CHILDBIRTH AS A PROFOUND EXPERIENCE: EXPLORING NARRATIVE AND IMAGE OF EXPERIENCES DURING BIRTH

by

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A Dissertation Submitted to the Faculty of

the California Institute of Integral Studies

in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy in Transformative Studies

California Institute of Integral Studies

San Francisco, CA

2014

CERTIFICATE OF APPROVAL

I certify that I have read CHILDBIRTH AS A PROFOUND EXPERIENCE: EXPLORING NARRATIVE AND IMAGE OF EXPERIENCES DURING BIRTH by Jennifer A. Schwartz, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Transformative Studies at the California Institute of Integral Studies.

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ABSTRACT

This study is an exploration into the profound, life-altering experiences that a small sampling of mothers had while giving birth. The primary question addressed is **"**What is the nature of experiences that can occur for the mother during childbirth?" A group of 15 mothers in the United States was asked to share the experiences they had during childbirth, highlighting those elements that they define as profound, spiritual, transformational, and/or empowering.

The research was conducted as a narrative and visual arts inquiry, using an initial survey, semi-structured interviews, and an art creation process to produce visual expressions of experiences. Also included is an autobiographical element created from the researcher's experiences of childbirth. While the individual experiences varied, the stories revealed eight general themes that are explored using elements of the narratives and a coding of the art images, resulting in several trends. Through narrative and art, the individual experiences of the mothers are shared, emergent themes are analyzed, and a larger picture of profound childbirth experiences is shown.

The nature of profound experiences during birth is highlighted in this study, as are the universal elements of birth.

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The analogy of birth was pivotal in my dissertation process, not only because I gave birth during the time that I was doing the research, but also because I was reminded constantly of the labor of love that creating a dissertation truly is. While this "pregnancy" was much longer than nine months, I was surrounded by midwives of all sorts on every side.

My first thanks go to my dissertation committee (see Appendix A). Susan, thank you for always being gracious as my timelines changed. Robbie and Arisika, thank for you seeing the importance and beauty of this project even before it started. I also have a great appreciation for each of the therapists who agreed to go on record in case there were problems for any of the mothers. Thankfully, there were not, but I was glad to know that someone had my back everywhere I went in this country.

Many, many thanks go to my mother, who not only brought me into this world herself, but was my travelling companion for most of the interviews, babysitter for my youngest while I met with mothers, an outstanding editor, and the biggest cheerleader I could ever have asked for. We travelled over 17,200 miles together by car, plane, and camper, and once she figured out how desperately I need my morning coffee, we never had a fight.

My own boys deserve so much gratitude. Without the experiences of their births I would never have found this path, and each of them continue to bring joy, love, and their own personal teachings into my life on a daily basis. My eternal love and gratitude go to each of you: to Corbin who taught me that living for

another was more important than living for myself; to Gabe who taught me that things rarely go the way they are “supposed” to go, and that it’s really okay; to Athan who taught me that sometimes teaching others is the most important thing one can be doing; and to Talysen, who taught me that leaning on others is the best gift you can give yourself.

Last but not least, my gratitude to Craig for starting me on this journey, and to Joseph for making sure I stayed in the race and made it to the finish line. Joseph, you are my rock, and I love you more than words!

Chapter 1: Introduction

> Babies come out one way or another. But what if it's about something bigger than that? – Meagan

Inquiry and Questions

This study seeks to highlight women's voices and women's experiences from a feminist perspective, with the aim of empowering all women to make conscious choices before and while giving birth. Women were asked to share narratives of their birth experiences and to create art pieces related to those experiences as part of the inquiry.

What is the nature of profound experiences that occur for the mother during childbirth?

- What circumstances or factors are associated with these experiences?
- How do women experience these life-changing moments?
- Are there themes common among the narratives and art collected or is each experience unique?

Context for This Study

Childbirth in the culture of the United States has undergone many changes over time. In the current culture, birth happens primarily in hospitals, where it is managed by medical doctors and is seen mostly as a physical event. As more women speak about the non-physical aspects of childbirth, the context in which birth is held is shifting.

This study exists in the context of postmodern third-wave feminism. Appignanesi and Garratt (2007) state that the options of liberal feminism were to coexist with men (accept the roles women had been given, as they begin shifting) or come out against men (fight the given roles and the men who had given them). In practice, as a result of liberal feminism, both of these things happened in what is now known as the first and second

waves of feminism. During the late 19th and early 20th centuries, the first wave of feminism focused on suffrage and opening up opportunities previously only available to men. Many scholars indentify the Seneca Falls Convention of 1848 as the beginning of this wave of feminism. Led by a group of Quaker women and Elizabeth Cady Stanton, the convention resulted in a declaration signed by approximately 100 of the 300 attendees, demanding women's right to vote, as well as equal rights to education, property and jobs, and in their families (Halsall, 1997). During this time, the landscape of childbirth was changing. As midwives began to be replaced by male midwives and doctors, disdain for women was growing. According to Wertz and Wertz (1989) a study of reports from a Boston maternity ward in the 1890's found notes referring to mothers as "too stupid or too lazy to deliver by themselves" (p. 139). This negativity towards women and the distrust of the natural birthing process was beginning to take hold in American hospitals.

The second wave of feminism dates to the 1960s and continued through the 1990s. Public expressions of this included women and their male supporters protesting beauty pageants, calling them oppressive and degrading (Rampton, 2008). Unlike the first wave of feminism, which was primarily (but not exclusively) spearheaded by white, middle-class women, the second wave of feminism attracted more women of color and those from diverse economic standings, even though the white mainstream feminist movement was overwhelmingly focused on gender oppression, while feminists of color explored multiple areas of oppression as targets of racism, sexism, and classism. The main focuses of this era of liberal feminism were employment and wage equality, access to what were considered male roles in the workplace, women's reproductive rights and

freedoms, and putting an end to sexism of all kinds. Women's study programs, and an explosion of writing regarding women's issues such as education, health care, government policies, violence and sexual abuse, to name a few, were a result of this second wave of feminism. This widening of career choices has played out in birth, as the politics of second-wave feminism opened the doors for women to enter careers in the medical field beyond that of being a nurse. By 2003, more than half of all medical school applicants in the United States were women, and 74% of OB/GYN residents were female (Groves, 2008, para. 9). While more women began to choose female obstetricians and female nurse practitioners as their primary caregivers, it was stereotypical feminine characteristics such as empathy, nurturing, ability to relate, etc., rather than gender, for which they were actually looking (Schnatz, Murphy, O'Sullivan & Sorosky, 2007).

Postmodern feminists, who are part of the third wave of feminism, instead celebrate the differences between men and women and embrace women not as the "other" but as part of the "all" (Ebert, 1991). The idea of clearly defined differences between the sexes has become more blurred. While second-wave feminists wanted to free women from the chains of domesticity, third-wave feminists see motherhood as one of many possible career choices. Generally, it is the idea of transversity—the respect for both feminine and masculine attributes and the diversity of men and women—that defines the current wave of feminism (Krolokke & Sorensen, 2006). There are those like Hirshman (2006), however, who still call for second-wave feminist values. She believes that postmodern feminists who choose to stay home with their children, for example, are taking a step backwards, thus harming the progress made by second-wave feminists. Third-wave feminists are more concerned with overall equality, leaving women the

freedom to make whatever choices are appropriate for themselves and their families. There is an appreciation for difference and a focus on equitable treatment instead of equal treatment.

The specific interest in feminism as it relates to this dissertation is rooted in the history of birth in the United States. As the first wave of the feminist movement "sought to banish the suffering of childbirth once and for all" (Cassidy, 2006, p. 91), women gave up more and more control of birth. Not only did women want to embrace pain relief for birth, but simultaneously the landscape of medicine was changing. The 1910 Flexner Report, in which all medical schools in the United States and Canada were investigated, resulted in the closing of many medical schools and the adoption of standards and practices by which medical training should be carried out (Ludmerer, 2010). The regulations that ensued effectively pushed women out of health careers, as most women at the time did not have the previous college education needed to enter medical training, and there were only a handful of colleges willing to accept women. One exception was John Hopkins University School of Medicine which opened in 1893. Funds were provided by four daughters of the John Hopkins Hospital Trustees, with the condition that women be admitted into the medical school program. While only one of the first three entrants received a medical degree, within a few years the graduation rates for women became comparable to those of men in the program (John Hopkins Medicine, n.d.).

Around this same time, advances in medicine were improving the quality of life for many people. Doctors gained a greater understanding of germs and began sterilizing their hands and equipment, hospital-borne infections took fewer lives, and surgical birth saved the lives of some women and infants who would have otherwise died during

childbirth (Wertz & Wertz, 1989). Not all of these advances were made ethically, however.

J. Marion Sims, considered the father of modern gynecology, discovered a way to repair vaginal fistulas, a tear between the vaginal wall and bladder or anus. McGregor (1990) describes that fistulas were not only a painful outcome of difficult births, but often led to the segregation of the women who suffered from them due to unpleasant smells and lack of bladder or bowel control. Sims perfected his repair technique primarily by experimenting on black slave women. He reportedly stated that black women did not need anesthesia, yet almost always used ether when performing the same surgery for white women. There is some debate as to whether this decision was driven by racism or simply a result of the development of anesthesia happening at the same time, however there is little debate as to the ethical nature of performing surgery, without consent, on women who were considered property and therefore unable to decline should they choose to do so (Wall, 2006).

Male doctors took control of birth—creating their own schools of male midwifery, closing down women-run midwifery schools (as well as schools of herbalism, rural medical schools, and African American–run medical training programs) (Beck, 2004; Hooker, 1997). By 1939, in the United States, male doctors were the primary caregivers at most births and more than half of all women were birthing in hospitals, even though women birthing at home were much more likely to live and have healthy babies (Wertz & Wertz, 1989). Feminists and anti-feminists were united in the formation of the National Twilight Sleep Association, demanding that all women be given access to the full anethesia called *twilight sleep* that gave obstetricians complete control over the

birthing mother and the birth process, while the mother was able to wake from labor rested and recovered (Caton, 1999).

According to accounts by Wertz and Wertz (1989), women, particularly Caucasian, middle to upper class women, no longer had control of their births and were robbed of what could be an empowering, profound experience. In this way, first-wave feminists, in their quest to overturn the social and religious belief that it was a woman's duty to suffer in birth, inadvertently contributed to a situation in which women have become less powerful—and historically, during some phases, completely powerless—in what can be an otherwise empowering situation. In addition, because of the changes in medical training and licensing, and the shift to hospital birth, the power in childbirth was given mostly to male doctors and obstetricians, creating a backlash in the bedrock of the feminist ideal of women empowering women. I intend for this study to empower women to take back birthing as a rite of passage and as a postmodern feminist expression that celebrates the power of women and the differences between sexes.

Birth is, by nature, a transdisciplinary experience. There is a physical component, usually overseen by midwives, nurses and obstetricians; an emotional or psychological component, somewhat studied but only nominally paid attention to except by the committed practitioner during the acutal birth process; and a social component that involves the family and community involved with the mother and child(ren). There are also a transformational component, rarely studied or discussed; an anthropological component, based in the history of childbirth in the culture that has resulted in the current state of birth in the United States; and a feminist component, in that birth is a critical element in the lives of many women.

There are also other components that often do not fit neatly into disciplinary lines. There are some interdisciplinary elements that occur naturally in birth as knowledge crosses disciplines. For example, most obstetric nurses are aware that when a mother is relaxed (the emotional or psychological component), her birth will progress more smoothly and quickly (physiological component). There are also doctors, nurses and midwives who tend to women in a multi-disciplinary way, attending to both physical and psychological elements of the birth process and/or utilizing both traditional Western (obstetric) and alternative methods of pain relief. Such practitioners often draw from disciplines such as anthropology, history, and cultural or religious studies. Rarely, however, have I encountered health care practitioners who relate to birth without limiting it to the various disciplines with which they are most knowledgeable. Many popular contemporary books about birth for expecting mothers—that is, those that are most widely recommended and read by pregnant women—include titles like *What to Expect When You are Expecting* (Murkoff, 2008) and *The Girlfriend's Guide to Pregnancy* (Iovine, 2007). These books are limited to descriptions of the physical and, occasionally, the psychological elements of pregnancy and birth. In other words, not only does it seem as though many health care providers are attending to little other than the physical, but mothers are also not being made aware—at least through popular literature—of the many factors that can make up their experience of giving birth. Seen as a whole, complex system, birth becomes much more than a physical event with a psychological component. It becomes, instead, a life-altering event that transcends science and discipline and cannot be pigeonholed in a disciplinary way.

One primary reason that this inquiry is important is because at the present time in the United States very little is known, honored, or shared in popular literature about the empowering aspects of giving birth. In popular culture, such as depicted in movies and television, we see birth scenes primarily showing a woman whose water breaks, after which she is immediately rushed to a hospital where she screams at her partner, takes pain medication, and then smiles holding a baby—with her make-up perfect and a bit of sweat on her brow. Sasha Brown-Worsham (2011), freelance journalist and popular CafeMom blogger, discusses this in a blog post:

> The way births are depicted in modern culture is almost always like this. They are either extreme and freaky—think *She's Having a Baby*—or they are loud and hilarious—think *Friends* or *Knocked Up*. Very rarely are they lovely or transcendent or meaningful or powerful. We ladies get two choices according to pop culture: Scary or hilarious. (para. 3-4)

Misconceptions about the realities of childbirth are deeply rooted in today's culture. I recall, shortly after the birth of my first son, hearing a popular daytime television host tell the women in her audience not to be heroes, but to opt for the epidural. Pop-star Britney Spears is quoted as saying she had a Caesarian section because she didn't "want to go through the pain" (Celebrity Baby Scoop, 2013, para. 16). Women in the media rarely share stories of their births that do not center on the themes of pain management or being saved from an emergency, and the medical profession views birth primarily as a biological event during which the mother's body—a machine—produces a baby—a product (Hesse-Biber, 2007). The history of childbirth practices in the United States, as outlined by Wertz and Wertz (1989) and others (Block, 2007; Cassidy, 2006; Epstein, 2010; Wagner, 2006), points to a system in which women's voices have been mainly silenced in favor of machine-like efficiency and standard hospital policies that

have been developed by elite male professionals who are considered the experts in determining what is best for the mother and baby and are enforced by professional fear and a distrust of the natural birthing process.

