), therefore their level of symptomatology was significantly higher than that of the control group. Thirdly, the experimental group manifested significantly higher levels of negative affect, and a significantly poorer affect balance (PA-NA). The experimental group also obtained a SOC score of 132.82, which is lower than the mean score of 137 estimated for South Africa by Strümpfer and Wissing (1998).

They did, however, not differ significantly from the control group, which had a mean score of 145.13, probably because of large standard deviations.

These differences between the experimental and control groups are difficult to explain. Most likely it could be due to chance, the small number of participants in the two groups and the lack of complete randomisation. From the current results it seems that the experimental group not only manifest poorer pre-test scores than the control group, but they could also be viewed as a group at risk.

Since the two groups were not similar on the prenatal measures, the effect of the intervention programme cannot be deduced from a pure comparison of postnatal evaluation scores between the groups. Therefore, it was decided to: (i) explore the significance of differences within each of the experimental and control groups, in order to also obtain more detailed information on the experimental group, and (*ii*) to determine the significance of differences between the experimental and control group, now using the mean difference scores between prenatal and postnatal evaluation on each variable, in order to determine the impact of the intervention programme.

## 3.3 Comparison of within-group differences in the experimental and control groups

Differences within the two groups were determined by means of paired t-tests, with a Bonferroni adjustment (Christensen, 1996), and are presented in Tables 4 to 9. The practical significance of these differences was calculated by establishing d-values or effect sizes (Steyn, 1999). The results are presented and interpreted in three clusters, namely aspects of psychological well-being related to early motherhood, aspects of psychological well-being related to the absence of pathology, and aspects of general psychological well-being.

### 3.3.1 Differences within the experimental group at two weeks postpartum

The difference in prenatal versus postnatal evaluation scores within the experimental group is presented in Table 4. The results indicate that mothers in this group exhibited an improvement in psychological well-being as measured on most indices, except the PLD.

**TABLE 4: Significance of differences between prenatal and postnatal evaluation within experimental group**

| Measures | Pre (sd) | Post (sd) | p | d |
|---|---|---|---|---|
| PLD | 12.48 (1.73) | 13.30 (2.51) | 0.22 | --- |
| FRB | 10.22 (1.44) | 11.43 (0.90) | 0.0002*** | 0.84++ |
| MSC | 25.65 (6.18) | 30.00 (3.99) | 0.0019** | 0.70+ |
| EPDS | 10.87 (4.95) | 7.33 (5.71) | 0.03* | 0.62+ |
| GHQ | 6.78 (5.18) | 5.29 (5.47) | 0.42 | --- |
| SWLS | 25.43 (5.65) | 29.35 (4.59) | 0.004** | 0.69+ |
| AFM (PA) | 35.56 (5.74) | 38.96 (7.04) | 0.02* | 0.48 |
| AFM (NA) | 21.60 (5.46) | 16.78 (4.85) | <0.0001*** | 0.88++ |
| AFM (PNB) | 13.95 (10.60) | 22.17 (10.87) | 0.0004*** | 0.76+ |
| SOC | 132.84 (22.93) | 147.74 (21.78) | <0.0001*** | 0.64+ |
| GSE | 15.10 (2.42) | 16.13 (1.90) | 0.02* | 0.42 |

**Note:** PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

* p = < 0.05 ** p = < 0.01 *** p = < 0.001
+ d = |0. 5| : medium effect ++ d = |0. 8| : large effect and practically significant

3.3.1.1 Aspects of psychological well-being related to early motherhood

Mothers in the experimental group showed a significant change regarding their *feelings about their babies, and their relationship with their babies* at two weeks postpartum (p = 0.0002), in the sense that they rated their feelings about and relationship with the baby as more positive than during pregnancy. This difference was also practically significant (*d = 0.84*). These findings are important in view of the fact that the development of attachment and the forming of a bond with the baby has been described as an important task of motherhood (Leifer, 1980; Mercer, 1986). A positive relationship with the baby could further contribute to self-actualisation in the mothering role (Stern, 1995).

There was further a marked increase in the mothers' sense of *maternal self-confidence* (p = 0.0019) at two weeks postpartum. The role of maternal self-confidence in the experience of psychological well-being has not been studied

extensively, but Ball (1987) has reported maternal self-confidence within the first week of delivery to be conducive to emotional well-being. Further, Matthey, Morgan, Healy, Barnett, Kavanagh and Howie (2002) recently reported that most expectant mothers in their study were concerned about their ability to cope with the demands of motherhood, as well as with specific facets such as feeding and settling the baby. It is possible that the intervention had addressed these fears, contributing to a strengthened sense of maternal self-confidence.

Although there have been some findings that indirectly suggested that *perception of the actual childbirth experience* could impact on postpartum psychological well-being (Maclean, McDermott & May, 2000; Tulman & Fawcett, 1991), there was no change regarding their perception of their actual labour compared to the expected labour. This could possibly be explained by the fact that all the women attended childbirth education classes, which could have prepared them for the experience of labour and delivery. Since the original questionnaire measured satisfaction of delivery, it is also possible that finer nuances of the perception of childbirth (excitement, disappointment, and fear) could have been neglected, resulting in an unchanged score.

It can be concluded that the results specifically suggest that the programme had some contribution in enhancing aspects of psychological well-being in early motherhood, such as the relationship with the baby, maternal self-confidence and maternal self-efficacy. It has previously been reported that prenatal experience of maternal self-confidence could influence postnatal maternal self-confidence (Pond & Kemp, 1992) and, as Green and Kaftersios (1997) reported, prenatal expectations of motherhood are related to the eventual experience of motherhood. Since this programme focused on enhancing the prenatal relationship with the baby, as well as increasing maternal self-confidence and facilitating maternal self-efficacy by means of ego-strengthening, it is possible that the intervention contributed to the improved scores on these measures of psychological well-being. The results therefore provide some evidence that hypnotherapeutic facilitation of psychological strengths and internal resources could impact on these specific aspects of the experience of motherhood.

#### 3.3.1.2 Aspects of psychological well-being as indicated by the absence of pathology

In the experimental group, mothers exhibited significantly lower levels of *depression* at two weeks postpartum in comparison to their prenatal evaluation ($p = 0.03$). This difference was practically significant ($d = 0.93$). This is an important finding, since the experimental group had elevated depression scores during pregnancy, and recent research suggested that depression during pregnancy predicted depression in the early postpartum period (Saisto, Salmela-Aro, Nurmi, Kononen & Halmesmaki, 2001b). Although there was no significant change in prevalence of *symptoms of pathology* as indicated by scores on the GHQ ($p = 0.003$) at two weeks postpartum, their was a tendency towards a lower mean score.

It can be concluded that the results suggest that the hypnotherapeutic intervention played some role in decreasing symptoms of depression in the early postpartum period, and that a prenatal hypnotherapeutic intervention, focused on the enhancement of strengths, may also alleviate symptoms of depression during this period.

#### 3.3.1.3 Aspects related to general psychological well-being

Mothers in the experimental group exhibited a significant positive improvement regarding aspects of general psychological well-being at two weeks postpartum. Specifically, they experienced an increase in *life satisfaction* ($p = 0.004$), more *positive affect* ($p = 0.02$), less *negative affect* ($p = < 0.0001$) as well as a more positive *affect balance* ($p = 0.0004$). They further reported a strengthened *sense of coherence* ($p < 0.0001$) as well as a stronger sense of *generalised self-efficacy* ($p = 0.02$), in comparison to prenatal scores. The difference in negative affect scores was found to be practically significant ($d = 0.88$).

These results suggest that the hypnotherapeutic programme contributed to an increase in general psychological well-being of mothers in the experimental group. The increase in the positive affect balance of the experimental group is similar to the findings of Black-Olien (1993), who reported that a prenatal education programme based on improving communication skills and relaxation, contributed to a higher positive affect balance. Further, the increase in scores on the SOC suggests that the

current programme also enhanced this facet in the experimental group. Finally, the strengthened sense of generalised self-efficacy could have been achieved through the process of verbal persuasion (Bandura, 1997a), which was part of the hypnotherapeutic programme.

In conclusion, the results suggest that several facets related to general psychological well-being could be enhanced by a hypnotherapeutic intervention based on the facilitation of psychological strengths. Specifically, the life satisfaction of mothers in the experimental group seemed to have improved after the intervention and the birth of their babies. No evidence could be found in the existing literature regarding interventions to improve life satisfaction by means of psychotherapeutic intervention or facilitation.

Secondly, the increase in positive affect and decrease in negative affect, as reflected by the mean scores of women in the experimental group, provide some evidence regarding the possibility of utilising hypnotherapy for the facilitation of positive affect. Specifically, hypnotherapy from a fortigenic perspective (i.e. focusing on facilitating strengths), and incorporating principles from Ericksonian and ego state therapy approaches (for instance, the inner resourcefulness of every person) could be an effective approach to decrease negative affect and increase positive affect. This is similar to the broaden-and-build theory of positive emotions by Frederickson (1998, 2000,2001).

Finally, there was in increase in the experimental group's sense of coherence (SOC). Antonovsky (1987) states that the SOC is stable after the age of 30, but most women in the experimental group were still in their twenties. This suggests that an intervention, aimed at facilitating psychological strengths, could possibly enhance this facet of psychological well-being.

#### 3.3.1.4 Summary

The results suggest that the hypnotherapeutic programme contributed to some extent in the acceleration of the postpartum adjustment of mothers in the experimental group, by enhancing their relationship with their babies, improving their maternal self-confidence and strengthening their perception of maternal self-efficacy. There was also a significant decrease in symptoms of depression and an increase in general psychological well-being in the experimental group at two weeks postpartum.

### 3.3.2. Differences within the control group at two weeks postpartum.

The control group did not exhibit significant differences between prenatal and postnatal scores on the research variables, as can be seen in Table 5.

**TABLE 5: Significance of differences between prenatal and postnatal evaluation within control group**

| Measures | Pre (sd) | Post (sd) | p |
|---|---|---|---|
| PLD | 13.21 (1.59) | 13.27 (2.25) | 0.87 |
| FRB | 10.87 (1.29) | 11.36 (1.00) | 0.17 |
| MSC | 28.78 (5.14) | 29.00 (4.86) | 0.82 |
| EPDS | 8.30 (3.58) | 8.91 (5.20) | 0.51 |
| GHQ | 4.04 (3.56) | 6.00 (5.32) | 0.09 |
| SWLS | 28.21 (5.16) | 29.00 (4.50) | 0.53 |
| AFM (PA) | 37.26 (6.33) | 37.40 (5.88) | 0.81 |
| AFM (NA) | 17.09 (6.10) | 16.92 (6.62) | 0.76 |
| AFM (PNB) | 20.17 (11.05) | 20.48 (11.55) | 0.76 |
| SOC | 145.13 (22.90) | 147.46 (22.58) | 0.26 |
| GSE | 15.93 (2.38) | 15.36 (2.85) | 0.06 |

**Note:** PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

### 3.3.3 Differences within the experimental group at ten weeks postpartum

At ten weeks postpartum, mothers in the experimental group continued to exhibit an enhanced sense of psychological well-being. The mothers' prenatal scores were compared with their follow-up-postnatal scores, shown in Table 6.

#### 3.3.3.1 Aspects of psychological well-being related to early motherhood

At ten weeks postpartum, mothers in the experimental group continued to experience an even *more positive relationship with their babies*, compared to their expectation during pregnancy, as indicated by $p = 0.0001$, and a practical significance of $d = 1.15$. It has been reported that mothers with postpartum depression have a less

**TABLE 6: Significance of differences between prenatal and follow-up postnatal evaluation within experimental group**

| Measures | Pre (sd) | Follow-up(sd) | p | d |
|---|---|---|---|---|
| PLD | 12.47 (1.73) | 13.43 (2.06) | 0.11 | — |
| FRB | 10.22 (1.44) | 11.87 (0.34) | 0.0001*** | 1.15++ |
| MSC | 25.65 (6.18) | 30.52 (4.09) | <0.0001*** | 0.78+ |
| EPDS | 10.87 (4.96) | 6.04 (4.17) | 0.0002*** | 0.93++ |
| GHQ | 6.78 (5.18) | 3.43 (4.49) | 0.003** | 0.64+ |
| SWLS | 25.43 (5.65) | 28.09 (4.85) | 0.02* | 0.46 |
| AFM (PA) | 35.56 (5.74) | 37.91 ( 7.62) | 0.06 | — |
| AFM (NA) | 21.61 (5.46) | 19.69 (6.96) | 0.09 | — |
| AFM (PNB) | 13.95 (10.60) | 18.22 (13.24) | 0.04* | 0.32 |
| SOC | 132.84 (22.93) | 144.87 (23.80) | 0.0008*** | 0.50+ |
| GSE | 15.11 (2.42) | 15.85 (2.51) | 0.09 | — |

**Note:** PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

* p = < 0.05 ** p = < 0.01 *** p = < 0.001
+ d = |0. 5| +: medium effect ++ d = |0. 8| : large effect and practically significant

positive view of their babies than mothers who have never experienced postnatal depression (Foreman & Henshaw, 2002). The fact that mothers in the experimental group experienced an enhancement in their perception of their relationship with their babies could therefore possibly be associated with their lowered depression scores (see paragraph 3.3.2.2).

Mothers' *maternal self-confidence* further continued to strengthen at ten weeks postpartum (p = <0.0001), suggesting that the hypnotherapeutic intervention was effective in sustaining an initial increase in maternal self-confidence, and facilitating an ongoing strengthening of this aspect of psychological well-being in the longer term.

Another variable, *maternal self-efficacy*, was only measured during the postnatal and follow-up postnatal evaluation (two weeks postpartum and ten weeks postpartum) as shown in Table 7. The results indicate that mothers in the experimental group experienced a stronger sense of maternal self-efficacy at ten

weeks postpartum, compared to two weeks postpartum (p = 0.001). It has been suggested that perceived parenting self-efficacy played an important role in adjustment to motherhood (Williams et al., 1987), and that there is an inverse relationship between perceived maternal self-efficacy and depression (Teti & Gelfand, 1991). Bandura (1997a) has previously stated that psychotherapy could enhance self-efficacy by providing tools for managing situations that may arise. It is therefore possible that the hypnotherapeutic intervention provided mothers in the experimental group with tools such as relaxation and a sense of inner resourcefulness while they were pregnant, and that consequent experiences of mastery during the postpartum period contributed to the strengthened sense of maternal self-efficacy.

**TABLE 7: Significance of difference between postnatal and follow-up postnatal evaluation within experimental group with regard to maternal self-efficacy (MSE)**

| Measure | Post (sd) | Follow-up(sd) | p | d |
|---|---|---|---|---|
| MSE | 12.34 (0.93) | 13.56 (1.56) | 0.001*** | 0.78+ |

*** p = < 0.001 + d = |0. 5|: medium effect

3.3.3.2 Aspects of psychological well-being as indicated by the absence of pathology

At ten weeks postpartum, levels of *depression* in mothers in the experimental group continued to decrease significantly (p = 0.0002), to an average score of 6.04, which is comparable to the average score of 5.9 reported by Elliot et al. (2000). The current score is also comparable to the recent findings of Evans et al. (2001), who reported a mean score of 5.84 at 8 weeks postpartum. This difference was practically significant (d = 0.93). This is a very important finding, since depression during pregnancy has been associated with depression in the postpartum period (Beck, 2001; Maldonado-Duran et al., 2000; Saisto et al., 2001), and a need exists for development of preventive measures (Cooper & Murray, 1998). Interestingly, a recent study by Lavertue, Kumar and Pekala (2002) could not find an improvement on scores of depression in a student population after hypnotherapeutic ego-strengthening.

However, the intervention consisted only of one session of an hour of ego-strengthening in a group format, a fact which could have influenced the results.

There was also a decrease in symptoms of pathology as indicated by scores on the GHQ ($p = 0.003$) at ten weeks postpartum. The current study therefore indicates that a focus on the enhancement of strengths (that is, a focus from a fortigenic perspective), used within the context of Ericksonian and ego state therapy approaches to hypnosis, may also alleviate symptoms of psychopathology.

#### 3.3.3.3 Aspects related to general psychological well-being

At ten weeks postpartum, mothers in the experimental group continued to experience increased life satisfaction ($p = 0.02$), positive affect balance ($p = 0.04$) as well as a stronger sense of coherence ($p = 0.0008$). These results suggest that the hypnotherapeutic intervention was effective in initially enhancing these aspects of psychological well-being, and continued to have an effect at ten weeks postpartum. This finding therefore suggests that the programme had a long-term effect in promoting life satisfaction, positive affect balance and a sense of coherence. Although there was no significant differences found regarding positive affect, negative affect and generalised self-efficacy, the tendency found was that scores were higher at ten weeks postpartum than during pregnancy, indicating a trend of maintained psychological well-being.

#### 3.3.3.4 Summary

Results regarding the difference between prenatal and follow-up evaluation in the experimental group indicate that their experience of psychological well-being was significantly stronger at ten weeks postpartum, compared to their prenatal experience. The most significant differences found were a more positive experience of their relationship with their babies and feelings about their babies, and a decrease in depression. These findings suggest that the hypnotherapeutic programme contributed to enhanced psychological well-being of mothers in the experimental group in the longer term.

that the hypnotherapeutic programme could have facilitated a more positive relationship between mothers and their babies in the experimental group.

There was also a significant improvement in a sense of *maternal self-confidence* in the experimental group, in comparison to the control group ($p = 0.01$). This difference had a medium effect size, suggesting that it could be practically significant. Martell (2001) found that many mothers did not trust their ability to care for their new-borns during the first week postpartum, and that it was a major challenge for these mothers to develop confidence in caring for their babies. In view of Martell's findings, it is possible that the prenatal hypnotherapeutic intervention enabled mothers in the experimental group to develop this maternal confidence sooner than mothers in the control group did.

#### 3.4.1.2 Aspects of psychological well-being as indicated by to the absence of pathology

Mothers in the experimental group exhibited a significant decrease in symptoms associated with *depression* ($p = 0.01$), as well as *symptoms of general psychopathology* ($p = 0.03$) at two weeks postpartum, compared to mothers in the control group (see Table 10). This difference showed a medium effect size, suggesting possible practical significance. These findings suggest that the hypnotherapeutic intervention had some effect in decreasing symptoms of depression in mothers in the experimental group, while the mothers in the control group exhibited unchanged levels of depression and general symptoms of psychopathology.

It has been suggested that depression during pregnancy could lead to depression in the postpartum period (Beck, 2001; Maldonado-Duran et al., 2000; Saisto et al, 2001b), and that intervention during pregnancy could prevent the escalation of postpartum depression (Elliot et al., 2000; Miller, 2002). Further, Terry (1996) found that effective coping resources could prevent postpartum depressive symptomatology, and the current intervention programme explicitly aimed at the strengthening of internal coping resources. Finally, Priel and Besser (1999) found prenatal bonding to be a protective factor in the development of postpartum depression. Since the hypnotherapeutic programme included the facilitating of prenatal bonding, it is possible that the programme contributed to lower depression scores in the experimental group.

**TABLE 9: Significance of difference between postnatal and follow-up postnatal evaluation within control group with regard to maternal self-efficacy (MSE)**

| Measure | Post (sd) | Follow-up(sd) | p | d |
|---|---|---|---|---|
| MSE | 11.95 (1.17) | 12.72 (1.07) | 0.11 | — |

3.3.4.2 Aspects of psychological well-being as indicated by the absence of pathology

At ten weeks postpartum, mothers in the control group indicated a decrease in symptoms of depression ($p = 0.01$), which was also practically significant ($d = 0.80$) (see Table 8). This finding suggest that mothers in the more resilient control group maintained their level of psychological well-being at two weeks postpartum, although there was a slight increase of psychological distress. They continued to improve spontaneously on measures related to depression, reaching a mean score comparable to the recent findings of Elliot et al (2000) as well as Evans et al. (2002). This finding suggests that mothers who experienced a relatively strong sense of psychological well-being in late pregnancy, were able to maintain existing low levels of depression, and to improve on these levels without intervention.

3.3.4.3 Aspects related to general psychological well-being

Mothers in the control group exhibited a significantly stronger sense of coherence at ten weeks postpartum ($p = 0.01$), than during pregnancy. The reported mean score for the group was much higher than the reported average of 173 for the South African population (Strümpfer & Wissing, 1998), which again suggests that these mothers were more resilient and perhaps stronger in a psychological sense. Strümpfer (1995) previously stated that a strong sense of coherence could continue to strengthen during a developmental transition, which could further explain the increase of SOC in the control group.

### 3.3.4 Differences within the control group at ten weeks postpartum

The control group exhibited some significant differences when prenatal versus follow-up scores were compared, as can be seen in Table 8.