There are many examples of the expectation of uniformity in childbirth. The following illustrates a few. Friedman's Curve, established by Dr. Friedman in 1955, created a norm by which women were expected to achieve one centimeter of cervical dilation per hour, with first-time mothers dilating more slowly than those who had already given birth (Davis-Floyd, 2003). Rather than using Friedman's chart as a way to observe the average length of labor progression, the numbers became a standard by which to evaluate a "failure to progress" and determine whether a mother would need medical intervention such as labor-inducing drugs or surgical intervention. A 2010 study indicated that more than half of mothers who underwent Cesarean sections for failure to progress had not reached six centimeters in dilation. Thus, they were still in very early labor and could very well have delivered healthy babies vaginally were the hospital clock not being watched and the birth process evaluated in terms of this curve (Zhang, Troendle, & Reddy, 2010).

Likewise, Zhang et al. (2010) have described that the timeline of the 40-week pregnancy has contributed to the rise in Cesarean births and a drop in natural, vaginal births. It has become commonplace for a woman who has gone even a day past her due date to request or accept an induction. Many women are told by their caregivers, "If you do not go into labor in the next few days, we will have to induce you." However, there is no statistical evidence to indicate that induction is necessary before 42 weeks (Cohain, 2012), and, in fact, the length of a normal pregnancy can vary by up to five weeks (Jukci,

Baird, Weinberg, McConnaughey, & Wilcox, 2013). These and other expectations of women's bodies adhering to calendars and timelines are factors in the current state of childbirth in the United States. While many authors agree that childbirth in the United States is far from ideal, there is still an understanding that "anything…is better than leather straps, twilight sleep, and locked down nurseries" (Simonds & Rothman, 2007, p. 283). Some things have changed for the better, while other problems have remained or arisen.

Even in this climate, however, there are women speaking up. It can be seen in blogs, websites, and the birth stories that women share online that more women want to move beyond the idea that birth must happen the way doctors and/or hospitals mandate it, and they are willing to share stories of empowerment and miracles. Perhaps for this reason, the occurrence of out-of-hospital births is growing in America. According to the Center for Disease Control (CDC), in 2012, the rate of home and birth center births reached 1.36%, its highest percentage since 1975 (as cited in MacDorman, Mathews, & Declercq, 2014, p. 1).

Four recent films, *The Business of Being Born* (Epstein, 2008), *Pregnant in America* (Buonaugurio, 2008), *Orgasmic Birth* (Pascali-Bonaro, 2008), and *Laboring Under an Illusion: Mass Media Childbirth vs. The Real Thing* (Elson, 2009), reflect this growing interest in looking beyond the culture of fear to see what is possible in the arena of natural, conscious birth. This inquiry will add to the small but growing body of research that explores the larger context of birth in all of its dimensions: physical, emotional, mental, spiritual, cultural, and social. Specifically, it will give voice and

validity to those experiences that mothers have that can be called profound, transformational, spiritual, or empowering.

Purpose and Significance of the Study

The purpose of this dissertation research is to gather together stories from women who have had profound experiences while giving birth. Almost any mother knows the joys of holding her baby for the first time, yet for those who remain alert and aware *during* the birthing process, there are often moments of profound transformation that occur throughout labor. It should be noted that being alert and aware could happen in different settings—such as home, birth center, or hospital—and under different circumstances, which can include necessary medical interventions and even surgery. By illuminating what is possible in the arena of experience during childbirth, I hope to encourage women to choose more conscious care for themselves and their babies. By making these choices, women can open themselves to have the kinds of profound experiences that my interviewees have described.

There are several primary problems highlighted by the study. On a larger scale, there is the problem of the increased use of technology and unnecessary medical interventions in births in the United States, which lead to greater infant and maternal mortality and fewer profound, empowering experiences. Further, when statistics from various nations around the world are considered, they show that "the likelihood of a woman dying in childbirth in the USA is five times greater than in Greece, four times greater than in Germany, and three times greater than in Spain" (Amnesty International, 2010, p. 1). Many factors contribute to these statistics. These include increased fear of malpractice suits, which are endemic among American doctors. For example, Dhankhar,

Khan, and Alan (2005) found a correlation between malpractice risk and an increased Cesarean section rate. American doctors often take actions to quicken or force birth—such as using labor-inducing drugs, forceps, or surgery—so that if problems do arise, they can argue that they used all available methods to prevent those problems.

There are also issues of racial and economic inequality. According to the aforementioned 2010 Amnesty International study, African American women are four times more likely to die while giving birth in the United States than Caucasian women. Interestingly, this statistic is not correlated with class or educational background, and in the last decade some researchers have identified racism as the cause of these health disparities. Smedley, Stith, and Nelson (2003) found that when all other factors were equal, such as economic status, presence or absence of medical insurance, and age or marital status of the mother, there were still inequalities in health care. The disparities go beyond the realm of childbirth: People of color are more likely to die of cancer, heart disease, and diabetes than whites, they reported.

Hospital-required, but often unnecessary, practices and interventions also contribute to maternal death and less than ideal birth outcomes. This "cascade of interventions" (Childbirth Connection, 2011, para. 1) can cause as many problems as it attempts to solve. Often when a mother is not progressing in labor as quickly as her care team would like, Pitocin (a synthetic hormone used to cause contractions in laboring mothers) will be used to increase contractions, creating more painful and intense contractions. This often leads to the administration of pain medications that can stall labor and can end in what was (most likely) an unnecessary Cesarean section. I assert that another critical factor that

contributes to these outcomes is a lack of context for having a conscious, informed birth, and a lack of shared stories among women to encourage conscious births.

In order to begin to create contexts for conscious birth (which I am defining as making informed choices while remaining alert and connected to the experience) and to encourage the sharing of stories of birth, this study has been designed to address issues surrounding childbirth, including validating non-physical experiences during childbirth and providing women who are making birth choices with one element of a new context from which to make those decisions. Over the course of 15 years I have spoken informally to many women who have had what they define as spiritual or transformational experiences while giving birth, and I have had these experiences myself, with the births of each of my four children. While the women with whom I have spoken vary in socio-economic status, religious affiliation, ethnicity, and sexual orientation, what we all have in common is having made choices to birth consciously, generally without medication. So, if it is true that childbirth is an embodied opportunity for women to encounter profound, transformational experiences, and it is true that there is a lack of context for these kinds of experiences (thus women in the United States generally choose to avoid the natural processes of birth), then it follows that illuminating the stories of women who have had these experiences could lead to a change in the conversations women have with one another about childbirth, and, by extension, what the medical profession may come to see as the entirety of birth. Changes in the cultural conversations surrounding birth would then alter both the kinds of choices women make about their births and the contexts in which these choices are held.

This inquiry is beneficial to a large range of women and caregivers. Women who are pregnant or are considering having children may use this study's findings to inform their birth choices. Women who have had life-altering experiences while giving birth could find validation in this study or may find a new context in which to understand their own experiences. Anyone in the medical or caring professions who works with pregnant or birthing women could benefit from this work, including obstetricians, midwives, nurses, hospital aides, doulas, post-partum caregivers, and childbirth educators. There are also practitioners in several areas of psychology and counseling who may find this study useful, such as therapists who work with families that may include pregnant mothers, as well as perinatal psychologists.

Furthermore, anyone in any discipline or field who is committed to empowering women—such as Women's Studies, Women's Spirituality, and Feminist Psychology—could use this study's data to support women in regaining the sense of power and access to profound experience that conscious childbirth can foster. The methodology itself, utilizing both narrative and visual arts processes and inquiry, is useful for any researcher exploring topics that cannot be completely expressed through language. Honoring transdisciplinarity—carrying knowledge into, between, and even beyond various disciplines (Volckmann, 2007)—can be critical for social researchers, and this study seeks to add to the body of work that does this in unique ways.

Method and Rationale

This study was conducted as a basic qualitative inquiry, using semi-structured interviews, an art creation process, and both narrative and visual-arts analyses. Interviews are a fundamental way in which research participants can relate experiences, while using

language that is most comfortable, and reflecting values, perspectives, and cultural discourse (DeVault & Gross, 2007). By allowing women to tell the stories of their births—and specifically highlighting those elements of birth stories that are not usually shared—the study looks at "what is missing, what is passed over, and what is avoided" (Pillow & Mayo, 2007, p. 164) in birth literature. Because this topic is also personal—and my spiritual birth experiences are crucial to my knowing and understanding the topic at-hand—I have incorporated personal anecdotes. These personal additions create not only an additional narrative, but they also link my personal experience to the exploration of the topic.

Many researchers have acknowledged the importance of multiple ways of knowing, multiple ways of understanding knowledge, and complexity (Kuhn, 2007; Montuori, 2005; Spradley, 2007). In a creative inquiry such as a dissertation on a transdisciplinary topic, therefore, it would follow that both the methods of collecting data and the methods by which the data is analyzed should encompass multiple ways of knowing. Narrative inquiry is one form of arts based research in that it involves story telling and writing (both creative arts) and narrative-based research that "produces art-based writings" (Leavy, 2009, p. 28). Visual art provides another distinct window into the feelings and experience for both the creator and the viewer and "opens up multiple meanings that are determined not only by the artists but also the viewer" (Leavy, 2009, p. 215). By using both narrative and visual arts based inquiries, the study provides multiple expressions of, and ways for interpreting, the varied experiences that occur for women while giving birth.

Since this study is designed to elicit stories and experiences using three kinds of analysis (narrative, visual-art, and autobiographical elements), it is a practical way to explore both what is said and what cannot be said in words about birth experiences, specifically profound, life-changing experiences. One assumption that I had, based on research into profound experience, is that women may find it difficult to put into words the entirety of their experiences that happened while feeling out of body, in an altered state of consciousness, and/or in touch with otherworldly elements. I know this was true for me and for other women who have described similar experiences to me in informal conversations. By adding the component of visual art, more of the experience can be expressed. It should also be noted that it is not always possible to capture the entirety of an experience, particularly when the experience occurs in an altered state of awareness. Thus the goal is to elicit as much of the experience as possible, given the limitations of this (or any) inquiry.

Personal Relationship to the Topic

My interest in birth began when I attended the birth of my oldest godson in 1992. While my friend had planned a natural birth, she chose during the process to accept narcotics. I watched her move from a space of being fully engaged and empowered in her experience to one of being, to put it bluntly, stoned and barely there. I attended several other births with similar circumstances, and when I was pregnant with my first son, I was determined to be fully engaged, awake, alert, and to experience every moment. Four births later, I have had four profound, transformational experiences of my own. I have also spoken informally to at least 25 other women who have had intensely life-altering experiences while giving birth. This is what drives my interest and my passion. It is not

necessarily a specific interest in obstetrics, psychology, or any of the other fields mentioned above, though these fields are included in my topic and interest. Rather, it is an interest in the whole process, the whole mother/child dyad, and the whole experience.

Definitions of Key Terms

The following are key terms used in this study, arranged in alphabetical order.

Altered State of Consciousness: Any state of consciousness in which the person involved feels either connected to other realities or disconnected from physical reality. These states are often referred to in literature surrounding meditation and/or religious practice.

Arts Based Inquiry: Research that incorporates art methods such as visual arts, creative arts, creative writing, film, dance, and many others. Leavy (2009) states that arts based processes are specifically useful for research that aims to "describe, explore, or discover" (p. 12). In the case of this project, arts based inquiry refers to both the art pieces created by the participants and the researcher and the process through which these pieces are created.

Birth Experience: The entirety of both what happened and the birthing woman's interpretations of the experience surrounding labor and birth.

Birth Outcomes: Measurable results of birth, such as length of labor, use of medications, maternal/infant mortality and/or morbidity, and Cesarean section rates.

Childbirth: For the purpose of this study, childbirth is defined as the period of time from the beginning of labor through the conclusion of the third stage of labor, namely the expulsion of the placenta. However, the experiences being explored will

occur mostly during active labor or before the birth of the infant(s). Used interchangeably with birth and labor throughout.

Culture: Includes geographic, historical, spiritual and societal factors that surround the communities in which the participants live and give birth.

Empowering: Used most often in place of the term profound experience. To enable or permit; refers primarily to those experiences that give us power or connect us with our own power.

Infant: All babies whose births are described will be referred to as infants for the purpose of this study.

Medical Model: See Technocratic Model in this section.

Midwives: Caregivers, almost exclusively women, who are not medical doctors and who are trained to attend births and support the laboring woman throughout pregnancy and childbirth. Midwives are trained either through nursing programs, midwifery programs, apprenticeships, or a combination of these.

Mother: For the sake of clarity, mother is used to identify the participants in the study, all of whom have been birthing mothers.

Natural Birthing Process: The normal flow of events in childbirth, when not interfered with except as truly necessary, such as those low-tech events that ensure the safety of the mother and/or baby (e.g. removing an umbilical cord from around a baby's neck).

Pain: Any physical discomfort felt by the birthing mother.

Peak Experiences: Non-ordinary experiences that are often described as life altering or life-defining. Profound experiences often fall into the category of peak experience.

Profound Experience: The experiences explored in this study are broadly referred to as profound experiences. Generally, this broad term is used to refer to any experience that a mother may refer to as spiritual, peak, mystical, transformational, religious, empowering, life-altering, or any other self-chosen term.