**TABLE 8: Significance of differences between prenatal and follow-up postnatal evaluation within control group**

| Measures | Pre (sd) | Follow-up(sd) | p | d |
|---|---|---|---|---|
| PLD | 13.21 (1.60) | 13.94 (1.95) | 0.10 | --- |
| FRB | 10.87 (1.29) | 11.77 (0.54) | 0.007** | 0.85++ |
| MSC | 28.78 (5.14) | 30.65 (2.34) | 0.02* | 0.36 |
| EPDS | 8.30 (3.58) | 5.61 (3.82) | 0.01** | 0.80++ |
| GHQ | 4.04 (3.56) | 3.28 (4.36) | 0.48 | --- |
| SWLS | 28.22 (5.16) | 29.44 (2.23) | 0.08 | --- |
| AFM (PA) | 37.26 (6.33) | 39.01 (5.55) | 0.13 | --- |
| AFM (NA) | 17.09 (6.10) | 17.55 (6.51) | 0.88 | --- |
| AFM (PNB) | 21.46 (11.80) | 20.17 (11.04) | 0.27 | --- |
| SOC | 145.13 (22.91) | 152.89 (18.63) | 0.01** | 0.33 |
| GSE | 15.93 (2.38) | 16.25 (2.08) | 0.32 | --- |

**Note**: PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

* p = < 0.05 ** p = < 0.01 *** p = < 0.001
++ d = |0. 8| : large effect and practically significant

#### 3.3.4.1 Aspects of psychological well-being related to early motherhood

At ten weeks postpartum, the mothers in the control group showed more positive *feelings about their babies* and their relationship with their babies (p = 0.007), which was practically significant (d = 0.85). There was further an increase in *maternal self-confidence* (p = 0.02). This could possibly be explained by gradual adjustment to the mothering role, since Pridham and Chang (1992) stated that most mothers feel familiar with infant care at three months postpartum. However, there was no change in their maternal self-efficacy (see Table 9). This finding suggests that maternal self-efficacy, which is domain-specific, might not be strengthened by gradual development in the mothering role alone.

related to early motherhood, absence of pathology and general psychological well-being.

**TABLE 10: Significance of differences between experimental and control groups on prenatal versus postnatal difference scores**

| Measures | Mean difference prenatal versus postnatal evaluation | | | |
|---|---|---|---|---|
| | Experimental group (sd) | Control group (sd) | p | d |
| PLD | 0.82 (3.20) | 0.09 (2.65) | 0.20 | — |
| FRB | 1.21 (1.31) | 0.50 (1.68) | 0.05* | 0.42 |
| MSC | 4.33 (5.89) | 0.31 (6.56) | 0.01** | 0.61+ |
| EPDS | -3.54 (7.62) | 0.59 (4.13) | 0.01** | 0.54+ |
| GHQ | -1.49 (6.57) | 1.77 (4.76) | 0.03* | 0.50+ |
| SWLS | 3.91 (5.97) | 0.81 (6.13) | 0.04* | 0.04 |
| AFM(PA) | 3.39 (6.55) | 0.31 (6.26) | 0.05* | 0.47 |
| AFM(NA) | -4.82 (4.01) | -0.34 (5.48) | 0.001*** | 0.81++ |
| AFM(PNB) | 8.21 (9.47) | 0.66 (10.24) | 0.005** | 0.74+ |
| SOC | 14.89 (14.97) | 3.13 (12.73) | 0.003** | 0.79+ |
| GSE | 1.02 (1.95) | -0.45 (1.11) | 0.001*** | 0.75+ |

**Note:** PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

* $p = < 0.05$ ** $p = < 0.01$ *** $p = < 0.001$
+ $d = |0.5|$ : medium effect ++ $d = |0.8|$ : large effect and practically significant

### 3.4.1 Differences between experimental and control groups at two weeks postpartum

#### 3.4.1.1 Aspects of psychological well-being related to early motherhood

At two weeks postpartum, mothers in the experimental group experienced, in comparison to the control group (see Table 10), a significant change in their *perception of their relationship with their baby*, with the actual relationship experienced as being more positive than expected ($p = 0.05$). This finding suggests

#### 3.3.4.4 Summary

Mothers in the control group experienced a spontaneous increase in some aspects related to psychological well-being at ten weeks postpartum, when their prenatal scores are compared to their follow-up postnatal scores. Specifically, they experienced more positive feelings about their babies, an increase in maternal self-confidence, a decrease in depression and a strengthened sense of coherence. The results suggest that these mothers could have grown in a psychological sense during the normal course of the developmental transition.

### 3.3.5 Conclusion

The results regarding the differences between prenatal and postnatal scores, as well as between prenatal and follow-up postnatal scores within the experimental and control groups, suggest that the hypnotherapeutic programme was effective in enhancing most aspects of psychological well-being in the experimental group. This strengthened sense of psychological well-being was evident both in the immediate postpartum period and at ten weeks postpartum.

The results specifically suggest that the programme contributed to some extent in enhancing aspects of psychological well-being in motherhood, such as the relationship with the baby, maternal self-confidence and maternal self-efficacy. The control group showed an increase in psychological well-being later in the postpartum period, indicating that the programme assisted mothers in the experimental group to experience a stronger sense of psychological well-being sooner after the baby's birth. This finding is important in view of the fact that mothers in the experimental group experienced higher levels of psychological distress in pregnancy, than did mothers in the control group.

## 3.4 Comparison of between-group differences of the experimental and control groups

The experimental and control groups were compared on mean differences in prenatal versus postnatal scores, and on prenatal versus follow-up postnatal scores by means of two-sample t-tests. The results are shown in Tables 10 and 11. It will be discussed and interpreted with regards to the clusters of psychological well-being

### 3.4.1.3 Aspects related to general psychological well-being

At two weeks postpartum, mothers in the experimental group showed a significant improvement in their *life satisfaction* in comparison to the control group ($p = 0.04$) (see Table 10). There is currently a lack of empirical studies related to life satisfaction during childbearing, as well as on the effect of psychotherapeutic intervention on life satisfaction. The current results suggest that it is possible to improve life satisfaction through a hypnotherapeutic intervention aimed at the enhancement of psychological strengths and inner resources.

The experimental group further showed a significant increase in *positive affect* ($p = 0.05$), a decrease in *negative affect* ($p= 0.001$) and a more *positive affect balance* ($p = 0.005$), in comparison to the control group. The decrease in negative affect in comparison to the control group, was practically significant ($d = 0.81$). Little is currently known regarding affect balance in childbearing women, or regarding the effect of psychotherapeutic intervention on affect balance specifically. The current empirical results suggest that the hypnotherapeutic programme contributed to a more positive affect balance in women in the experimental group in the early postpartum period. The decrease in negative affect is probably linked to the decrease in depression and general symptoms of psychopathology in the experimental group (see paragraph 3.4.1.2).

It is further evident that the experimental group exhibited a significant strengthening in their *sense of coherence* at two weeks postpartum, when compared to the control group ($p = 0.003$). This difference is practically significant, with an effect size of 0.79. Antonovksy (1979) maintained that the sense of coherence is stable by the age of 30, but Strümpfer (1995) suggested that it could be enhanced by developmental transitions. It can be concluded that the hypnotherapeutic intervention facilitated an enhanced sense of coherence in women in the experimental group during the early postpartum period.

Finally, mothers in the experimental group showed a significant increase in their sense of *generalised self-efficacy*, in comparison to the control group. Self-efficacy has been described as a broad and stable sense of personal competence to deal effectively with a variety of stressful situations (Schwarzer, 1993), a coping resource (Schwarzer & Scholz, 2000) and a salutogenic strength (Antonovsky, 1991). The

increase in generalised self-efficacy in the experimental group suggests that the hypnotherapeutic intervention enhanced this aspect of women in the experimental group, by making them aware of various inner resources available to them. There is a lack of evidence in the existing literature regarding the role of generalised self-efficacy in the perinatal period, and the current findings make a unique contribution in this regard.

#### 3.4.1.4 Summary

When mean difference scores between the prenatal and postnatal evaluation are considered, mothers in the experimental group showed a more significant increase in psychological well-being, compared to the control group, as indicated by a positive experience of relationship with the baby and maternal self-confidence. Mothers in the experimental group also showed a more significant decrease in symptoms of pathology in comparison to the control group, and a significant increase in aspects related to general psychological well-being. The results indicate that the prenatal hypnotherapeutic programme was effective in enhancing most aspects of psychological well-being of women in the experimental group at two weeks postpartum, in comparison to the control group.

### 3.4.2 Differences between experimental and control groups at ten weeks postpartum

#### 3.4.2.1 Aspects of psychological well-being related to early motherhood

At ten weeks postpartum, the mean difference scores between the two groups on aspects related to early motherhood were not significant anymore (see Table 11). This could possibly be explained by the fact that mothers in both groups had gradually become more comfortable with the baby and their roles as mothers. This coincides with the findings of Martell (2001), who reported that mothers' confidence seemed to improve as they became aware of the fact that their babies thrived on their feeding and care. The results further suggest that both groups were now functioning at similar levels of psychological well-being, as related specifically to motherhood. This finding is important since mothers in the experimental group were psychologically more vulnerable than those in the control group during the prenatal evaluation, and recent research suggests that psychological distress such as depression could have a negative impact on the mother-infant relationship

(Maldonado-Duran et al., 2000). Therefore, the current intervention aimed at enhancement of psychological strengths could have assisted mothers in the experimental group in reaching levels of psychological well-being that were comparable to those of the control group.

**TABLE 11: Significance of differences between experimental and control groups on prenatal versus follow-up difference scores**

| **Measures** | **Mean difference prenatal versus postnatal evaluation** | | | |
|---|---|---|---|---|
| | **Experimental group (sd)** | **Control group (sd)** | **p** | **d** |
| PLD | 0.95 (2.80) | 0.88 (2.11) | 0.46 | — |
| FRB | 1.65 (1.43) | 1.05 (1.47) | 0.10 | — |
| MSC | 4.86 (4.88) | 2.81 (5.00) | 0.09 | — |
| EPDS | -4.82 (5.08) | -2.44 (3.58) | 0.04* | 0.47 |
| GHQ | -3.34 (4.90) | -8.83 (4.99) | 0.05* | 0.50+ |
| SWLS | 2.65 (5.10) | 2.05 (4.96) | 0.34 | — |
| AFM(PA) | 2.34 (5.70) | 2.12 (5.73) | 0.45 | — |
| AFM(NA) | -1.91 (5.26) | 0.16 (4.73) | 0.13 | — |
| AFM(PNB) | 4.26 (9.81) | 2.29 (8.62) | 0.24 | — |
| SOC | 12.02 (14.87) | 10.22 (15.06) | 0.35 | — |
| GSE | 0.73 (2.03) | 0.27 (1.15) | 0.18 | — |

**Note:** PLD= Perception of labour and delivery; FRB= Feelings about baby and relationship with baby; MSC= Maternal Self-Confidence; EPDS= Edinburgh Postnatal Depression Scale; GHQ= General Health Questionnaire; SWLS= Satisfaction with Life Scale; AFM (PA)= Affectometer Positive Affect; AFM (NA)= Affectometer Negative Affect; AFB (PNB)= Affectometer: Affect Balance; SOC= Sense of Coherence Scale; GSE= Generalized Self-efficacy Scale.

*p = <0.05 + d = |0. 5| : medium effect

3.4.2.2 Aspects of psychological well-being as indicated by the absence of pathology

Mothers in the experimental group continued to show a significant decrease in symptoms of depression (p = 0.04) and general psychological distress (p = 0.05), at ten weeks postpartum, in comparison to the control group (see Table 11). The decrease in general symptoms of pathology showed a medium effect size, suggesting possible practical significance. When mean scores for the two groups are considered, mothers in the experimental group exhibited scores that indicated a

stronger existence of pathology during pregnancy, but at ten weeks postpartum these scores were on a par with those of the previously "more healthy" control group. This also suggests that the prenatal hypnotherapeutic programme continued to have an ameliorative and protective effect in the longer term.

It can be concluded that the hypnotherapeutic intervention, based on enhancing psychological strengths, contributed to a decrease in depression and possibly prevented the exacerbation of symptoms during the later postpartum period. The results support the anecdotal evidence cited by McCarthy (1998, 2001), that a hypnotherapeutic childbirth preparation programme based on Ericksonian principles, could prevent postpartum depression. The decrease in depression scores are also similar to the research reported by Liossi & White (2001), who found that a hypnotherapeutic programme, including ego-strengthening, was effective in the enhancement of quality of life in terminally cancer patients as reflected by lowered depression scores.

#### 3.4.2.3 Aspects related to general psychological well-being

At ten weeks postpartum, there were no significant differences regarding prenatal and follow-up postnatal psychological well-being between the two groups, with regard to facets related to general psychological well-being (see Table 11). The mean scores also indicate the tendency that the experimental group reached similar levels of psychological well-being to the control group, while they were functioning at significantly lower levels of psychological well-being during pregnancy. This suggests that the experimental group was able to maintain their enhanced psychological well-being, while the control group continued to improve without intervention. The tendency could possibly be explained by the fact that the experimental group benefited from the hypnotherapeutic intervention to enhance and maintain their levels of psychological well-being, while mothers in the control group, who were possibly more resilient, experienced an increase in well-being by drawing upon their existing internal resources.

#### 3.4.2.4 Summary

At ten weeks postpartum, there were few significant differences between the two groups when compared on most indices of psychological well-being, except for aspects related to the absence of pathology. Specifically, mothers in the

experimental group showed a decrease in depression and general symptoms of pathology, in comparison to the control group. The finding indicates that the hypnotherapeutic programme, focusing on the enhancement of strengths and inner resources, possibly assisted mothers in the experimental group to reach similar levels of psychological well-being as the control group at ten weeks postpartum, and alleviated their previous symptoms of depression and general psychological distress.

### 3.4.3 Conclusion

The experimental and control groups were compared on the mean differences in prenatal versus postnatal and follow-up scores. The results suggest that the hypnotherapeutic intervention contributed to an enhanced sense of psychological well-being in the early postpartum period, as measured by variables related to motherhood, absence of pathology and general psychological well-being. At ten weeks postpartum, the significance of differences was less obvious. However, a very important finding was that mothers in the experimental group continued to show a significant improvement in psychological well-being as indicated by the absence of pathology. Specifically, there was a continued decrease in depression and general symptoms of pathology. This finding gives compelling evidence that a hypnotherapeutic intervention, focusing on the enhancement of strengths and inner resources, could alleviate depression and psychological distress during the perinatal period, as well as prevent the exacerbation of symptoms.

## 3.5 Concluding summary regarding quantitative component

The results suggest that the prenatal hypnotherapeutic programme contributed to a significant improvement in the postnatal psychological well-being of the experimental group. Despite randomisation the control group was "healthier" or "stronger" in a psychological sense during the prenatal evaluation, while the experimental group exhibited symptoms of psychological distress such as depression and negative affect, therefore being possibly more "vulnerable" in a psychological sense. However, after the intervention the experimental group functioned at levels similar to that of the control group, which gives some evidence regarding the effect of the hypnotherapeutic intervention in alleviating and preventing symptoms of psychopathology. This improvement in psychological well-being of the experimental group is important since recent research has found psychological distress in late

pregnancy to be a risk factor in the development of postpartum depression (Forman, Videbech, Hedegaard, Salvig & Secher, 2000).

When differences between prenatal, postnatal and follow-up evaluation within the experimental and control groups are considered, the tendency found was that the experimental group significantly improved on most measures of psychological well-being, both at two weeks and ten weeks postpartum. The control group initially maintained their levels of psychological well-being, and at ten weeks postpartum they showed increased well-being on measures related to psychological well-being in motherhood, a decrease in depression and a strengthened sense of coherence, which is generally accepted to be a good indicator of general psychological well-being. This improvement could possibly be ascribed to normal development and to becoming more at ease with their new roles and responsibilities as mothers.

The experimental and control groups were further compared on mean differences in prenatal versus postnatal scores (two weeks postpartum), and on prenatal versus follow-up postnatal scores (ten weeks postpartum). The results indicate that the experimental group showed a significant improvement on most aspects of psychological well-being at two weeks postpartum, in comparison to the control group. At ten weeks postpartum, there were no significant differences between the two groups, with the exception of aspects related to the absence of pathology where the experimental continued to exhibit a significant improvement in comparison to the control group. This finding is important since it has recently been suggested that prenatal intervention with mothers exhibiting psychopathology could be beneficial to later infant mental health (Maldonado-Duran et al., 2000), as well as the general mental health of the mother (Elliot et al., 2000; Miller, 2002).

In conclusion, it can be said that results regarding the differences within the experimental and control groups suggest that the prenatal hypnotherapeutic programme had a significant effect in promoting first-time mothers' postnatal psychological well-being in the early postpartum period. Results regarding differences between the two groups further suggest that mothers in the experimental group experienced an increase in psychological well-being as seen in mean scores that represent more healthy levels of psychological functioning. The most evident contribution of the programme was in alleviating and preventing depression and general symptoms of pathology.

# 4. REMARKS REGARDING IMPACT OF THE PROGRAMME (QUALITATIVE COMPONENT)

The verbal and written responses of the women in the experimental group to specific questions were analysed. The main aim of these questions was to get information regarding the impact of the programme from mothers in the experimental group, described in their own words, as experienced at two weeks postpartum (postnatal interview), and ten weeks postpartum (follow-up postnatal interview) respectively.

## 4.1 Postnatal interview/essay (two weeks postpartum)

### 4.1.1 Qualitative comments

Mothers in the experimental group were asked the following question:
"What impact did the programme have for you in your present situation?"

The strongest theme that emerged from their answers, was that mothers felt that the ***programme assisted them in coping with labour and delivery, by using inner strengths***, as reflected in the following statements:

"It meant a lot to me. It made me feel very *positive* about everything. All the internal strengthening really helped. I realised, *I can do it,* I can trust my instincts. From the moment that my contractions started, the images you used were going through my mind. It really helped. I *could choose to focus on these images* if things got really uncomfortable";
"The self-hypnosis helped me to focus on my breathing and *I did get through most of the labour without pain relief.* I withdrew completely within myself and was very much *in touch with my inner source of strength";*
"I feel it helped me to *relax* during labour, to *accept the labour pains* as one step closer to giving birth".
"It taught me *self-control.* I was rather unsure when I went into labour, but I was *surprised at myself for coping so well during labour* and the following days. It definitely helped me to have an *easier delivery* and to work with the doctor and nurses";
"I was definitely *more prepared for the delivery* and calmer about my ability to manage my baby. I have learned skills that I have since applied successfully,

especially during delivery, like relaxation and reminding myself that I have all the *internal resources to manage a situation successfully.* It definitely helps at times when I need patience. I will definitely recommend the programme to all mothers who would like to prepare themselves for having a baby";

"It helped me to remain *calm, especially when my baby had to go to ICU.* I never expected it to happen";

"The programme *helped me during the early stages of labour* while I was still at home. However, once I reached the hospital *I seemed to lose focus on the pain* and was not in control anymore. I did, however, have a very short labour and managed the first 6 hours of 8 ½ hours relatively easily on my own";

"I had to have an *emergency caesarean*, and without the programme I would not have *coped with changing my hopes* in less than 24 hours. I was shocked at first, then I *saw the positive side*, actually enjoyed my caesar and the birth of my baby very much".

These statements suggest that the women relied on hypnosis as a resource and a coping tool, although not necessarily exclusively for pain relief. It also proved helpful in enhancing positive affect and optimism during difficult deliveries, and provided the mothers with a sense of control. The women's remarks are also characterised by words and phrases utilised in the hypnotherapeutic programme, indicating that they have actually internalised some of the concepts of relaxation, inner strengths and coping resources.

A further prominent theme was that the programme, and self-hypnosis in particular, ***contributed to postnatal well-being*** as experienced in a sense of calm, control and relaxation. Self-hypnosis was described as a ***coping tool*** to be applied in a variety of situations:

"It taught me *calm and serenity.* Even when I experienced many tumultuous emotions inside, I was *capable of remaining in control. Inner calm brings perspective and solutions";*

"Today I still hold my baby, breathing deeply, *thinking calm thoughts, relaxing my body.* This seems to have a *calming effect on my baby*";

"I have *learned skills that* I have since applied successfully, like *relaxation* and reminding myself that I have all the *internal resources to manage a situation* successfully";

"I use the *relaxation technique* often and then it helps me to be *in control* and to realise that nothing is really that bad. It really helps me";

"I am much *calmer now* than I thought I would be. The programme made me realise that I do have the ability to *persevere*".

These statements suggest that the impact of the programme was wider than just the immediate experience of birth. Many women expressed beliefs of self-efficacy related to relaxing in difficult situations. They also implied a strengthened sense of generalised self-efficacy, as seen by the reference made to being in control and being able to handle different situations. From a salutogenic perspective, these comments further suggest that the mothers experience life as manageable and predictable. The comments indicate that the content of the hypnotherapeutic programme could have contributed to these enhanced experiences of psychological well-being.