Spiritual Experience: Those experiences purported to bring one closer to one's source (God/Goddess, The Universe, Higher Power, etc.), or those experiences that are framed within one's spiritual or religious beliefs. Spiritual experiences are unique to one's beliefs surrounding spiritual views. Also see Profound Experience in this section.

Technocratic Model: A term coined by Davis-Floyd (1992) that refers to the standard model of birth in the United States. Often, birth following this model is expected to adhere to a scientific schedule that attempts to fit the body's natural process into a scientific model of birth (for example, dilation of approximately one centimeter per hour) and medical interventions that are routine rather than used when necessary.

Researcher's Assumptions

Having experienced four natural births, all of which I describe as being spiritual in nature, I do have a bias toward natural birth and toward the opportunity for profound experience. I have given birth in a birthing center, at home, and in a hospital, so I do know that it is possible to have transformative experiences in any of these settings. However, I also know that I had to fight for my natural birth in the hospital and the moments of spiritual experience that occurred. The environment was not conducive to a

peaceful, joyful birth, nor were there caregivers in the hospital in which I birthed who were committed to creating or supporting that kind of experience. I also firmly believe that anyone who chooses to be aware during the birthing process will often experience something profound or spiritual. These experiences may be fleeting or long-lasting, but I bring with me the belief that there are messages available to us from many sources, when we are willing to listen and that bringing new life into existence is a profound act of the individual and the universe.

As a person with a long career in public speaking and coaching, I assumed that through the interview process I would be able to make women feel comfortable and that they would be willing to share very personal details about their births and the profound experiences that occurred. This was not always the case and was something I needed to be mindful of as my research progressed. However, in most cases, this assumption held true.

I also bring with me an assumption that anyone can make art. Not everyone will be Van Gogh or Picasso, but anyone can create an artistic expression of herself or her experience. I say this as someone who was told from a young age that I had no talent in the arena of visual arts. I was a musician my entire life and knew that I had the capacity to create beauty. However, it was not until I was in my mid-30s that I threw aside the limiting conversations that I had believed and I began creating visual art—first with paper and photos, and later with oil paints, which I love. I now consider myself an artist. Knowing this about myself, I believe that anyone can create beauty, whether it is through a difficult or complex form such as oil paintings or something as simple as creating a collage.

Chapter 2: Review of the Literature

This review of the literature concentrates on six main areas of research in the realm of childbirth: 1) the culture in which birth takes place, 2) the effects of socio-economic factors on birth experience and outcomes, 3) the kinds of care received by women during birth, 4) the purpose of pain during childbirth, 5) the nature of peak and profound experiences, and 6) research into spiritual or mystical experiences of childbirth. These categories represent the major areas of writing concerning childbirth experiences in the United States and are, therefore, covered in this review of the literature. The dissertation does not intend to argue that these kinds of experiences happen only during home births or drug-free births, but does begin with the premise that honoring natural processes allows for a greater chance of experiencing these kinds of profound events. Also included in this section is a review of literature surrounding arts based research, as the art included in the study is critical to understanding the mothers' experiences.

The Culture of Childbirth in the United States

In Colonial America, midwives were the primary caregivers for births and female friends and family members gathered with the laboring woman to support her through the first weeks of her child's life (Wertz & Wertz, 1989). Historical studies of childbirth, particularly as depicted in art throughout the world, have shown that what are now considered alternative practices of birthing with midwives, in squatting positions, and surrounded by family, are actually traditional and not new (Ashford, 1988). The last 150 years of birthing culture, however, has seen a profound shift in birthing practices. Midwives, especially in New England, were criminalized and accused of witchcraft and, subsequently, replaced by male doctors; natural pain relief was replaced by allopathic

medicine and medical technology; and the attitude surrounding birth shifted from one of empowering women who were undergoing a natural process to one of looking out for trouble and intervening whenever possible, so as to avoid potential complications and/or lawsuits (Block, 2007; Cassidy, 2006; Ehrenreich & English, 1972; Sterk, Hay, Kehoe, Ratcliffe, & VandeVusse, 2002). Traditional birthing practices have become "alternative" in the eyes of the hospital-based, obstetrician-attended birth that is now the norm.

Beginning in the 1970s, there has been a backlash of women, including mothers, caregivers, and researchers, many guided by their feminist values and beliefs, who have been questioning the medical, technocratic model of childbirth, as well as its results (Arms, 1975; Block, 2010; Gaskin, 1977; Goer, 1999; Kitzinger, 1971, 1980, 2000). Some attribute the beginnings of this backlash to an article and series of letters published in *Ladies' Home Journal* (Shultz, 1958) that openly discussed the type of abuses many women were experiencing in labor and delivery wards. This was the first public acknowledgement of stories of abuse and cruelty towards laboring mothers. The article and letters included stories of women being tied to beds, having their legs tied together to prevent birth, and being threatened and even struck by doctors and nurses. Women responded *en masse* to the original article and letters flooded in to the magazine in solidarity. The conversation had been started, and women became willing to discuss the state of birth. It is unfortunate that while Shultz's article began the conversation, it has not yet resulted in enough change to end the abuse of laboring women. Goer (2010) followed up on Shultz's work 50 years later with another look at abuse in obstetrics, showing that while many of the overt forms of cruelty have changed, the hierarchical abuse by doctors continues in many hospitals.

Literature discussing birth reflects this cultural change, as the language of the medical model is being replaced by a complex web of language that includes social, personal, and medical factors (van Teijlingen, 2005). Researchers are discussing the negative effects of the positivist, pathological approach to birth that has been the norm for over 100 years (Downe & McCourt, 2004), while popular authors are highlighting the ways in which doctors and hospitals can interfere with the natural birthing process (Wagner, 2006; Wolf, 2003). Davis-Floyd (1994, 2003) speaks explicitly to the damaging effects of the technocratic model of childbirth to both mother and child. An activist for out-of-hospital birth, her writings reflect the sacredness of birth that has been lost to the heroics of doctors whose technological practices for delivering babies have overshadowed the mother's experience, needs, or desires.

Most advocates in the arena of birth argue that not all medical intervention is bad or unneccessary, however.[1] The World Health Organization (WHO) recommended that national Cesarean rates for all countries should fall between 10-15% (Gibbons, et al., 2010, p. 4), indicating that in some births, surgical intervention is a necessity. Mothers at high risk for birthing complications—such as those with heart defects, placenta previa (a condition where the placenta is blocking the cervial opening) or those experiencing an active outbreak of herpes—need specialized care and this often includes surgical intervention for the benefit of the mother and/or child (Gaskin, 2002). The rate of Cesarean births in the United States as of 2012 was 32.8% (Martin, Hamilton, Osterman, Curtin, & Mathews, 2013, p.8), declining slightly from 32.9% in 2009 (Hamilton , Martin & Ventura, 2011, p.4). The argument is not that profound experiences cannot happen

[1] There are those, however, who have argued solely for unassisted childbirth, in the home, either completely alone (Shanley, 1994), or with only the support of the husband (Moran, 1997).

when medical intervention is present, but rather that the context of medical intervention (Necessary or unnecessary? Informed or uninformed? With or without the mother's consent?) is critical in terms of supporting or prohibiting these kinds of experiences.

In 2008, the American College of Obstetricians and Gynecologists (ACOG) introduced Resolution 205 to the American Medical Association (AMA) House of Delegates. This resolution called for legislation that supports birth taking place only in hospitals and licensed birth centers. The statement reflects the general attitude and beliefs of obstetricians that birth is a medical event necessitating a doctor's supervision and/or requiring emergency medical interventions. A January 2011 press release, also from ACOG, states:

> Although the absolute risk of planned home births is low, published medical evidence shows it does carry a two- to three-fold increase in the risk of newborn death compared with planned hospital births…planned home births among low risk women are associated with fewer medical interventions than planned hospital births. (par. 1)

Nowhere in this statement is the "published medical evidence" referenced. However, the evidence that is referenced in a similar 2013 ACOG article (Chervenak, McCullough, Brent, Levene, & Arabin, 2013) refers to a 2010 meta-analysis study of planned home births versus planned hospital births. Most of the studies included in that analysis (Wax, Lucas, Lamont, Pinette, Cartin, & Blackstone, 2010) were from outside of the United States, and the two American studies cited were from 1984 and 1996. ACOG stands by its statement when, in fact, various studies have proven home birth to be safer for low-risk mothers than hospital births (Cheyney et al., 2014; de Jonge, et al., 2009; Janssen et al., 2009; Johnson & Daviss, 2005). It is believed that much of this safety comes from the absence of unnecessary interventions and hospital-borne infections.

While pointed to, but not proven in the existing research, the question is nonetheless pertinent: How can doctors who view births as a medical emergency allow for events of a profound or spiritual nature? When the prevailing view of obstetricians involves surgery (over 30% of all births), pain-relieving drugs (86% of births), and labor-stimulating drugs (47% of births), it is difficult to conclude that most obstetricians support, allow for, or even recognize the power of the laboring woman and the opportunity for spiritual growth inherent in the childbirth process (Declercq, Sakala, Corry, & Applebaum, 2006, p. 34).

There have been numerous studies that prove this prevailing view wrong. For example, while pain medications appear to be seen as a necessary element of the childbirth landscape in the United States, a study by Christiaens, Verhaeghe, and Bracke (2010) showed that cultural conversations played a greater role in the use of medication during labor than medical need. In a study comparing 327 Dutch and Belgian women, Belgian mothers were six times more likely to ask for—and receive—pain medication during labor. As these researchers note, the acceptance of labor as a "normal, physiological process and family event" (p. 1) in the Netherlands contrasts greatly with the more medicalized view of childbirth in Belgium, in which "labour pain is perceived as a needless inconvenience easily resolved by means of pain medication" (p. 1). The context of care was the predominant determining factor, and Belgian statistics regarding pain relief are closer to the United States than Dutch statistics. It could be argued that the attitude of obstetricians and the general culture of birth in the United States are more influential in birth choices than what is best for the mother or child and that the elements of childbirth that would create the most satisfying and profound experiences for the mother are overlooked in this equation.

Socio-Economic Factors Affecting Birth Experience and Outcomes

Amnesty International (2010) summed up the inequality in maternal health care services in the United States that result in imbalanced birth experience and outcomes when examined along socio-economic lines.

> The way in which the health care system in the USA is organized and financed is failing to ensure that all women have access to affordable, timely and adequate maternal health care services. As a result, women, and in particular women of color, women living in poverty and immigrant women, are more likely to enter pregnancy with untreated or unmanaged health conditions; to receive little or no prenatal care because of delays in receiving coverage; to face crippling debt following labor and delivery; and to have limited access to postpartum care. (p. 35)

Childbirth Connection's 2006 and 2013 reports noted several factors in which ethnicity and socio-economic factors affected birth outcome and experience.

- In the 2013 study, 63% of Black and 64% of Hispanic mothers in their survey reported being on Medicare or similar government assistance, as opposed to 36% of Caucasian mothers, up from 51%, 52%, and 36% respectively from the 2006 study (p. 47).
- According to the 2006 study, 49% of first-time Black mothers had Cesarean births, as compared to 33% of Caucasian mothers and 24% of Hispanic mothers (p. 68). These numbers were not measured in the 2013 study.
- In contrast, according to the 2006 study, 47% of Black mothers and 55% of Hispanic mothers described feeling "capable" during their birth experiences, as opposed to 39% of Caucasian mothers (p. 68). Again, these numbers were not measured in the 2013 study.

There are clear racial and socio-economic disparities in the 2006 study, yet they do not necessarily follow expected lines of thought, especially with regard to experience of

birth. In the 2013 version of the study, women were asked if they were treated poorly in a hospital because of race, ethnicity, cultural background, or language. Fourteen percent of the women surveyed reported they felt they were treated poorly sometimes, usually, or all of the time due to these factors.

Other research shows clearer delineation between racial groups. The CDC reported that in 2004, Black women were 3.7 times more likely to die from maternal causes than Caucasian women: 34.7 deaths per 1,000 versus 9.3 deaths per 1,000 (Minino, Heron, Murphy, & Kochanek, 2007, p. 12). This number dropped significantly in 2007 (the most recent statistics available), with Black mothers 2.7 times more likely than Caucasian mothers to die from maternal causes (Xu, Kochanek, Murphy & Tejada-Vera, 2010, p. 13). This still represents a significant inequality along racial lines, even if the gap is closing. However, it should also be noted that maternal death for Caucasian women rose in 2007, to 10 deaths out of every 1,000 women (p. 13). As of 2013, in the United States, 7.96 women per 1,000 die from maternal causes annually (Kassebaum et al., 2014, p. 11).

Many researchers state that the underlying reasons for these racial disparities are unclear; however there is a general consensus that stress on the mother is a primary factor. Chronic stress caused by social inequalities such as racism, poverty, and environmental issues—both before and during pregnancy—can cause health problems that can lead to pre-term birth and low birth weight of the infant (Blackmore, Ferre, Rowley, Hogue, Gaiter, & Atrash, 1993; Dominguez, 2008; Hogue & Vasquez, 2002). In particular, the stress caused by racism is blamed for poor health of the mother, leading to poor birth outcomes including low birth weight.

It has also been argued that, in general, the available statistics for maternal mortality may be far underestimated. Mortality statistics include death during delivery, for example, but do not reflect deaths that may occur after release from a hospital, even when those deaths can be linked to complications from Cesarean sections, such as bowel obstruction or placental retention. There is no national standard for classifying causes of death, another reason maternal deaths may be underreported. In addition, in preparing death certificates, only 21 states ask whether the deceased woman had recently been pregnant in the weeks or months before her death, thereby creating another instance in which cause of death may not be attributed to maternal causes (Gaskin, 2008).