Some of the mothers reported that the programme specifically ***made them aware of strengths and resources as well as a sense of increased maternal self-confidence:***

"All the *internal strengthening really helped*, I realised I can do it, *I can trust my instincts*";

"It made me feel much calmer and made me realise that I am *emotionally and physically stronger than I thought* and I *can cope very well with motherhood*";

"Inner calm brings perspective and solutions. Especially when I do not understand what my baby needs, I can remain calm and rational. When I focus inside, I *can manage situations*. It will be very *valuable in the years to come.*"

The comments of the mothers suggest that they experienced an enhanced sense of well-being, as related to their maternal self-confidence and maternal self-efficacy. Again, mothers implied that the current programme empowered them in a broader sense and that they experienced their perceived strengths and internal resources as something that could be applied over a longer period of time.

### 4.1.2 Conclusion

The qualitative remarks on the impact of the hypnotherapeutic intervention during the early postpartum period, confirm that it contributed to various aspects of psychological well-being in mothers in the experimental group. The most common theme was that mothers experienced themselves as better able to cope than they expected in labour and delivery. They further described self-hypnosis as a coping

tool that could be applied in various situations, suggesting an increased sense of generalised self-efficacy. Finally, mothers indicated that the intervention empowered them by making them aware of internal resources that could be utilised over a longer period, suggesting a strengthened sense of coherence.

## 4.2 Follow-up postnatal interview/essay (ten weeks postpartum)

### 4.2.1. Qualitative comments

The question asked was:
"What did participation in the programme mean to you at this time of your life?"

Most mothers indicated that they still used self-hypnosis as a ***coping tool***, to enable them to ***remain calm*** and to ***gather strength*** to deal with daily demands, as can be seen from the following remarks:

"It helped me to keep my emotions from running away with me, because I was able to *stop and go inside myself* a little and focus before things got out of hand";
"The programme helped me *when I was very tired or desperate*. Then I used the *relaxation techniques*. It helped a lot";
"I still use self-hypnosis, just to relax and it *helps me to see things clearer.* It is a wonderful *coping tool*";
"I still use hypnosis *when I am tired and I want to relax*. I think it makes things easier";
"This programme taught *me self-control and to cope in any difficult situation*. It also taught me *to stay calm*, which can be difficult when the baby is irritable. I would have appreciated it if my husband could also have participated in such a programme, since he feels left out at times and does not always know how to stay calm in a difficult situation. It would be wonderful if new moms and dads could participate in such a programme as standard procedure";
"The programme taught me to *calmly move through a problem*, to be *relaxed* and to tell my baby that I love her and will be there for her. I use my *coping skills* when I need to."

These mothers' comments suggest that they continued to use self-hypnosis even after a long period has elapsed since the initial intervention. By implication this

means that the intervention programme succeeded in providing new mothers with durable resources that they could continue to apply in their lives as mothers. These suggestions also imply a continued sense of generalised self-efficacy in dealing with daily demands.

A further theme that emerged was that mothers experienced themselves as being ***more aware of internal resources*** as well as a ***sense of personal growth:***

"At times when I was unsure and afraid, I could rely on the knowledge that *I have the inner strength to manage all situations*, even though it might take a bit of time to work it out. It is comforting to know that there are not always guidelines, and that you can trust your inner feelings. It really helped me when I had to have a caesarean section. Although I was not keen on it, I remained calm";

"I was very scared when I was pregnant. My mother and I have a few painful issues and I was scared I would not cope with pregnancy and would not love my baby. The programme *helped me to see a lot of things in perspective* and made me realise that I do have *good qualities within*, and *resources* that I could draw upon. I prepared for a natural labour but in 24 hours that had changed. Without the programme, I would have felt like a failure for having to have a caesarean. The *programme helped me to cope* and to embrace the change. I *saw the positive side* (i.e. having a healthy baby) and I am happy and proud of how things went";

"My baby has times where she just cries. My husband just says he does not know what to do. *Being a mother, I just know,* even if I can't explain it. She does not always stop crying immediately when I hold her. Before I was a mother, I was impatient with other babies, even panicky or angry. But now my tone of voice, my touch is calm, even if she cries until she's blue in the face. It is as if I move through the situation, remaining calm, it is *as if my whole being just "flows"*, and before long she is also calm and peaceful. *I remain calm* even if I feel upset deep inside. *I got patience from somewhere,* patience I did not have with other people's children".

The remarks indicate that these mothers experienced an increased sense of inner resourcefulness that was maintained well into the postpartum period. Some mentioned a more generalised sense of self-efficacy (feeling able to handle most situations), while others remarked on their confidence in the role of mother (e.g. soothing the baby). These comments can be seen as indicative of an increased sense of psychological well-being from a pragmatic perspective. One mother

experienced an enhancement in feelings of positive affect (feeling positive about a caesarean section).

Finally, one mother remarked that the programme enabled her to ***recuperate more swiftly*** after her caesarean section:
"It really helped when I had to have a caesarean section. Although I was not keen on it, I remained calm. I also think I recuperated swiftly, thanks to the programme".

### 4.2.2 Conclusion

The remarks of the mothers at ten weeks postpartum give some evidence regarding the impact of the hypnotherapeutic intervention in the longer term. In most cases, a minimum of three months had passed since the intervention, and yet most women remarked that they were still applying self-hypnosis as a coping tool. In addition, many women continued to experience a sense of growth and of the existence of internal resources, not only as mothers but also in other aspects of their daily lives.

## 4.3 Summary

The comments from mothers in the experimental group suggest that they experienced some benefits from participating in the programme. During the early postnatal period, mothers indicated that the programme assisted them in coping with labour and delivery, and contributed to their postnatal psychological well-being, and that they still used self-hypnosis as a coping tool. Later, at ten weeks postpartum, they evaluated the impact of the programme as providing them with coping tools, as well as enabling them to access internal resources and contributing to personal growth. The mothers' remarks during both evaluations further suggest that they experienced an enhanced sense of self-efficacy and more confidence in their roles as mothers. It was interesting to note that mothers continued to be aware of core aspects of the programme, such as relaxation, inner strength, and calm, even after months had passed since the intervention took place. It can therefore be concluded that the hypnotherapeutic programme contributed to enhanced psychological well-being, as reported by mothers in the subjective evaluation of the programme, and that the impact remained evident in the longer term.

## 5. CONCLUDING SUMMARY

Results from both the quantitative and qualitative studies give some support to the conclusion that the hypnotherapeutic programme contributed to improved postnatal psychological well-being of mothers in the experimental group.

From the quantitative data it can be concluded that the hypnotherapeutic programme was effective in enhancing psychological well-being related to motherhood, as reflected by an enhanced relationship with the baby and increased maternal self-confidence and maternal self-efficacy. These findings were also confirmed in the mothers' qualitative remarks. Although the quantitative results did not indicate any change in the perception of labour and delivery, mothers in the experimental group reported in the qualitative interview that they benefited from hypnosis during labour and delivery.

The results from the quantitative study further suggest that the hypnotherapeutic intervention resulted in a decrease in symptoms of depression and general symptomatology. This impact was less pronounced in the qualitative remarks of the mothers, but indirectly, references made to better coping and experiencing positive affect, imply the absence of pathology.

Finally, the within-group differences of the quantitative study showed an increase in general psychological well-being in mothers in the experimental group, as evident in increased life satisfaction, more positive affect, less negative affect, a strengthened sense of coherence and increased sense of generalised self-efficacy. In the qualitative remarks of mothers in the experimental group, the increased sense of coherence and generalised self-efficacy was most obvious.

It can be concluded from both the quantitative study, and the qualitative remarks from mothers in the experimental group, that the hypnotherapeutic programme that was aimed at enhancing strengths, and was developed from Ericksonian and ego state therapy perspectives, contributed to their enhanced psychological well-being in the postpartum period. Final conclusions and recommendations will be presented in Chapter 7.

# CHAPTER 7

# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

## 1. INTRODUCTION

In this chapter, the main conclusions regarding the literature review and development of the hypnotherapeutic programme will be presented, followed by the main results from the empirical study. Possible limitations of the study will be noted and recommendations will be made for future research.

## 2. CONCLUSIONS BASED ON A REVIEW OF THE LITERATURE

### 2.1 Facets related to early pregnancy, early motherhood and psychological well-being with a view to programme development

The first aim of this study was to explore and explicate the relevant literature on pregnancy, early motherhood and psychological well-being, in order to abstract important facets and perspectives to utilise as a background for the development and implementation of an intervention programme for the facilitation of psychological well-being in first-time mothers.

#### 2.1.1 Facets relating to pregnancy

From the literature it became clear that pregnancy can be described as a period of preparation for motherhood, associated by changes in the experience of self and interpersonal relationships (Lederman, 1996; Smith 1999). Specific important aspects during this period are role adjustments, such as the development of maternal identity (Rubin, 1984; Trad 1991), as well as the development of maternal attachment (Maldonado-Duran et al., 2000). It was concluded that both these aspects should be included in a prenatal intervention programme. Finally, the third trimester seems to be the most relevant period for intervention, since mothers are then more focused on

the imminent labour and the practical aspects of motherhood (Lederman, 1996; Zwelling, 2000a).

### 2.1.2 Facets related to childbirth

Childbirth elicits intense emotional experiences in a woman, making it an event of great psychological importance (Nichols, 1996; Nichols & Gennaro, 2000). It has been suggested that a positive experience of childbirth could contribute to feelings of mastery and satisfaction (Leifer, 1980), indirectly implying that such a positive experience could be associated with psychological well-being. However, little is known regarding the occurrence and facilitation of these positive emotions. Attention has frequently been given to measures of managing pain during labour and delivery, and there seems to be growing support for non-pharmacological measures such as relaxation (Humenick et al., 2000) and hypnosis (e.g. Hilgard & Hilgard, 1994; Oster & Sauer, 2000). In conclusion, a prenatal intervention aimed at promoting psychological well-being should also address the mother's preparation for labour and delivery, and equip her with the necessary tools to deal with the process in a way that promotes mastery, satisfaction and general psychological well-being.