Research into the connection between birth outcomes and experience has been conducted in Sweden (Bergström, Kieler, & Waldenström, 2009; Waldenström, 1999; Waldenström, Borg, Olsson, Skold, & Wall, 1996), Australia (Dahlen, Barclay, & Homer, 2010), and Greece (Sapountzi-Krepia, et al., 2010), among many others. Few studies, however, have equated birth outcome to birth experience and even fewer have looked at socio-economic and racial factors as they relate to experience. Due to unexpected outcomes and the small sample size of the Listening to Mothers studies (Declercq, Sakala, Corry, Applebaum & Risher, 2002; Declercq et al., 2006; Declercq, Sakala, Corry, Applebaum & Herlich, 2013), it is not possible to draw generalized conclusions concerning these factors as they relate to birth experience.

Kinds of Care

Early American midwives, like their European predecessors, held a space for the sacred in birth. In Colonial times, midwives were thought to have more of a "special social and quasi-religious" (Wertz & Wertz, 1989, p. 6) purpose in birth than a medical one. Gaskin (2002) spoke of the modern midwife as one who understands the spiritual energy of others and the universal laws of working with those energies. Rather than relying on technology, a midwife tends to stand as a partner to the laboring woman, offering support when needed to both the mother and her partner and intervening in the natural process of birth only when necessary. These emphases are defined as: care as watchful attention, promotion of personal agency, and trust in the natural process of labor (Clinchard-Sepeda, 2006). Of course, there are personality and protocol differences between midwives. Some midwives practice in hospitals or birth centers under the supervision of physicians. Others work only with women having their babies at home.

There is much debate and diversity of law from state to state regarding licensure and training of midwives. In the United States, there are three primary types of midwives: Certified Nurse-Midwives (CNMs), trained in university-based programs that include both nursing- and midwifery-based training; Certified Midwives (CMs), trained solely as midwives in university programs; and Certified Professional Midwives (CPMs), trained in private midwifery schools or via aprenticeship. Most CNMs and CMs attend only hospital births, though a few do attend births in birth centers and homes, while CPMs attend only out-of-hosptial births. According to the Midwives' Alliance of North America website, as of 2014 it is currently illegal to practice midwifery as a CPM in 9 states; CPMs are legal, licensed, and regulated in 27 states and alegal (unlicensed, unregulated) in the remainder. There does appear to be general consensus among midwives, as shown

in research conducted with them, as to the sacred nature of birth and its importance as a ritual in the lives of women (Linhares, 2007). It is the model of care, however, rather than the credentials of caregiver, that marks the biggest difference between those who assist women in childbirth. Obstericians following a similar model of care can provide the same context, one which honors spirituality and empowerment for the birthing woman.

It is not only the caregiver and model of care that allows for profound experience to occur during childbirth. The kind of birth makes a difference in the mother's experience as well. In a study of mothers' experiences of birth, mothers were more than twice as likely to describe themselves as having felt capable during vaginal birth than Cesarean birth and twice as many women who had Cesarean births described themseves as having felt helpless. More than three times as many women who experienced vaginal birth described themselves as feeling powerful (Declercq et al., 2006, p. 38).

In this same 2006 study, it was found that approximately 50% of all mothers surveyed agreed that medical intervention with birth should only be used when absolutely necessary (p. 56). This number increased to 55% in the Listening to Mothers 2013 study (Declercq et al., p. 45). Yet in the 2006 group, 41% of the mothers had their labors induced by their caregivers, 76% received epidural anesthesia, and almost all of the mothers (94%) received various amounts of electronic fetal monitoring (EFM). In the 2013 group, 41% of the mothers had their labors induced and 67% received epidural anesthesia (Declercq et al., 2006, p. 56). There was no reporting of EFM in this study.

It should be noted that epidurals have numerous risks including fetal distress, maternal fever, respiratory arrest, and abnormal uterine contractions (Mehl-Madrona & Mehl-Madrona, 2008) and EFM is associated with higher Cesarean rates, especially when

used as the primary method of assessing risk to the mother or fetus (American College of Obstetricians & Gynecologists, 2005). Additionally, Cesarean births have been linked to a higher rate of post-partum depression as well as lower satisfaction with the birth experience (Weisman et al., 2010). There is also extensive research, through various avenues, of the effects of birth on the infant later in life (Grof, 2000; Odent, 2002; Proskauer, 2007). This research points to the negative effects of the technocratic model of birth on infants and the ways in which these negative effects continue in life. All in all, this medicalized form of care would seem to prohibit rather than create profound or spiritual experiences.

Purpose of Pain in Childbirth

Medical textbooks and books for expectant mothers that describe the process of labor and birth explain the many physical purposes and reasons for pain during childbirth. Hall (2011) describes this in medical terminology for the medical student or practitioner, while Murkoff (2008)—author of *What to Expect When You are Expecting*, the top-selling book purchased by and for expecting mothers—speaks directly to the pregnant mother in plain language. Regardless of the language being used, what is being described can be paraphrased thusly: As the uterus contracts, it dilates the cervical opening, causing pain; this dilation and the accompanying physical response of pain is required for the baby to move down the birth canal. The stretching of the perineum during the pushing stage is often referred to as the "ring of fire" because of the burning sensation it can cause. Yet again there is purpose to the pain as the expansion allows the baby to leave the birth canal and be born. Culturally, we relate to pain as something to be managed, avoided, or alleviated (Mander, 2000). This is something that modern proponents of

natural and conscious childbirth say must be altered for our maternity system to encompass the non-physical aspects of the childbirth experience (Shanley, 1994).

There are some mothers who report experiencing no pain during childbirth. Morgan (2003) describes her third daughter's birth as painless, pleasurable and joyful. There are several writers, and many mothers, who have had orgasmic births, which Davis and Bonaro (2010) described as "astounding pressure and sensation in the vagina as birth approached, followed by a flood of release and emotion as the baby emerged" (p. xi). Proponents of various pain control techniques such as hypnosis (Mongan, 2005), relaxation and breathing techniques (Lamaze, 1984; McCutcheon-Rosegg, 1996), elimination of fear (Dick-Read, 2004) and religious practice (Moran, 1997) make claims of pain-free birth being possible, and a few women simply state that there was no pain involved during the birthing process (Day-Mansour, 1994).

Other writers speak of the purpose of pain in childbirth from an emotional, psychological, or personal perspective. Odent (1992) refers to the purpose of this pain as reminders of our mammalian roots, allowing the mother to have her primal instincts take over during birth. He also speaks of the mother going off to another planet, in an altered state of consciousness. The intense physical feelings of labor, he says, contribute to this shift in realities. Shanley (1994) spoke of labor pain as a doorway to get outside of oneself; Gaskin (2002) called it the reflex that takes women out of their thinking minds into their feeling minds; and Morgan (2003) reminded women that embracing the pain of birth creates joyous, pleasurable birthing experiences.

Pain in childbirth serves another purpose as well. Pain in any endeavor takes the bearer into a different state. Whether it is the marathon runner pushing through the 17th

mile, the Tae Kwon Do black belt doing the 157th push-up (that was a personal breaking point for me!), or the laboring mother in the 19th hour, one crosses a threshold that allows for something that wasn't possible before. As McGrath (2007) stated, "Every mother who gives birth must make the journey—cross the boundary—into motherhood" (p. 8). It is that crossing that can cause profound experience.

Regardless of the specific viewpoint, there is agreement that there is purpose to the pain in childbirth and that the modern idea of a doctor saving women from this pain is harmful to the non-physical aspects of childbirth, as well as a barrier to the natural physical progression of the birthing process. It is also agreed, or at least implied by these and other authors, that pain is the doorway to the kinds of profound experiences that women have while giving birth.

Peak Experience

Guiley (1991) summarized Maslow's definition of peak experience as "self-validating, self-justifying moments with their own intrinsic value; never negative, unpleasant or evil; disoriented in time and space; and accompanied by a loss of fear, anxiety, doubts, and inhibitions" (p. 438). It should be noted that while Guiley's definition implies all peak experiences are positive, Maslow and others identify negative experiences as peak as well. Pain, deprivation, fear, fasting, and other experiences can cause peak experiences and are not necessarily described as positive. Peak experiences are also referred to in the literature as non-symbolic experiences, mystical experiences, spiritual experiences, non-ordinary states of consciousness, transcendent or transformational experiences (Lahood, 2006; Martin, 2010). Maslow (1959) stated that peak experiences happen in a variety of ways for different people, yet he was "startled" to

hear a woman speak of giving birth in this way. Peak experiences, according to Maslow, were necessary for self-actualization and growth. In the years since Maslow coined the term, authors have related peak experiences to a wide array of life experience and activies such as athletics (Ravizza, 2007), business (Thornton, Privette, & Bundrick, 1999) and even encounters with dolphins (DeMares & Krycka, 1999). Common to these and other writings is the theme of personal growth. Regardless of the mode or context of the peak experiences, they had profound effects on those experiencing them.

Maslow (1971) originally thought that peak experiences happened to those who had developed to the top levels of the Hierarchy of Needs (See Figure 1.). He later discovered that children and those in various stages of this hierarchy were capable of having these peak experiences. Recently, Martin (2010) concluded that the persistence of peak or non-symbolic experiences is available to people at all stages of ego development. In other words, experiencing transcendence is not only possible for the self-actualized individual, but is accessible to all.

A review of recent literature concerning birth experience showed several trends related to peak experience, including women's reference to childbirth as "a significant landmark in women's life… a pivotal life event…[and] an important life experience" (Larkin, Begley, & Devane, 2009, p. e54). This random sampling of 62 papers written between 1990 and 2005 also identified birth experience, according to mothers, as complex, individual, and a process. This is not to indicate that all who experienced birth as life-changing had positive experiences, however. The study included papers with titles

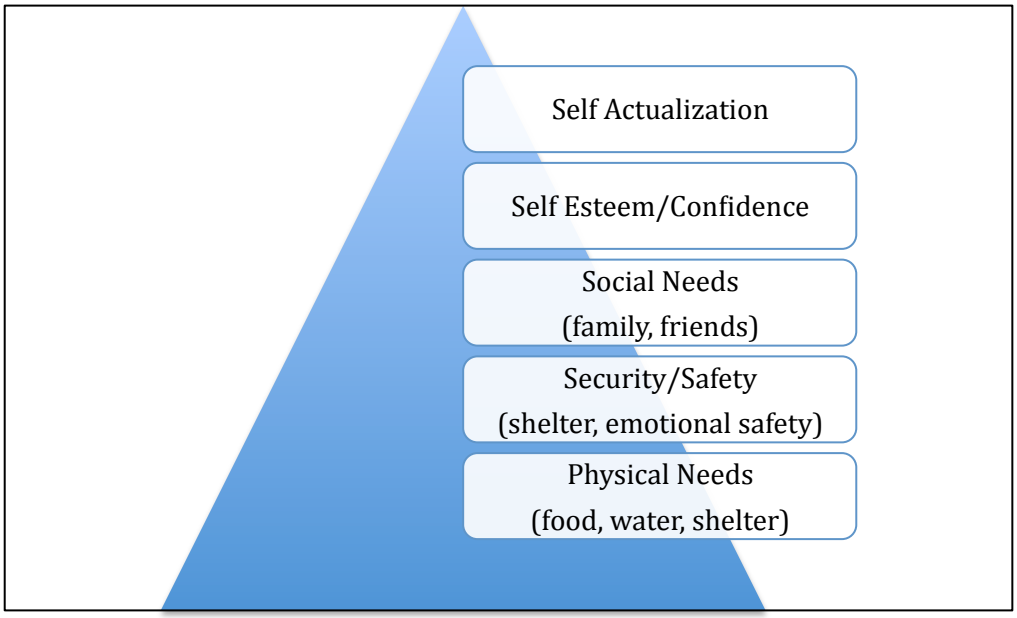

Figure 1. Adapted from Maslow's Hierarchy of Needs. Copyright Jennifer A. Schwartz.

such as "'I Felt as Though I'd been in Jail': Women's Experiences of Maternity Care During Labour, Delivery, and the Immediate Postpartum" (Baker, Choi, Henshaw & Tree, 2005) and "I Felt Violated: Women's Experience of Childbirth-Associated Anger" (Mozingo, Davis, Thomas & Droppleman, 2002). Grof's (2008) extensive work using both LSD and breathwork to re-experience one's own birth experiences is another window into the trauma that birth can be. In birth, as in all of life, it seems as though peak experiences can occur during times of great stress, great joy, and great change.

Pregnancy and childbirth are being seen more and more as transformative events for women. Swan-Foster (2012) describes ways that expectant mothers can connect to their intuition in order to foster psychological transformation. Birth experiences *are* peak experiences for many women. The physical response to birthing creates a feeling of ecstasy, as a cocktail of hormones is released into the mother's body (Buckley, 2002; Gaskin, 2003). The effects go well beyond the physical, however. Lahood (2007) cites

numerous narratives of women who had spiritual experiences while birthing. These experiences ranged from seeing angels to receiving care from nurses who did not physically exist. Lahood argued that demonizing these non-ordinary events—labelling them as witcthcraft and defining midwives as witches and demons—allowed for the historical turn in which women no longer relate to birth as an opportunity to experience these spiritual moments. Yet for women who birth consciously and embrace this potential reality, the experiences can be some of the most empowering in the life cycle.

Spirituality as a Part of Childbirth

Women have opportunities to experience spirituality through their bodies as they move through the natural phases of life. Menstruation, pregnancy, childbirth, and menopause are all times of change during which women can embrace non-physical realms of reality (Paik, 1999). Clark and Khalaf (2010) are among researchers who have worked to inform the medical profession of the importance of incorporating spirituality as well as religious beliefs into the maternity system. Their work highlights the importance of a woman's point of view—seen through a spiritual or religious lens—in the experience and outcome of her birthing process. It is possible to embrace the sacred even in the most medicalized birthing situations, such as true emergencies (Ayers-Gould, 2000), and it is important that women are aware that conscious birth and spiritual experiences prompted by the birthing process are not only possible, they are the right of the birthing woman (Davis-Floyd, 2003).