### 2.1.3 Facets related to the postpartum period

The period following the birth of a baby has been described as a time of emotional upheaval for most women (Barclay et al., 1997; Miller, 2002). It is a time of transition, where the mother continues to assume the mothering role. This transition is a fluid process, rather than time-bound and discrete (Martell, 2001). The practical implication of nurturing a helpless infant has been described as a test for the mother's resources. Recent researchers have found that many mothers felt ill prepared for the demands of motherhood (Barclay et al., 1997; McVeigh, 1997). Literature from a pathogenic perspective suggests that aspects such as fatigue, self-confidence, psychological preparation and coping skills could impact on the emotional experience of early motherhood. There is continuing concern regarding postpartum depression and its effect on both mother and infant (Maldonado-Duran et al., 2000; Miller, 2002).

It can be concluded that the early postpartum period is characterised by both physical and psychological demands, and that few mothers feel equipped to deal with these demands. An intervention aimed at facilitating postnatal psychological well-

being should therefore include specific coping tools to assist mothers in meeting the demands of the early postpartum period.

### 2.1.4 Facets related to current prenatal preparation programmes

An overview of current childbirth preparation practices, such as the Dick-Read method and Lamaze classes, indicated that these programmes are mostly focused on providing practical information regarding childbirth and childcare, with less attention being given to psychological aspects (see Ondeck, 2000, for an overview). Hypnosis has been one approach in preparing mothers for childbirth, often resulting in the decrease or elimination of the use of medication for pain relief (e.g. Hilgard & Hilgard, 1994; Schauble et al., 1998). However, most hypnotherapeutic approaches have neglected psychological aspects of childbirth and the postpartum period, with the exception of Oster and Sauer (2000) and McCarthy (1998, 2001), who addressed concerns such as anxiety regarding labour and increasing satisfaction with the birth experience.

It was further evident that general childbirth education classes do not necessarily promote postpartum adjustment or psychological well-being (Lumley & Brown, 1993; Nichols, 1995), and that programmes aimed at promoting these aspects have not been widely implemented. There also seems to be an absence of knowledge regarding the utilisation of pregnancy and the postpartum period as a period for maintaining and promoting psychological well-being. It was concluded that a prenatal intervention aimed at promoting psychological well-being should give more attention to the general psychological aspects of the perinatal period, as well as the positive aspects associated with this developmental transition.

### 2.1.5 Facets regarding psychological well-being

#### 2.1.5.1 Theoretical perspectives on psychological well-being

The field of psychology has generally been associated with a focus on pathology, also called the pathogenic orientation (Strümpfer, 1990), where the emphasis was mostly on illnesses and vulnerabilities. In recent years a new paradigm has started to emerge, characterised by a focus on wellness and health in contrast to the traditional focus on pathology (Strümpfer, 1990, 1995; Wissing , 2000), and research in the field of psychological wellness is burgeoning (Ryan & Deci, 2001).

One of the first researchers who proposed the study of health instead of disease, was Antonovksy (1979, 1987). He coined the phrase "salutogenesis", referring to the origins of health. Since Antonovksy's concept was focused mostly on physical health, Strümpfer (1990; 1995) proposed the concept of "fortigenesis", meaning the "origins of strengths". Later Wissing (2000) suggested using the term "psychofortology" (the science of psychological strengths) to refer to the scientific domain within which psychological strengths could be studied. This is what Seligman and Csikszentmihalyi (2000) refer to as "positive psychology". It was concluded that this *emerging salutogenic and fortigenic paradigm* provides a relevant theoretical perspective from which to study psychological well-being in new mothers, since childbirth remains a life-changing event that has the inherent potential to facilitate psychological wellness and growth.

A review of the literature regarding psychological well-being indicated that there are several perspectives on psychological well-being, that provide different contributions to the understanding of psychological well-being. Some models are focused on the structure of psychological well-being, and others refer to the dynamics of psychological well-being.

- *Models related to the structure of psychological well-being*

Models on the structure of psychological well-being may be divided in three clusters. The first group defines psychological well-being in terms of the subjective experience of happiness **(hedonic perspective)**, as seen in research on subjective well-being (e.g. Diener, 2000), focusing on life satisfaction and the preponderance of positive affect over negative affect. Another cluster defines psychological well-being more with reference to values, meaningfulness, needs and personal growth **(eudaimonic perspective)**. This perspective is evident in research on psychological well-being done by Ryan and Deci (2000) as well as Ryff and her colleagues (Ryff & Keyes, 1995; Ryff & Singer, 1996, 1998). The concept of sense of coherence (Antonovksy, 1979, 1987) can also be seen to be related to an eudaimonic perspective on psychological well-being.

The third cluster **(pragmatic perspective)** sheds light on the role of self-efficacy beliefs in behaviour and behavioural outcomes (e.g. Bandura, 1977, 1997a, 1997b). This cluster has not been studied extensively as part of previous research on psychological well-being, but it has been maintained that a strong sense of self-

efficacy could be related to a higher sense of psychological well-being (Carver & Scheier, 1999; McGregor & Little, 1998; Wissing & Van Eeden, 2002). It was concluded that each of these models contributed to the understanding of psychological well-being, and that facets of all three could be included in a study investigating psychological well-being.

- *Models related to the dynamics of psychological well-being*

Models related to the dynamics of psychological well-being are useful in exploring the role between stressors and well-being (e.g. Kumpfer, 1999; Moos, 1994) and the role of positive emotions in well-being (Frederickson, 1998, 2000, 2001).

According to Moos (1994), environmental stressors and resources, as well as individual factors and life experiences, have an impact on the individual's cognitive appraisal of a situation. Consequently this will determine the selected coping strategy, which in turn influences the degree of well-being or dysfunction manifested in the individual. In the context of Moos's model, pregnancy and early motherhood can be seen as a developmental transition. Adaptation to this life event will depend on appraisal and coping responses, and can eventually lead to enhanced psychological well-being.

Kumpfer's (1999) model provides a framework for understanding how the transition to motherhood can be viewed as a challenge that could promote psychological growth. Specifically, the domain of internal self-characteristics described by Kumpfer (1999), could possibly be enhanced by means of a hypnotherapeutic intervention, resulting in successful adaptation to motherhood.

Finally, Frederickson (1998, 2000, 2001) maintain that experiences of positive emotions broaden people's momentary thought-action repertoires, resulting in the building of enduring personal resources. These resources could range from physical and intellectual resources, to social and psychological resources (Frederickson, 2001). In the context of the current study, an intervention programme should therefore emphasise the experience of positive emotions. It was concluded that the models on the dynamics of psychological well-being further broaden the understanding of the concept in the current study, and that Frederickson's broaden-and-build theory is exceptionally useful as a background for the current study.

Conceptualisation and operationalisation of psychological well-being in the current study was done against the background of the psychological aspects of the perinatal period, as well as the background of theoretical perspectives on psychological well-being. Accordingly, psychological well-being in the current study was operationalised and explored in terms of three clusters, which will further be explicated.

#### 2.1.5.2 Aspects of psychological well-being related to early motherhood

The following aspects of psychological well-being related to early motherhood were explored.

- *Perception of labour and delivery*

Findings from the literature indicated that a woman's experience of labour could impact on her experience of psychological well-being (Maclean, McDermott & May, 2000). Prenatal expectations of labour seem to influence the actual experience of labour (Green, Coupland & Kitzinger, 1990), therefore it was concluded that intervention during pregnancy, aimed at enhancing a positive expectation of labour and delivery, could play an important role in preventing pathology and promoting psychological well-being in general. Perception of labour and delivery was measured by a scale adapted from the Childbirth Perceptions Questionnaire (Padawer et al., 1988)

- *Experience of relationship with baby*

The development of maternal attachment has been described as an important task of motherhood (Leifer, 1980; Mercer, 1986). Studies from a pathogenic perspective have indicated that depression, anxiety and lack of support during pregnancy could have a negative effect on prenatal attachment (Condon & Corkindale, 1997). Since prenatal attachment has been found to be a predictor of postnatal attachment (Green & Kaftersios, 1997; Leifer, 1980), it was concluded that a prenatal intervention programme should focus on facilitating both prenatal and postnatal attachment. This aspect of psychological well-being was measured by a scale developed for the current study, based on research done by Woollett and Parr (1997).

- *Maternal self-confidence*

Literature regarding the role of maternal self-confidence in the experience of psychological well-being is lacking. The available literature suggests that prenatal experience of maternal self-confidence could influence postnatal maternal self-confidence (Pond & Kemp, 1992) and that depressed mood could have a negative effect on maternal self-confidence (Fleming et al., 1988). These findings imply that a prenatal intervention should aim at facilitating and promoting maternal self-confidence. Maternal self-confidence was measured by using a subscale from the Childbirth Attitudes Questionnaire (Ruble et al., 1990).

- *Maternal self-efficacy*

Maternal self-efficacy can be described as feelings of efficacy in the maternal role (Teti & Gelfand, 1991). It has been indirectly associated with psychological well-being, since maternal self-efficacy was found to be a mediating variable in the development of depression in mothers of infants (Teti & Gelfand, 1991). However, little is known regarding the role of maternal self-efficacy in a broader conceptualisation of psychological well-being. In this study, maternal self-efficacy was included in a pragmatic perspective on psychological well-being in new mothers. This aspect was measured by using selected items from the Maternal Self-Efficacy Scale (Teti and Gelfand, 1991).

2.1.5.3 Aspects of psychological well-being related to the absence of pathology

A large body of research has been done regarding the prevalence of psychopathology during pregnancy and in the postpartum period. The focus has mostly been on depression.

- *Depression during pregnancy*

Depression during pregnancy has recently been receiving more attention. A study by Evans et al. (2001) found prenatal depression to be common, and prenatal self-reported scores for depression were found to be higher than in the postpartum period. It has been suggested that depression during pregnancy could spill over into

the postpartum period (Beck, 2001; Maldonado-Duran et al., 2000). These findings imply that an effective prenatal intervention programme could contribute to the alleviation of current distress and prevent the escalation thereof in the postpartum period (Miller, 2002).

- *Postpartum depression*

Research on postpartum depression is voluminous, and it remains to be an area of concern for clinicians. Although there is still debate whether postpartum depression is a distinct syndrome, it is viewed as a serious disorder (Boath & Henshaw, 2001), having considerable impact on mothers' adjustment and interpersonal relationships (O'Hara et al., 1990). Although there is no single approach to the treatment of postpartum depression, some empirical studies suggest that postpartum depression could be prevented by brief interventions during pregnancy (Elliot et al., 2000; Miller, 2002). In the context of psychological well-being, the absence of symptoms of prenatal and postpartum depression could be seen as suggesting a stronger sense of psychological well-being.

These aspects of psychological well-being were measured by the Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987) and the General Health Questionnaire (Goldberg & Hillier, 1979)

2.1.5.4 Aspects related to general psychological well-being

- *Life satisfaction*

Satisfaction with life can be described as a cognitively based or a rational evaluation of well-being (Diener et al., 1999). It is based on an individual's own criteria (Diener, 2000), and has been associated with the frequency of positive emotions (Emmons & Diener, 1985) as well as self-esteem and optimism (Lucas, Diener & Suh, 1996). The reviewed literature showed an absence of information on satisfaction with life during childbearing, yet researchers working in the field of psychological well-being (e.g. Wissing & Van Eeden, 2002) have found life satisfaction to be an important component of psychological well-being in general. It was concluded that life satisfaction among new mothers should be investigated in the current study, to achieve an understanding of psychological well-being as seen from their own subjective evaluation. Further, an evaluation of life satisfaction added to the hedonic

perspective on psychological well-being, as explored in the current study. Life satisfaction was measured by means of The Satisfaction with Life Scale (Diener et al.,1985).

- *Affect balance*

The presence of positive affect, together with the absence of negative affect, has often been used to describe a component of subjective well-being (Diener, 1984; 2000; Diener & Larsen, 1993; Ryan & Deci, 2001). However, it is the balance between positive and negative affect, with preponderance of positive affect, that is important, rather than the complete absence of negative affect (Diener & Larsen, 1993). There are some indications in the literature that both positive and negative affect could play a part in postpartum psychological well-being (Black-Olien, 1993; Dimitrovsky, Lev & Itskowitz, 1998; Priel, Gonik & Besser, 1993). However, there is still limited knowledge regarding the nature of the affect balance in childbearing women. Since a healthy affect balance has been associated with more positive psychological well-being (Wissing & Van Eeden, 2002), it was included as an important construct in the current study. Affect balance was measured by the Affectometer 2 (Kammann & Flett, 1983).

- *Sense of coherence*

A person's sense of coherence has been described as the extent to which one has an ongoing feeling of confidence that internal and external stimuli are predictable, structured and explicable, that one has resources to cope with challenges, and that there is some sense or meaning in taking up these challenges (Antonovsky, 1987). It has been suggested that a strong sense of coherence may contribute to effective management of stressful life circumstances (Antonovksy, 1979), making it a relevant aspect to consider in investigating psychological well-being in the transition to motherhood.

No literature could be found regarding sense of coherence, pregnancy and early motherhood. However, literature on the construct of sense of coherence suggest that a strong sense of coherence may promote the mobilisation of generalised resistance resources to facilitate effective coping (Antonovksy, 1979). Further, Strümpfer (1995) stated that a strong sense of coherence could continue to be strengthened

during developmental transitions, thereby contributing to psychological well-being. The concept of sense of coherence was included in the operationalisation of psychological well-being in the current study, since it has previously been found that a strong sense of coherence could be related to enhanced psychological well-being (Wissing & Van Eeden 2002). Its inclusion further added an eudaimonic perspective to exploring psychological well-being. This aspect of psychological well-being was evaluated by means of the Sense of Coherence Scale (Antonovsky, 1979).

- *Generalised self-efficacy*

Generalised self-efficacy has been described as a broad and stable sense of personal competence to deal effectively with a variety of situations (Schwarzer, 1993). Little research has been done regarding the role of generalised self-efficacy during childbearing. A moderate sense of self-efficacy has been found to be related to a more positive experience of motherhood (Mikus, 1981, cited by Antonucci & Mikus, 1988). From the field of psychological well-being in general, it has been found that feeling competent and confident with respect to important goals is associated with enhanced well-being (McGregor & Little, 1998). The concept of generalised self-efficacy was therefore included in the current operationalisation of psychological well-being. It can further be seen as part of exploring psychological well-being from a pragmatic perspective. Generalised self-efficacy was measured by the Generalized Self-Efficacy Scale of Schwarzer And Jerusalem (1995) in the current study.

With these conclusions the first aim has been obtained.

## 2.2 Relevant facets of clinical hypnosis as therapeutic intervention strategy, with a view to programme development

The second aim was to explicate theoretical perspectives on, and practical applications of, clinical hypnosis, as a background for the development of a hypnotherapeutic intervention aimed at maintenance or facilitation of psychological well-being in first-time mothers.

### 2.2.1 Hypnosis defined

Hypnosis was defined as a procedure during which a health professional or researcher suggests that a client experiences changes in sensations, perceptions, thoughts or behaviours (Kirsch, 1994). However, there is no single explanatory model of hypnosis to account for all the various facets of hypnosis. Further, several clinical approaches to hypnosis exist. In the current study, two of these approaches, namely the Ericksonian approach and ego state therapy, were selected.

### 2.2.2 The Ericksonian approach

The Ericksonian approach to hypnotherapy is characterised by the principles of utilisation, the uniqueness and resourcefulness of every person, the fact that hypnosis potentiates resources, a teleological orientation, permissiveness, indirection, multilevel communication, and accepting the unconscious mind to be positive and generative (Battino, 1999a, 1999b; Frederick & McNeal, 1999; Gilligan, 1987; Yapko, 1992, 1995; Zeig & Rennick, 1991). Walters and Havens (1993,1994) have noted that the Ericksonian approach to hypnotherapy could play an important role in the evolving salutogenic paradigm, finding several similarities between Ericksonian principles and this paradigm.

Within the Ericksonian approach to hypnotherapy, hypnotic phenomena are extensively used to reach therapeutic goals. In the context of the current study, the most commonly experienced hypnotic phenomena were described and it was suggested how these phenomena could be utilised in a prenatal hypnotherapeutic intervention. It was concluded that the Ericksonian approach, with its emphasis on the resourcefulness of clients, utilisation of inner resources and orientation towards both the present and the future, could provide a therapeutic orientation from which to develop a hypnotherapeutic programme aimed at promoting and maintaining psychological well-being.

### 2.2.3 The ego state therapy approach

According to the ego state therapy model, the psyche is not a homogeneous whole, but is composed of distinguished parts specific to the individual (Emmerson, 2000). These parts are referred to as ego states. Phillips and Frederick (1995) stated that ego states are energies within the greater personality and that they are adaptational.

Later Frederick and McNeal (1999) referred to "conflict-free" ego states that could be utilised as internal resources.

Hartman's (2002) utilisation model of ego state therapy was presented as theoretical foundation for the development of the proposed hypnotherapeutic programme. Hartman (2002) integrated the utilisation approach characteristic to the Ericksonian perspective with the ego state therapy approach and methods of Watkins and Watkins (1997), resulting in a dynamic model based on ten pivotal points.

Within the context of ego states as potential resources, ego-strengthening has often been used as a technique in ego state therapy. According to Frederick and McNeal (1993), ego-strengthening techniques increase the interplay between positive, helpful aspects of the personality. Direct suggestion, imagery, and projective ego-strengthening were described as some of the techniques that could be used in ego-strengthening. Specific techniques that were utilised in the current study, were the Inner Strength technique, Inner Advisor technique and the Inner Love technique (Frederick & McNeal, 1999). It was concluded that ego-strengthening techniques could be instrumental in the promotion and maintenance of psychological well-being, and therefore ego-strengthening was extensively utilised in the development of the prenatal hypnotherapeutic programme.

### 2.2.4 The use of hypnosis in obstetrics

A survey of literature indicated that hypnosis has extensively been applied in obstetrics, but the focus was mainly on preparation for labour, and specifically for pain relief during labour and delivery. Only recently did authors such as McCarthy (1998, 2001) and Oster and Sauer (2000) begin to address psychological processes during pregnancy and childbirth. Empirical studies regarding the effect of hypnotherapeutic intervention during pregnancy were limited to studying birth outcomes such as length of labour and amount of analgesia required (e.g. Harmon, Hynan & Tyre, 1990; Jenkins & Pritchard, 1994), which leaves a dearth of information regarding the effect of hypnosis on aspects such as postpartum mood, psychological experience of delivery or the relationship between mother and baby. Further, all the reviewed outcome studies focused only on the immediate postpartum period, resulting in limited knowledge regarding the effects of prenatal hypnotherapeutic intervention in the longer term. Irving and Pope (2002) recently reviewed existing literature on the effect of hypnosis during childbirth preparation, and concluded that

more rigorous research was needed to verify the benefit of hypnosis in postnatal psychological outcomes. In the current study, it was concluded that more research is needed regarding the role of hypnosis in addressing psychological aspects of obstetrics in a wider sense.

The analysis of literature on the use of clinical hypnosis for current purposes provided clear guidelines for programme development, thus the second aim has been obtained.

## 3. PROGRAMME DEVELOPMENT

The third aim was to develop a hypnotherapeutic programme based on existing theoretical knowledge regarding pregnancy, childbirth and early motherhood, as well as clinical hypnosis, with specific emphasis on Ericksonian principles and ego state therapy techniques.

An intervention programme was developed, based on existing knowledge regarding pregnancy and early motherhood, psychological well-being and hypnosis. The focus of the programme was on activating and utilising existing inner resources within the context of Ericksonian and ego state therapy approaches. The programme consisted of detailed scripts for six individual sessions, each with a specific focus, namely:

- Guiding toward self-hypnosis and commencing ego-strengthening;
- Further facilitation of inner resources by means of ego-strengthening;
- Facilitating the experience of labour and delivery;
- Facilitating bonding and development of motherhood identity;
- Facilitating postpartum well-being; and
- Meeting individual needs.

Specific objectives and expected outcomes were set for each session.

With the completion of this programme the third aim of this research was obtained.

## 4. PROGRAMME EVALUATION

The fourth aim was to evaluate the effect of the hypnotherapeutic programme by means of an empirical study.

The effect of the hypnotherapeutic programme on the psychological well-being of first-time mothers was evaluated by means of a two-group pretest-posttest-follow-up comparative design, as indicated by aspects such as perception of labour and delivery, experience of relationship with their babies, level of maternal self-confidence and maternal self-efficacy, levels of depression and symptomatology, levels of life satisfaction, affect balance, sense of coherence and experience of general self-efficacy. All selected measuring instruments manifested good Cronbach reliability indices.

The main findings and conclusions from the empirical study are the following:

### 4.1 Aspects of psychological well-being related to early motherhood

The hypnotherapeutic programme contributed to a significant improvement in mothers' experience of their relationships with their babies, maternal self-confidence and maternal self-efficacy, both at two weeks postpartum and at ten weeks postpartum, when differences between prenatal and postnatal scores within the experimental group were calculated. The programme did not have an effect on their perception of labour and delivery.