It is unclear, based on previous research, the degree to which a mother's upbringing, culture, and religious or spiritual views contribute to the spiritual experiences she has while birthing, yet there seems to be some connection between the two. One

mother, after entering an altered state in which a man in a suit told her he was there to help her have her baby stated, "I suppose because I have a Catholic background I might just think like that" (Lahood, 2009, p. 165). All knowledge is constructed socially, in the context of culture, beliefs, views, and values (Kim, 2007), so while the research may be lacking in making the connection directly, it could be argued that spiritual experience in birth will most likely be in alignment with the mother's culture, spiritual life, views, and values.

Lahood (2009) uncovered another element of spirituality during childbirth in the more than 40 interviews he has done with mothers—the mother's encounter with death. For the mothers in Lahood's research, these are "very real, actual, brush(es) with mortality which (have) a profound emotional, psychological and spiritual component" (p. 169). For each story he recounts, the brush with death and the spiritual experience are consistent with the views and ideas of the culture and/or religion in which it occurred. Yet despite differences in content, the context seems to be the same: As a woman births, she must let go of herself as she has known herself and be born into the mother she can now become.

The Nature of Arts Based Research

Barone and Eisner (2012) define arts based research as "an effort to extend beyond the limiting contraints of discursive communication in order to express meanings that otherwise would be ineffable" (p. 1). Arts based research, therefore, is a way to experience and understand the world that cannot be seen in words. The art created in this study is not meant to be used to psychoanalyze the participants or provide healing

experiences for them. Instead, it is a way to reveal more of the experience that each mother expressed.

Using art for healing, therapy, and self-knowledge is not new. Many women preparing for childbirth are introduced to the process of birth art through *Birthing Within: An Extra-Ordinary Guide to Childbirth Pregnancy*, written by Pam England and Rob Horowitz in 1998. Through both the book and workshops taught across the country, mothers are encouraged to face their fears about birth, heal past birth trauma and set intentions for their upcoming births, all through creating art. Booth (1997) recommends using art to transform one's experience of life and set goals, while Allen (1995) describes art processes useful for understanding oneself and healing one's past.

Arts based research is not limited to the visual arts. Leavy (2009) discusses ways to integrate music, poetry and dance into scientific research. Narratives, too, are a form of art, according to Leavy. In this way, this entire study is an arts based project, in as such that the stories told are also art in another form. With regard to visual art, Leavy describes such participatory methodology as a way to access hidden elements of social life, connecting the individual experience with universal experience. This was one of the intents of this study: to illuminate experience through visual media.

While arts based research can be difficult to critique along traditional lines (art is subjective, and therefore difficult, if not impossible, to quantify), Barone and Eisner (2012) recommend several criteria for assessing arts based research. The sixth of these criteria is evocation and illumination: Does the research—and the art included in the research—allow the reader to feel the meaning of the story? Does the art shed new light on the content of the research? Art can capture meaning that words and qualitative

research cannot. Using diversity in research methods can therefore add to the understanding of a subject.

Conclusion

There are many disciplines and lenses through which one can look at birth experience. The kinds of profound experiences that others and I have had while giving birth are brought on through a complex web of psychological, physical, cultural and other factors. Today, many researchers and writers see birth in light of this complex web, and a focus on the non-physical aspects of birth can be seen in the literature discussed above. However, very little has been discussed in terms of the peak experiences that women have while giving birth. Lahood's (2007) research honors the opportunity for empowering experiences to present themselves to women as they give birth. He ends one article with the following questions, which also guide my inquiry:

> Could it be that the process of childbirth may be secreting not only a whole raft of unnamed spiritual events but also the great unadorned, unrecognized and secret 'religion' of the human family—the embodied love, care and relationship found between mother and child? Do these voices reveal a hitherto unspoken women-centered trans/personal domain—a tacit participatory reality—human love co-created, regenerated and sensuously embraced on the breast of a breathing parental and relational spirituality? (pp. 184-185)

With this research, I hope to bridge the gap between the lived experiences of women and the idea of spiritual experience as an integral part of the birthing experience.

Chapter 3: Method

This study is a basic qualitative inquiry, utilizing a structured survey, semi-structured interviews, and an art creation process, accompanied by narrative and visual art analyses.

Research Tools

A questionnaire was used to solicit participants (see next section, Research Participants). This survey was created using Survey Monkey and was made available online. I reached out through many online forums, email lists, and personal friends in the birthing community (midwives, doulas, etc.) and asked for mothers who had given birth within the past two years to complete the survey. This process took almost two years, primarily because I gave birth to my fourth child during the research process and put aside any active involvement for some time. Data from these initial questionnaires provided information such as age, location, ethnicity, and other demographic data. The answers to these questionnaires also included a short narrative about the mother's profound experience. Because each woman provided this description, all questionnaires received were incorporated into the research.

The primary method of data collection for research occurred through semi-structured face-to-face interviews and an expressive art process. Interviews were held in each participant's home or another convenient location of her choice, such as a coffee shop or park. Fifteen narratives were collected. Interviews were taped using two digital recorders for redundancy. Each interview began by asking the mother to recall her birth story, questions were asked for clarity and as needed, but generally the interviews proceeded as a conversation, with little interruption from the researcher. Patton (2002)

calls this an informal conversation interview, in which the researcher and participant are in dialogue with one another, with a specific focus during the conversation. During the course of each interview, I took written notes of the events that were profound or life altering in nature shared by the mother, and asked for more details when necessary.

The second portion of data collection occurred immediately following the interview. Participants were offered a wide array of media with which to create an art piece, including varieties of paper, pencils, crayons, markers, fabric, glue, clay, magazines, stickers, watercolors, and oil pastels. I then reviewed with the participant the elements of birth she had shared that were profound, transformational, or spiritual in nature, and she chose one that was the most important to her. Next, I asked each of the participants to create a piece of art that captured the feelings and experiences described. Participants were given as much time as they needed to complete these projects, which was anywhere from 10 to 45 minutes. I generally went in and out of the room or area while the mother worked, often entertaining her children so that she could focus on the task. After the art project was completed, I asked the participant to tell me about her art piece and this part of the interview was also recorded. This, too, was a semi-structured interview, in which I asked specific questions about elements of the art pieces.

Before completing the interview, I asked the following question of each participant: “Did creating this art piece change anything about the way you would now describe your birth experience? If yes, in what way(s)?” This too was recorded for later inclusion in the analysis process. I also asked each mother how this birth experience shaped her or changed her as a mother if this was a second or consecutive birth.

Participation Criteria for Participants

All participants were mothers who have given birth one or more times. Participants must have lived in the United States for at least two years before giving birth. Participants must have given birth within the last two years and must be currently mothering the child(ren). Ages of the mothers ranged from 18-45 years of age. I selected participants from various geographic locations, and travelled to each city to conduct the interviews in person. I chose participants who reflect a variety of ages, races, ethnicities, educational levels, sexual orientations, and religious affiliations. Mothers who had traumatic births—such as emergency hospitalizations, stillbirths, premature infants, or other traumatic birth outcomes—are not included in the interview portion of this study, as recalling these events can be traumatic, and could require the support of a trained therapist. Therefore, mothers were asked to self-identify traumatic births as a part of the survey process, and those who stated their births were traumatic were not included in the pool of potential interviewees.

Participant selection was done by charting all potential participants and selecting a cross-section of mothers so as to encompass as many as possible of the following qualities: low, middle, and high-income family (as designated by demographics for the geographic area); Caucasian, Hispanic, Black, and Asian participant; young (18-26), middle (27-35) and older (36-45) participant; lesbian, bi-sexual, and heterosexual participant; no degree, high school degree, college degree, and advanced degree participant; and religious, spiritual, and non-religious participant.

Rationale for Selection

It was important to include diverse voices in this study, as my assumption is that profound childbirth experiences are universally accessible to all women. While the overarching culture being studied is that of the United States, there are differences in birthing culture, outcomes, and experiences across the country. In addition, it was important that a broad range of age, race, ethnicity, educational level, sexual orientation, and religious/spiritual diversity are represented, even though the sample size is small.

Women were asked to participate only if they had given birth within the last two years. By limiting participation in this way, there was a greater chance of hearing the most accurate story of the birth experience. As we tell stories over time, some details become lost and some details take on mythical qualities. For this reason, the time of the birth was crucial to the interview process in this study. I had intended to include only details of the birth for which I was interviewing the mother. However, often women with multiple children began their birth stories with details from a previous birth. While the majority of the elements that are highlighted in this study are those from the birth that occurred in the two years prior to the interview, there are some details from previous birth experiences that were too crucial to leave out of the analysis. In addition, one mother is not the birth mother of the child born within the two prior years, but the story of healing that occurred during the most recent birth was a profound experience regardless. I chose to include her story as it so well illustrated the healing power of birth.

Recruitment of Participants

Several midwives, obstetricians, managers of birth centers, and moderators of online mothering groups and birth-related email groups across the United States were

asked to place fliers in their offices and/or send a preliminary email to their clients or groups with the intent to recruit potential participants (Appendix B: Study Flyer). Respondents were asked to complete a preliminary survey online, by following a link to a Survey Monkey survey (Appendix C: Survey) that asked basic demographic questions and whether the potential participant has had what she would consider a profound, spiritual, transformational, or empowering experience while giving birth. (See next section, Procedures for Data Collection, for survey details.) Participants who met the qualifications for selection were mapped using geographical location, age, religious affiliation, ethnicity, and race. All participants remained anonymous until/unless they were contacted for potential participation. Only email addresses were collected at the initial stage.

Benefits and Risks to Participants

It was anticipated that these interviews and art creation processes would be generally enjoyable for the mothers involved and that the mothers could also gain further insights into their own experiences through their participation. During the process, it was possible that a mother may have experienced strong emotional reactions—both positive and negative—to either the interview and/or the art creation process. This study did not include mothers who had traumatic birth experiences, so the risk to the mothers was minimal. In the case that any participant had a negative reaction to the interview and/or art creation process, I would have provided her with the needed information to contact a local therapist who specializes in trauma. None of the participants utilized this option during or after the interview process.

Procedures for Data Collection and Analysis

The following steps outline the procedures used for research and data collection.

1. Participant recruitment occurred as described above.
2. Using the collection of all potential participants (that is, all who completed the online survey) I selected 21 women to create geographic, cultural, economic, ethnic, age, sexual orientation, religious, and racial diversity. An email was sent to all applicants chosen for the interview group, requesting further participation in the study. Women who agreed to participate were also sent required forms (Appendix D: Sample Consent Form, Appendix E: Statement of Confidentiality, and Appendix F: Participant's Bill of Rights). No further contact ensued with the participant until her Consent Form was received, with the exception of a follow-up reminder to return the Consent Forms when needed. All surveys received were kept on file until all participant interviews were completed, in the event that any participants did not complete interviews and new participants needed to be selected.
3. Initial email conversations took place with each participant, both to schedule a time and place for the interview and to collect any missing data from the initial questionnaire. Six of the 21 mothers were unable to complete the requested interviews. One had a sick child on the day of the interview, one forgot our appointment and was unable to reschedule, two moved between being contacted and my visit to their area, and two agreed to an interview but did not respond to the request to schedule.

4. Fifteen interviews were held, and I personally conducted each interview. The interviews took place in the homes of the participants, in coffee shops, and in one case, at a park. It was explained that interruptions from infants and other children are expected and accepted. Often, I paused the recorders as mothers tended to their children's needs, and we then resumed our interview. The interviews took from one to two hours.
5. Before beginning interviews, I explained to the participant the nature of the study, as well as my personal interest in doing this study. I also gave the participant an opportunity to ask any questions she may have. This initial time created familiarity and put the mother at ease. I also explained my recording and note-taking procedures and asked her how she would like to deal with interruptions from her child(ren).
6. Interviews were recorded with two digital audio recorders, creating redundancy in the recordings in case of technical difficulties. The mother was reminded that these recordings are for research use only, would not be shared with any outside parties, and would be kept on a password protected computer.
7. Participants were asked to tell their birth stories. I asked questions as needed for clarity. After the initial birth story was recorded, an unstructured conversational interview continued, as I asked the mother about elements of her birth story that are relevant to the concept of profound aspects of the birth.
8. After the stories and interviews were completed, we moved into the visual expression element of the process. I presented the mother with a wide variety of art materials and had a brief conversation about her comfort level in creating art.

Women who felt uncomfortable about creating art were encouraged to make simple drawings or use magazine images to create collages.

9. Once an art form was chosen, I spent a few moments discussing the more profound elements of the mother's story, so that she could choose what to include in her art. Often, I spent the art creation time engaging her child/children while she was working on the art piece so that she was not interrupted. Many of the children also created art with us at this time.
10. Once the art piece was completed, I asked the mother to tell me about the piece, both what it meant to her and any feelings/emotional responses to the piece or to the creation process. This portion of the interview was also recorded.
11. Finally, I asked the mother the following question: "Did creating this art piece change anything about the way you would now describe your birth experience? If yes, in what way(s)?"
12. Digital photographs were taken of the art pieces. The actual creations were left with the mothers. Unfortunately, I did not use the same redundancy with photos as I did with interview recordings, and as a result several images were lost. I was able to recover some of these from the mothers, while three were no longer available.
13. The mother was provided contact information in case there was anything she would like to add to her narrative after the interview. I also informed her that I might call or email her if I had any questions during transcription.
14. Interviews were transcribed and photographs were placed on a secure external drive to protect their integrity.