When differences between the experimental and control groups were examined, it was evident that the hypnotherapeutic programme had contributed to a significant increase in psychological well-being, as related to mothers' experience of their relationship with their babies and maternal self-confidence at two weeks postpartum. At ten weeks postpartum, there were no differences between the two groups, and mothers in the control group actually improved on these measures on their own.

From the qualitative data, the strongest theme that emerged was that mothers felt that the programme assisted them in coping with labour and delivery, by using their inner strengths. The comments of the mothers also suggested that they experienced

an enhanced sense of well-being, as experienced in an increased sense of maternal self-confidence and maternal self-efficacy.

It can be concluded that the hypnotherapeutic intervention enabled mothers in the experimental group to adjust to specific aspects of motherhood sooner than the control group, resulting in an accelerated experience of psychological well-being.

## 4.2 Aspects of psychological well-being related to the absence of pathology

The hypnotherapeutic programme had a significant effect on the decrease of depression at two weeks postpartum as well as ten weeks postpartum, when differences in mean scores within the experimental group were calculated. In contrast, the control group only showed a decrease in depression at ten weeks postpartum. Further, the experimental group did not exhibit a significant decrease in general symptoms of pathology at two weeks postpartum, but it was evident at ten weeks postpartum. The control group showed no change in general symptoms of pathology at either evaluation, although their mean score at two weeks postpartum suggested an increase in general symptomatology.

When the differences in mean scores between the two groups were calculated, it was evident that the hypnotherapeutic intervention contributed to a decrease in depression and symptoms of psychopathology both at two weeks postpartum and at ten weeks postpartum. The absence of symptoms of pathology is generally associated with enhanced psychological well-being. Results from the qualitative component indicate that mothers in the experimental group experienced a stronger sense of positive affect, and generally felt that they were coping well with their current life situation, which could be viewed as indirect evidence of decreased depression and psychological distress.

It can therefore be concluded that the hypnotherapeutic programme, with its emphasis on eliciting strengths and resources, was effective in increasing postnatal maternal psychological well-being as evident by the absence of pathology. This is an important finding since the experimental group had shown significantly more symptoms of psychopathology and depression during the prenatal evaluation.

## 4.3 Aspects related to general psychological well-being

Results of the empirical study suggest that the programme contributed to a significant improvement in mothers' life satisfaction at two weeks postpartum, as seen by the significance of differences within the experimental group between prenatal and postnatal scores. There also was a marked increase in their experience of a healthy affect balance, with a preponderance of positive affect over negative affect. These findings lend support to enhanced psychological well-being from a hedonic perspective. The programme also seemed to have contributed to a strengthened sense of coherence at two weeks postpartum, which is generally accepted to be a good indicator of general psychological well-being. This indicates enhanced psychological well-being from an eudaimonic perspective. Finally, the current study suggests that the hypnotherapeutic programme contributed to a stronger sense of generalised self-efficacy, indicating enhanced psychological well-being from a pragmatic perspective. In contrast, the control group did not exhibit any changes on the variables of psychological well-being at two weeks postpartum.

At ten weeks postpartum, the differences in mean scores between prenatal and postnatal evaluation within the experimental group was significant with regard to life satisfaction, affect balance and sense of coherence. At this stage, the control group now also showed an improvement regarding the sense of coherence.

When differences between the mean scores of prenatal and postnatal evaluation are considered, it is evident that the experimental group showed a significant increase in all measures related to general psychological well-being at two weeks postpartum, when compared to the control group. However, at ten weeks postpartum, differences between the two groups were not significant.

Results from the qualitative component of the study give strong support of the enhancing effect of the programme on the psychological well-being of mothers in the experimental group, both in the immediate postpartum period and in the longer term. Many mothers described self-hypnosis as a coping tool which they continued to use even after a long period had elapsed since the initial intervention. By implication this means that the intervention programme succeeded in providing new mothers with durable resources that they could continue to apply in their lives. There were also

evidence of an increased sense of generalised self-efficacy as well as an increased sense of personal growth and meaningfulness.

It can be concluded that the hypnotherapeutic intervention contributed to enhanced psychological well-being in the experimental group at two weeks postpartum, and that this was maintained at ten weeks postpartum, even though scores did not differ significantly any longer from those of the initially stronger and more resilient control group. The basic hypothesis set in Chapter 1 can therefore only be accepted with regards to certain aspects of psychological well-being at two weeks postpartum, namely feelings about and relationship with the baby, maternal self-confidence, levels of depression and symptomatology, levels of life satisfaction, affect balance, sense of coherence and experience of general self-efficacy. The hypothesis can also only be accepted with regard to levels of depression and symptomatology at ten weeks postpartum.

With completion of the empirical study, the fourth aim was obtained.

## 5. LIMITATIONS OF THE CURRENT STUDY

The main limitation of the current study was the lack of complete random assignment of participants to the experimental and control groups, and the relatively small number of participants in each group, which suggests that caution should be applied in generalising the results. Secondly, probably because of the above, the groups were not completely equal with respect to psychological well-being during the prenatal evaluation. Another limitation concerns the content of the hypnotherapeutic programme. With the focus being mostly on the preparation for the immediate postpartum period, perhaps too little attention was given to promoting well-being later on in the postpartum period, resulting in less significant differences between the experimental and the control group at the follow-up evaluation.

# 6. RECOMMENDATIONS

## 6.1 Recommendations for clinical practice

The following recommendations for clinical practice are made:

1. Since current childbirth preparation practices lack a broader psychological component in the preparation for birth and early motherhood, and the current study has proved to be effective in enhancing psychological well-being in early motherhood, more attention should be given to this aspect in general childbirth education. There is a wealth of possibilities for the co-operation of professionals working in obstetric care (nurses, midwives and obstetricians) and psychologists, to ensure that new mothers experience enhanced psychological well-being in the transition to motherhood, as well as to ensure more positive birth outcomes in general, such as decreased incidence of caesarean sections and less use of medication.
2. The identification, treatment and prevention of postpartum depression remain an ongoing concern for professionals working with women in the childbearing years. The current study revealed that an intervention aimed at enhancing psychological strengths could both alleviate symptoms of depression, and prevent the escalation of depression during the postpartum period. A wider implementation of similar interventions with pregnant women is recommended as treatment for prenatal depression and prevention of postnatal depression.
3. More attention should be given in clinical practice to the building and facilitating of psychological strengths. Although clients more often than not present with symptoms of pathology, a salutogenic and fortigenic orientation to psychotherapy could enhance general psychological well-being and provide clients with skills to contribute to the decreasing distress and preventing the exacerbation of symptoms, as seen by the results in the current study.
4. Current hypnotherapeutic interventions lack a focus on more positive aspects of psychological functioning, and are often geared towards ameliorating pathological aspects rather than promoting growth. It is recommended that more attention be given to these positive aspects, which would open up more possibilities in the application of hypnotherapy.
5. Finally, the term "hypnotherapy" is generally applied to refer to the therapeutic application of hypnosis. However, in the current study, the intervention was

aimed at a population of women within a specific developmental phase, who did not necessarily present with psychopathology. Instead of referring to this type of intervention as a hypnotherapeutic programme, consideration should be given to the development of a new term. A term such as "hypno-facilitation" could be considered for interventions aimed at enhancing psychological strengths and internal resources, in accordance with a fortigenic perspective versus a pathogenic perspective.

## 6.2 Recommendations for further research

1. Further research using larger groups is needed to elaborate on the current findings.
2. More research needs to be done to fully understand the nature and manifestation of psychological well-being during pregnancy and early motherhood, since most of the current literature emphasises a pathogenic perspective, whereas a fortigenic perspective could be more empowering.
3. The current programme could be elaborated on, with the aim of facilitating longer-term psychological well-being, as well as continuing with reinforcing hypnotherapeutic interventions at various intervals during the first postpartum year.
4. Finally, there is a need within the field of Ericksonian and ego state therapy approaches for empirical studies regarding the effectiveness of these approaches. Further empirical research is needed to promote and sustain Ericksonian and ego state therapy approaches in the scientific domain.

# 7. CONTRIBUTION OF THE STUDY

The current study contributed to new knowledge on a theoretical level, and opened up new perspectives on the application of theory on a practical level:

1. The current study contributed to the knowledge of more positive aspects of psychological functioning during pregnancy, childbirth and early motherhood, since there is still a lack of knowledge regarding these facets within the transition to motherhood. It is the first study, to the current author's knowledge, to extensively focus on the perinatal period from a salutogenic and fortigenic perspective.

2. Findings from the current study could contribute to the enhancement and maintenance of psychological well-being in new mothers, especially if the programme is incorporated into childbirth education classes. In this sense, the study could broaden the understanding of professionals in the fields of nursing, midwifery and obstetrics.
3. The study makes a contribution to the domain of psychofortology, by providing evidence that the enhancement of psychological strengths in a specific target group (first-time mothers) could lead to increased psychological well-being.
4. Results of the current study provides evidence for a different approach in alleviating depression during pregnancy and the postpartum period, namely by means of enhancing psychological strengths and coping resources through a hypnotherapeutic intervention based on Ericksonian and ego state therapy approaches.
5. The study has widened the scope and application of hypnotherapy in obstetrics, by addressing broader psychological aspects related to childbearing. It has also verified the anecdotal evidence of McCarthy (1998, 2001), that prenatal hypnotherapeutic preparation for childbirth could prevent the development of postpartum depression
6. The study has contributed to the scientific and clinical understanding of hypnosis. Specifically, in the field of Ericksonian and ego state therapy approaches, very little empirical research has been done. Matthews (2000) has emphasised that a need exists for empirically based research to test the efficacy of Ericksonian therapy. In general, clinical anecdotes and uncontrolled single case studies are common in Ericksonian literature. The current study therefore delivers a contribution to the empirical exploration of the application of Ericksonian approaches to hypnotherapy. It is also is one of the first studies to the current author's knowledge, to empirically assess the effect of specific ego-strengthening techniques.
7. Finally, on a theoretical level, the study has contributed to an expanded application of the Ericksonian approach and ego state therapy, by embedding them in a fortigenic meta-perspective. The study has thereby opened up possibilities for a broader application of hypnotherapy, going beyond the treatment of existing pathology, and focusing on promoting and maintaining psychological health and well-being. On a practical level, it provides an empirical evaluation of a strengths-based intervention to maintain and promote psychological well-being.

## 8. CONCLUDING REMARKS

During the study I was privileged to share a private and momentous experience in the lives of a group of women. It made me realise that we all have so much more resources than we thought we had, to cope with challenges and opportunities in life. It also repeatedly filled me with wonder about the miracle of life.

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