Analysis of Narrative Data

All interviews were transcribed, and the short narratives from the survey were transferred into a more usable format. I had intended to use narrative analysis software, but found that it worked better for me to read, analyze, and re-read the texts myself. As I was not looking to form hard conclusions, this method of highlighting significant statements and forming general assumptions about each story was a more holistic way of presenting the stories. The intent of narrative inquiry is to "write a narrative view of experience… situated and lived out on storied landscapes as [the] theoretical methodological frame" (Clandinin & Connelly, 2004, p. 128). As such, each narrative is an expression of personal experience. However, for the purpose of this study, themes from the narrative data were found. These themes illustrate various ways in which birth stories overlap as well as the commonalities of experience within the stories. As themes emerged, illustrations from the various narratives were found that best illuminate the particular theme. Many of the stories are quoted directly to allow the stories to speak for themselves.

Analysis of Visual Data

"Visual images represent a created expression of experience" (Leavy, 2009, p. 215) and can evoke emotional and other responses without being analyzed. The images are presented in the final dissertation in their entirety, allowing the reader to experience them for him or herself.

In addition, the images created by the research participants were analyzed in order to observe commonalities in the artwork. This followed the steps outlined by Rose (2006). The process, simplified, is as follows:

1. Collect images.
2. Select categories for coding – these should be exhaustive (covering all aspects of the research concerns), exclusive (categories cannot overlap one another), and enlightening (interesting and relevant to the research).
3. Code the images.
4. Interpret the results by drawing comparisons between the images and the codes.

The most critical aspect of this process is selecting categories for coding. It is important to note that all categories could not be defined until the images were collected. However, there are some categories that were included initially: images of mother present, images of baby present, images of other family members present, images of caregivers present, images of non-physical beings present, art medium used, primary color scheme used, and words used (for example, text in a collage). Rose suggests applying the categories to all of the images, in order to find what elements of the images, if any, have not been included in the coding. Therefore, steps #2 and #3 were repeated several times until all elements of the images were identified and included in the coding process.

Interpreting Data from Narrative and Visual Analysis

As this study focuses on narrative and visual inquiry and emphasizes personal experience, there are no hard conclusions to be drawn from the data collected. Rather, the final dissertation is a collected expression of profound experiences of birth. Similarities among narrative and art expression are presented, along with the themes that emerged in

both sets of data. As all of the expressions derive from personal experience, all stories collected are considered to be true and real for the participants.

Delimitations and Limitations of This Inquiry

The scope and focus of this study have been purposefully designed to best illuminate the personal experiences of the participants.

Delimitations. This study is meant to explore the experiences of the women involved, but not intended to create data that can be used to draw hard conclusions about larger groups of women or childbirth in general. Rather, the study intends to provide stories and art to illuminate the human experience of giving birth and to illustrate the thematic commonalities shared by many women during the birthing experience. The study is delimited to the interactions with the mothers who participated, the narratives they shared, and the art they created. The study is delimited to mothers in the United States, and no women who experienced traumatic births are included in this research. In addition, only mothers who have given birth in the last two years are included. One exception to these criteria was Eliza, who did not give birth to the child whose story she tells, but gave birth to a previous child. However, the healing experience of the most recent birth was equivalent to having had the experience personally, so it is included in this study.

The study is meant to share personal narratives, art, and experiences of childbirth, but not to explore how choices were made before the births (such as interviewing caregivers, creating birth plans, or the like) or to include narratives of previous birth experiences for women with more than one child. However, mothers sometimes included details of previous births, as they shaped choices and experiences in the more recent

birth, and those details are often included in the analysis. The inquiry seeks to illuminate the profound experience—spiritual, transformational, empowering, and other—as it unfolded for the mother. Additionally, the study does not seek to critique birth choices made, such as medical interventions or hospital transfers, but rather include them in the narrative of experience.

This study looks at the experience of the mother during birth. Other people present, such as the fathers or partners, caregivers, and other friends or family members, will have their own experiences and memory of the events and will likely influence the experience of the mother. While the experiences of others are important, they are not explored in this study.

Limitations. Social research of this kind has several inherent limitations. First, because the narratives and art collected are based on individual experiences and constructed into unique expressions, it is not usually prudent to draw conclusions about larger populations. While this study may present findings common to the experiences of the women involved in this study, these same findings may not apply to a similar but different group of mothers.

Second, because the study involves a diverse group of mothers, there is little possibility of seeing the depth of a particular group of women's experience. No conclusions can be drawn based on the small sample size and the diversity of the women about the experiences of a particular group.

Third, as a researcher with very personal experience in this area, I am aware that there is always a danger of being biased by my own ideas, experiences, and expectations.

For this reason, several outside readers were involved in my research process and were asked to look specifically for bias in my writing.

Fourth, there is always a need to remember that the narratives shared are only those being shared in the moment – they may or may not accurately reflect actual experience. The comfort of the mother in sharing intimate details of her birth experiences varied from woman to woman, as did the specific details they remembered during the interview process. All of these factors could influence the outcomes of this study, especially if they are not examined.

Finally, while the inclusion of art in this dissertation is an integral part of the exploration into the stories of the mothers, I am not trained as an artist, art therapist, or in specific arts based methods of research. While I have noted themes and similarities, someone trained in any of these areas of expertise may have very different interpretations of the art included.

Issues of Validity

Narrative research is difficult to validate, in that stories are personal in nature, and vary each time they are told. For the purpose of this study, all narratives collected are considered true. The validity of the story itself will not be checked for accuracy in any way because "all [people] have their own interpretation of events, and each is equally valid" (Clandinin & Connelly, 2004, p. 85). Wells (2011) argues that narrative research should be evaluated for trustworthiness more than validity and that it is more essential to validate the research processes, relevance, and presentation than the narrative data itself.

This study presents portions of narrative from direct transcription. Full transcripts will be kept on record but will remain confidential. It also includes, in some cases,

descriptions of the nature of the interview. For example, did the mother seem comfortable and was the interview a pleasant conversation or more like a formal interview? In addition, I kept a journal of my own experiences and examinations, which I used to both capture my experience and record the findings that were emerging. Riessman (2008) recommends this audited trail of the research process, thus validating the study and its methods while conducting the research. Pieces of this journal were used in recording the findings.

Further validity of this study could be realized as other researchers build upon it or use it as a way to validate their own work. This, Wells (2011) offers, is the most useful way to answer the question of relevancy for any social research study. It is my intent that this study will be useful, both for my own future research as well as for others committed to exploring the experience of birthing mothers.

Chapter 4: Findings

> I caught my own daughter at our home birth. I felt so connected to her and to every other mother on Earth. I had the same feeling of connectedness to all mothers on Earth during the birth of my son. - Grace

The experiences expressed by the mothers responding to this study centered on several themes, including connectedness with other mothers, religious experience/connection with God, a new-found trust in their bodies, and a feeling of empowerment. Each mother had a unique story, and yet these themes ran through many of their narratives and art. The following sections outline the findings from the short narratives, interviews and art.

The Surveys

Between April 12, 2011, and February 3, 2013, 279 Survey Monkey surveys were collected. Of these responses, 55 women reported having had traumatic experiences and were therefore filtered out of the potential interview pool as well as from the short

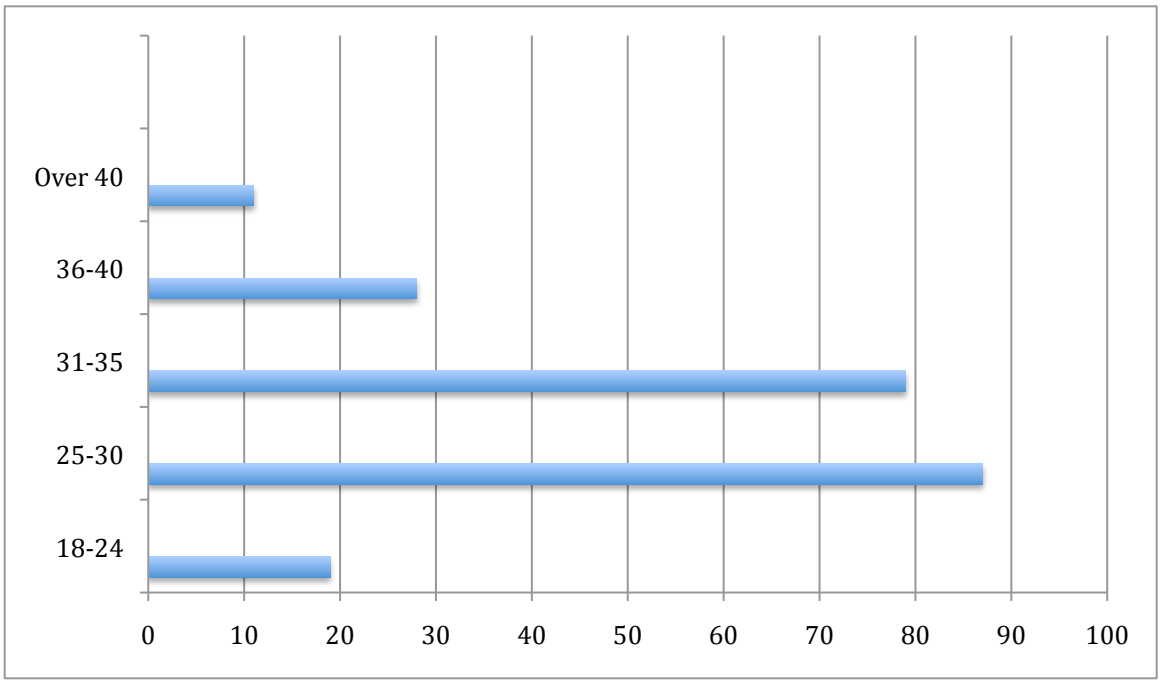

Figure 2. Age of respondents. Copyright 2014 by Jennifer A. Schwartz.

narrative analysis. This left 224 respondents and potential interviewees, ages 18 to 45.

The respondents had a wide range of educational levels and income. Most were

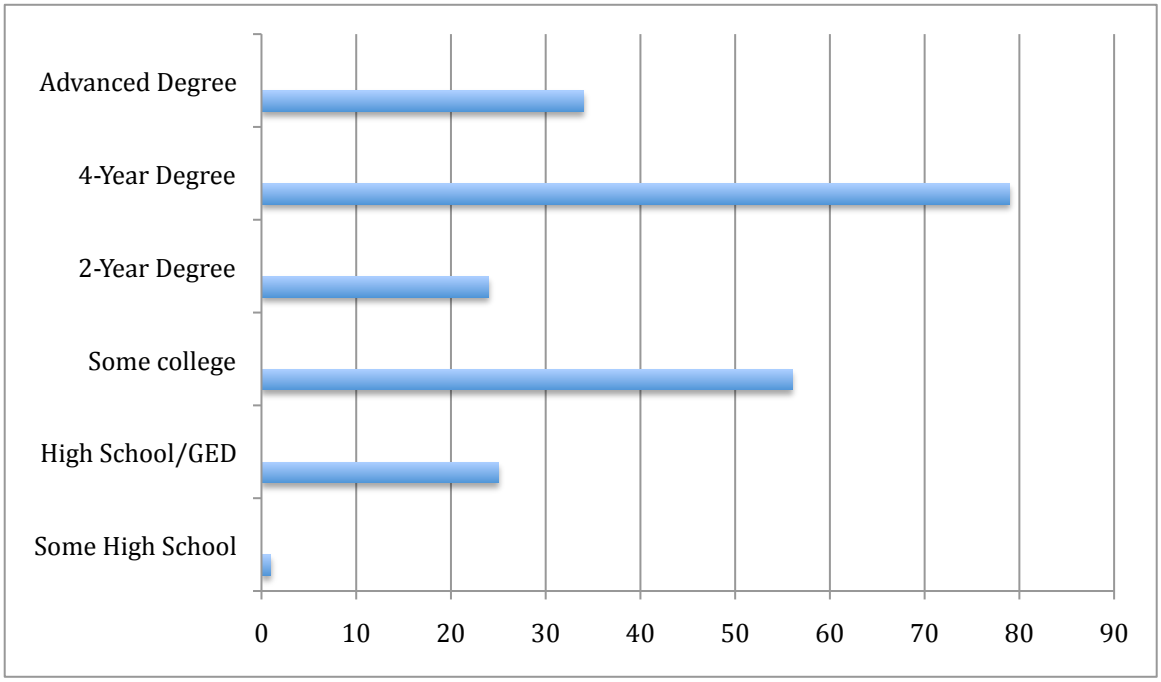

Figure 3. Educational level of respondents. Copyright 2014 by Jennifer A. Schwartz.

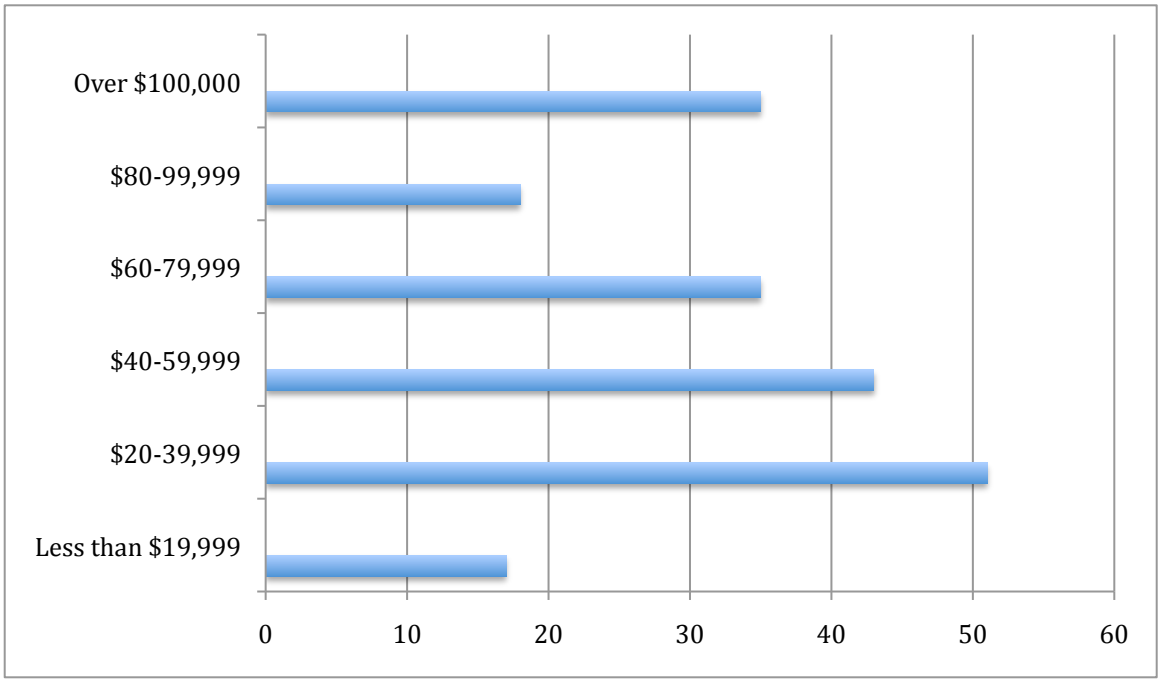

Figure 4. Annual household income of respondents. Copyright 2014 Jennifer A. Schwartz.

married at the time of their survey responses and held a variety of spiritual/religious practices. Though the majority were heterosexual and Caucasian, six other ethnicities and

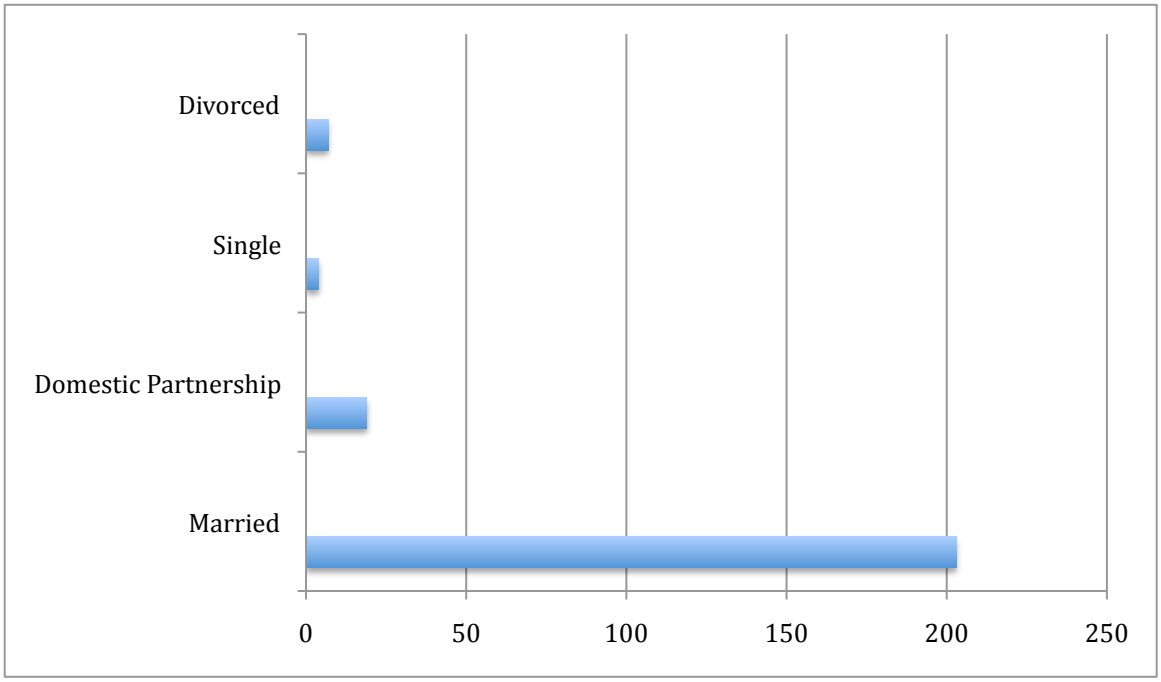

Figure 5. Marital statues of respondents. Copyright 2014 Jennifer A. Schwartz.

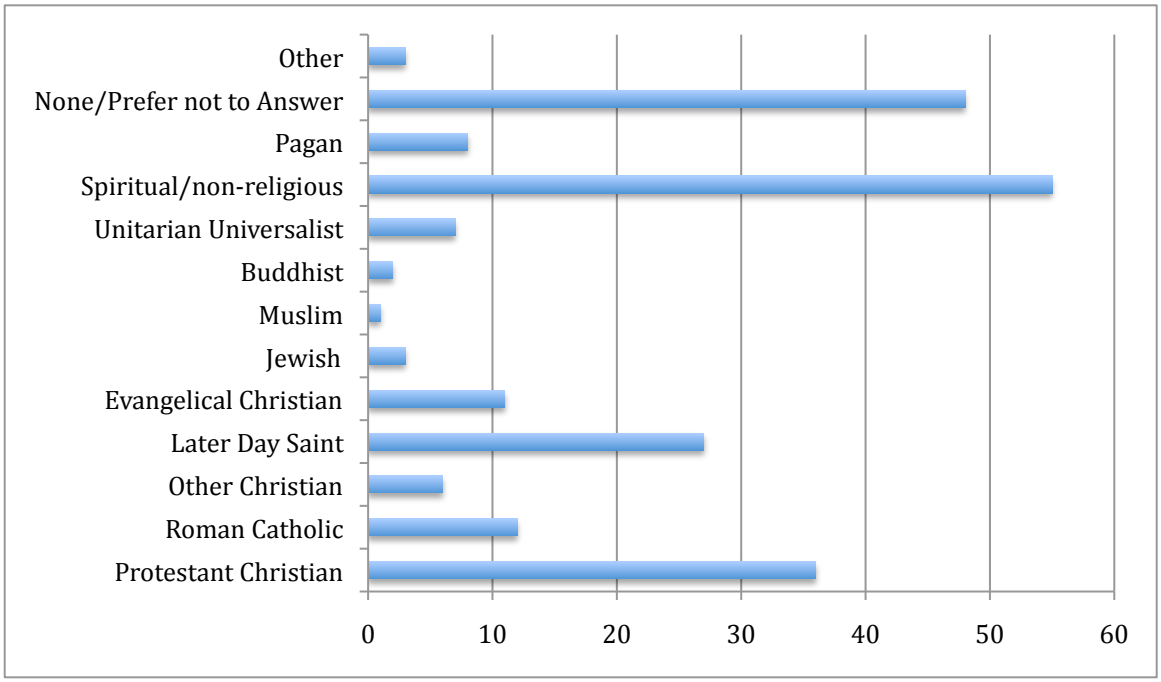

Figure 6. Religious identification of respondents. Copyright 2014 Jennifer A. Schwartz.

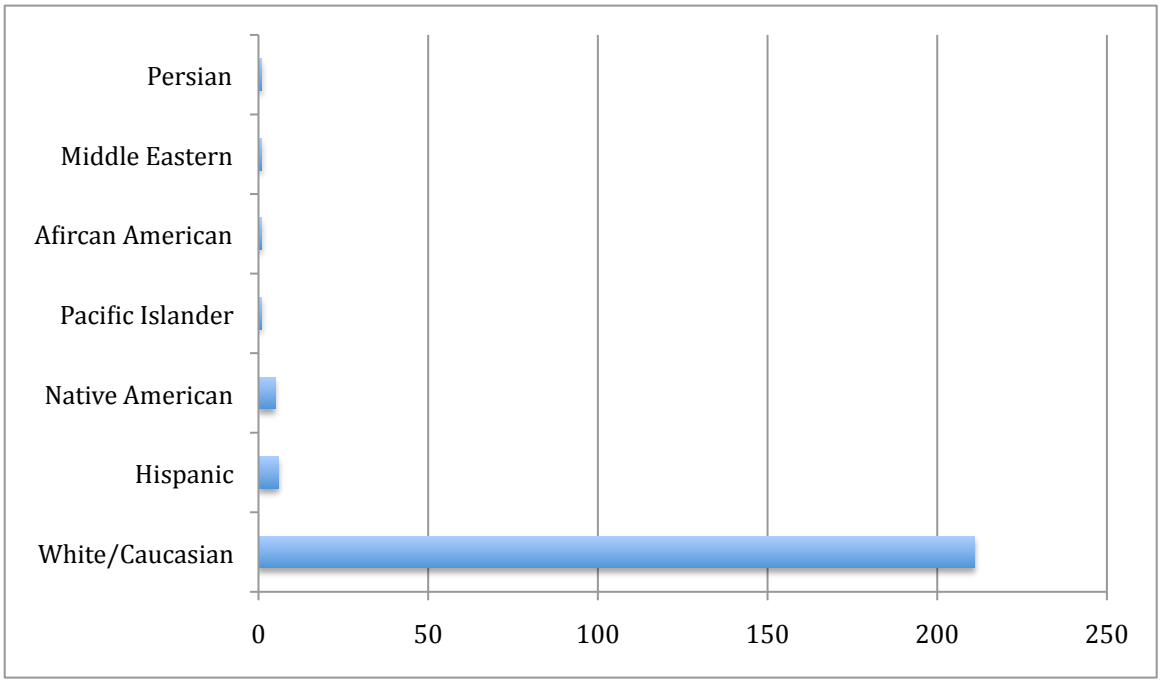

Figure 7. Racial identity of respondents. Copyright 2014 Jennifer A. Schwartz.

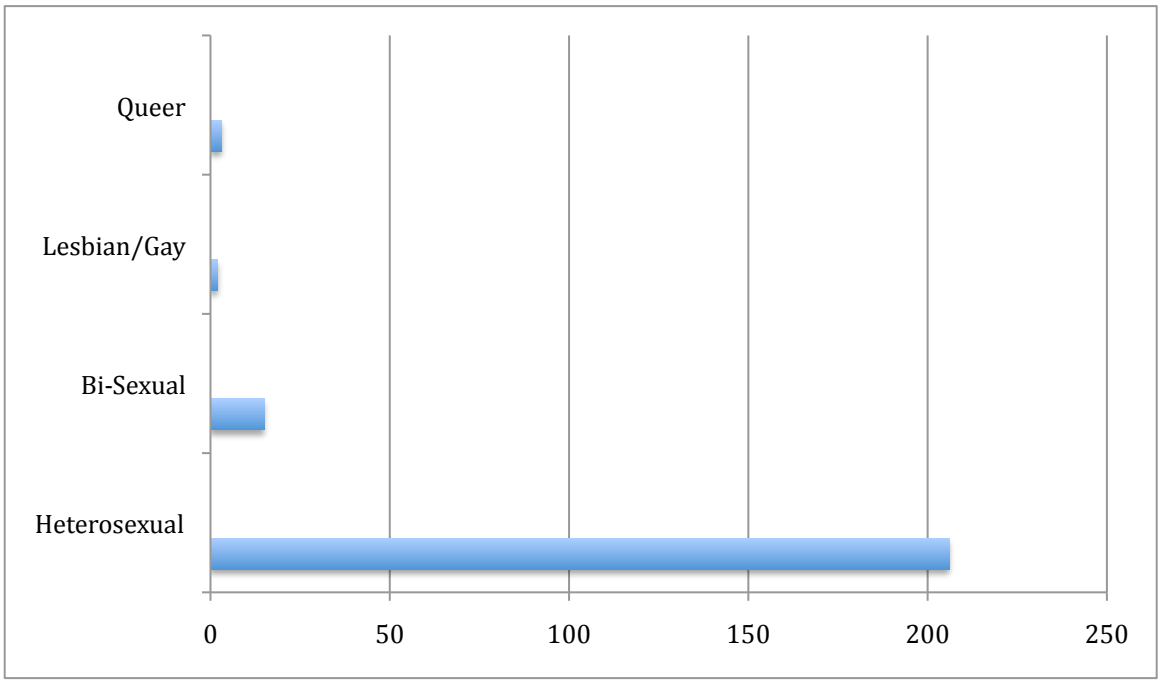

Figure 8. Sexual orientation of respondents. Copyright 2014 Jennifer A. Schwartz.

three other sexual identities were represented in the data.

Analysis of Short Narratives

As part of the initial Survey Monkey survey, each mother was asked for a brief description of her profound experience(s). An analysis of these 224 responses revealed several general themes. Specifically, the survey asked the mothers to:

> Briefly describe the experience you had while giving birth that you would define as profound, spiritual, transformational, or empowering. Your answer only needs to be a few short sentences; further details will be necessary only if you participate in the next phase of the study.

There was no limit to the length of this brief response. Most mothers wrote a short one or two sentences; a few wrote much longer descriptions. While reading through the responses, I created categories to group together similar types of comments. I continued adding to existing categories and creating new categories until the entirety of the responses was included in these groups. Some responses are included in more than one

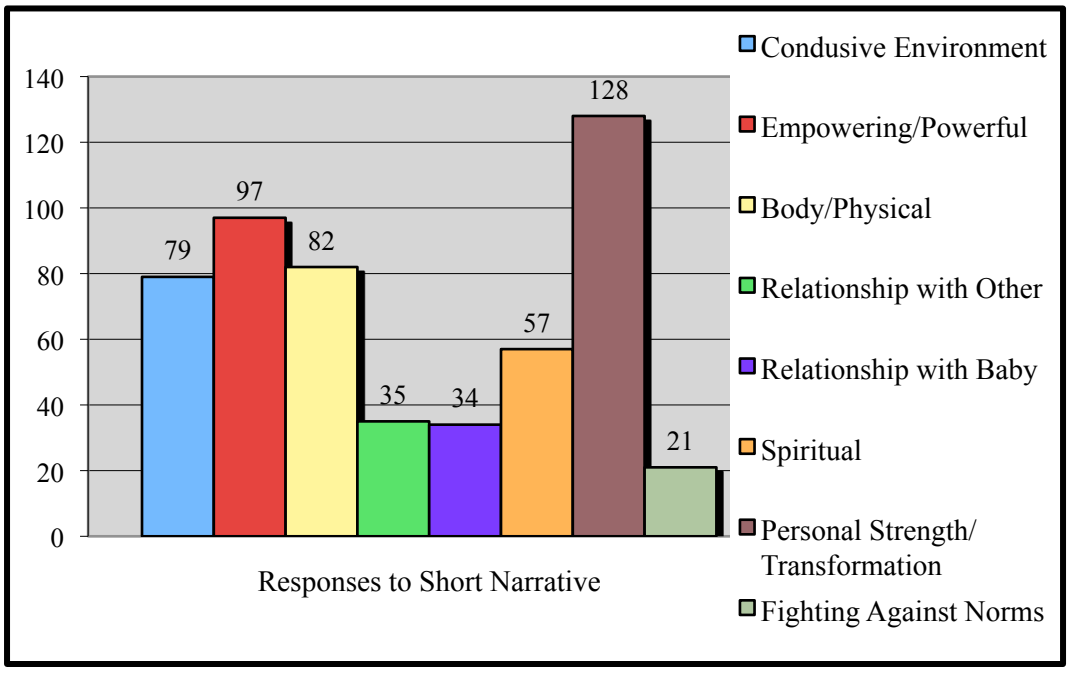

Figure 9. Responses to short narrative. Copyright 2014 Jennifer A. Schwartz.

category, such as when a mother made a comment about feeling that her environment was critical to the experience and then stated that she felt empowered by the process. The categories are shown in the table above.

Conducive environment. "I gave birth at home in a comfortable setting." "I had a natural birth with a midwife at a birth center." "Everyone on staff [at the hospital] was supportive and listened to me."[2]

Approximately 44% of the mothers (94) mentioned the location of their birth in their responses. Seventy-nine of the mothers made specific reference to the location of their birth and the contribution the location or setting made to their profound experience. Some of these 79 mothers did not provide enough information to know where the birth took place, but were clear that the setting was important. One mother stated, "I had a drug-free birth. I helped the process along by walking around a local park and then ended with a water birth that was just beautiful!" Based on these kinds of comments, it seems as though, in this sample, the actual location was not as critical as having a supportive environment in which to labor and birth. This varied from mother to mother, as some were more certain the setting was crucial to the experience. "It was a home VBAC [vaginal birth after cesarean] birth. A hospital would not have given me that choice and [would have] forced a repeat C-section." Several of the mothers stated that having had previous births in hospitals, the choice to give birth this time at home or in a birth center was much better for them.

[2] Please note that the names of survey respondents being quoted in the Analysis of Short Narratives section are not included, as these respondents did not always provide their names and therefore will remain anonymous.

Empowering/powerful. “Easy, empowering, and uneventful.” “I discovered my strength.” “So amazing and reassuringly empowering.”

The terms *empowering, powerful*, and other related phrases were used by 45% (97) of the mothers. Many times, the terms were used in isolation, so it is unclear exactly what the mother felt was empowering. However, there were some mothers who stated this more clearly. “Giving birth without an epidural was empowering,” said one mother. Others listed elements of their birth experience such as making informed decisions, realizing that their bodies knew what to do, and healing from previous negative or traumatic birth experiences. It is notable that medicated, unmedicated, and surgical births were described as empowering by this group of mothers.

Body/physical. “The most profound part was the way my body worked and took over pushing and how amazing it felt to go with my body rather than not push.” “I was amazed at how powerful and perfect my body had performed.”

Comments about physical aspects of birth were also common. Eighty-two of the mothers made specific references to the process of pain, the way their bodies worked, and how empowered they were by their bodies’ performances. “I never knew how strong I could be or how much I could go beyond my own physical pain,” was a common theme among these mothers. Some of the references also referred to the acceptance of pain management as empowering, such as the mother who stated she was “glad to make it to 8 centimeters with no medical intervention.” In a culture in which a common joke refers to getting the epidural as soon as you find out you are pregnant, handling even a part of one’s labor without pain management can be seen as a victory by many mothers.

Regardless of what a mother found empowering, 38% reported that their physical experience was empowering for them.

Relationship with others. "My husband embraced me and held me. There was something in that moment that was profound." "I experienced more love, support, strength and compassion in 8 hours than I had ever experienced in my life, from my amazing husband, my fantastic doulas (one being my mother), my midwife, AND myself."

It is rare in today's culture for mothers to give birth completely alone, although there are both planned and unplanned exceptions. In most cases, mothers are surrounded by teams of birth professionals (doctors, midwives, nurses, doulas), family, and friends. Thirty-five mothers commented that the support of others contributed to their profound experience. Most common was the mention of the husband or partner, but doulas, midwives, nurses, friends, and other children were also mentioned. "It brought my husband and I even closer," one mother reported, while another said, "It was amazing to have our little family there altogether to welcome the newest addition." Many of the women who birthed unassisted (that is, at home without the help of any medical professionals) remarked that being there with their husbands or partners was one of the most profound elements of the birth.

When my last son was born in 2012, my three older sons were in the room. One of the most beautiful moments of that birth was looking at my (then) 13-year-old who was in tears. He hugged me and said, "I am just so happy to see you so happy!" It is amazing the level of connection one can feel with others who are present at a birth.

Relationship with the baby. "Holding my baby in my hands for the first time was the greatest miracle." "I felt our child working with me to be born."

Holding their babies for the first time is a common profound experience among mothers. Many women say that becoming a mother doesn't feel real until that moment. For some mothers there is also a profound connection with their baby during labor. Thirty-four of the mothers surveyed described a connection with their baby as a part of their narrative. The first contact was reported as profound by 22 of the mothers, while the remaining 12 listed things such as "visualizing every detail of the baby descending down the birth canal," and "feeling my babe and I working together to bring her down and out into this world." For this 16% of the mothers, being connected with their child was a profound experience.

Spiritual aspects. "I felt every woman on the planet with me as I circled on the birth ball." "I was praying through the contractions."

More than one-quarter of the mothers (57 women, 26%) reported having a specific spiritual experience while giving birth. The term *spiritual* is used here to include religious references as well as connections with a higher power, connections with ancestors, or connections with the unexplainable. Religious references to God, Jesus, Heavenly Father/Mother, or prayer were made by 20 of the women, while the remaining 37 either used the terms *sacred* or *spiritual* or described other kinds of spiritual experiences. Several mothers stated they felt connected to other mothers giving birth or the ancestral line of mothers to which they were now connected. One mother stated she had a "floating, out-of-body feeling," while another referred to being "somewhere between the veil of this world and the world beyond." Details of these spiritual

experiences varied from individual to individual but were a common thread among many of the mothers.

Personal strength/transformation. "I felt that I could achieve anything after having given birth." "There was nothing about it that didn't leave me untransformed."

The most common theme among the narratives were statements about personal strength and transformation. Sixty percent of the mothers (128) stated that their birth experiences were transformational for them. Among these responses were the mothers who found this birth experience to be healing after a previous birth, as well as those who found strength they did not previously know they had. "I am forever a different, stronger, more powerful woman because of the experience," said one mother. "Being fully present has made that birth the most empowering experience of my life," stated another. Another theme among these responses was that of being in control. A number of women reported that knowing they were in control of their choices was profound for them, while others were surprised at how in control of their bodies and emotions they felt. Ironically, other mothers remarked that their ability to lose control and give up power was the profound part of giving birth! Experiences differ, but the personal transformation available in birthing was recognized by many of the mothers.

Fighting against the norms. "It was empowering to know that I was capable of giving birth naturally, especially to do so in a place [such as a hospital] where it is not the norm." "I did it [gave birth in a hosptial with no pain medication] despite people telling me I was crazy."

A final theme was the mothers finding power making choices outside of the "norms" of birthing in the United States. For most, this was having an unmedicated birth

in a hospital setting or delivering a breech baby vaginally. For one mother, who gave birth to twins in a hospital after three previous natural birth center and home births, it was the act of pushing while being ignored by the nurses around her. “I pushed, and what part of me still knew I was in their environment felt a bit rebellious,” she said. For all of the 21 mothers (10%) who “fought against the norms,” the empowerment they felt was an important part of their birth experience.

Other responses. There were two responses that did not fit into any of the above categories. One mother wrote, “Induction, breastfeeding, pain mangement.” I was unable to deduce what she felt was profound from this statement. The other was more clear and wrote, “Don’t know that I had any of this….I don’t know that I could call the births by the above adjectives.”

Summary of the short narrative analysis. Each mother’s experience of birth is unique. Yet, there are common themes that emerged in this study, even among the short narratives that were provided by the survey respondents. It is clear that among these mothers, giving birth was an empowering and transformational experience. What is unclear in about a quarter of the responses is what exactly made it so. While these mothers responded saying, “Yes, my birth was spiritual/empowering/transformational!” there was not enough information to understand what was behind the choice of adjectives used. In the remaining responses, the stories begin to create a picture of the birth choices, attendants, personal beliefs and environments that created opportunity for profound experiences.

The Interviews

Interviewees had to be selected from the pool of potential participants. I read all of the 224 short narratives, highlighting those who spoke of profound experiences. Of the 63 that most exemplified profound experience (based on a search for key words and personal judgment of the short narrative), a chart was created with all demographic information. From that data, I selected mothers to contact based on two criteria:

1) Did the mother add to the diversity of the study?
2) What was the mother's geographic location?

Because I travelled throughout the country, I grouped the interviews by proximal location. In the end, 15 interviews were completed. The following data outlines the demographic data of the 15 mothers who were interviewed.

Age: Five mothers fell into each age category, 25-30, 31-35, and 36-40.

Educational Level: Three mothers had high school diplomas, two had some college, two had 2-year degrees, six had 4-year degrees, and two had advanced degrees.

Annual Household Income: Three mothers had incomes of $20-39,000, five mothers had incomes of $40-59,000, two mothers had incomes of $60-79,000, one mother had an income of $100-149,000, and two mothers had an income of over $150,000. Two mothers chose not to answer.

Marital Status: One mother was single, one mother had a partner, and the other thirteen mothers were married.

Religion: Four mothers identified as Christian, one mother was Muslim, one mother was Pagan, seven mothers were Spiritual/non-Religious, and one mother identified as "None." One mother chose not to answer.

Ethnicity: Twelve mothers identified as White, one mother identified as African-American, and one mother identified as White and Hispanic. One mother chose not to answer.

Sexual Orientation: Twelve mothers identified as Heterosexual, one mother identified as Bi-Sexual, one mother identified as Lesbian, and one mother identified as Queer.

Mothers' Stories

Each interview was unique, both because the mothers' stories are unique and because the rapport, sense of intimacy, and level of focus varied. Overall, mothers were eager to share their stories and often thanked me afterwards for the opportunity to do so. Many times children were present – either the babies about whom the mother was sharing or older siblings. The children would often come sit by their mothers to nurse, to hear the stories, or just to be close by. Sometimes, the mothers needed to tend to children's needs and would return to resume the conversation. Our meetings were less like formal interviews and often more like two women sharing tea while the children played (my infant accompanied me on some of the earlier interviews).

Each story told creates a picture of a distinct moment in time. Each mother had her own unique experience to share. There were, however, commonalities among the stories, and themes that began to emerge. Each story included, in its unique way, the timeline of events a particular mother and baby needed to bring new life into being. More than

feeling grateful for the research goals that were being accomplished, I felt honored to be included in the sharing of the intimate details of each mother's personal journey. What follows is a short analysis of each story, including quotes from the mother and identification of the most applicable eight categories of profound experience created in the previous Short Narrative Analysis section. Most of the mothers shared elements of their experience that could fit into all of the eight categories. Here, I highlight only the most prevalent ones.

Also included with each story is the art piece created by the mother, as well as her reflections of the piece. The actual art analysis follows these sections. In order to allow the reader to experience the art before examining them through my assessments, some page breaks occur in the text in this section.

Brianna, baby Peter, home birth. Key Experiences: Conducive Environment, Body/Physical, Personal Strength/Transformation.

"It was the most amazing day of my life. And I can't think of another day that trumps it" (Brianna).

Healing the trauma of one birth can often happen through the experience of a subsequent birth. This was definitely the case for Brianna who knew, even before becoming pregnant with her second child, that her first birth experience was not something she wanted to repeat. She said that it was a long time before she felt any connection with her oldest child, due to an induction and epidural. After several pregnancy losses and the stillbirth of another child during the second trimester, Brianna finally gave birth to her son, at home. "I need this deep, spiritual impact that I knew I was a participant in what I had done," she said. Not only did Brianna experience being able to

give birth in her home where she felt comfortable, but also she felt her midwife allowed her to follow her instincts and honored her wishes to let the birth process proceed naturally.

Feeling her son's head as he emerged was another profound aspect of Brianna's birth experience. "That little moment before I finally got to hold him where he's in between worlds, and I'm like, Yes! This is what I wanted!" While Brianna had a difficult time coping with back labor, she loved that she was able to feel everything, unlike her previous experience with an epidural that made her feel as though she hadn't really given birth. "It was hard work, but it was worth it," she said. Having followed her instincts in birth, Brianna felt that she was more able to parent the way that felt right for her after her son was born.

Figure 10. Art image created by Brianna.

Brianna described her art as a tree with a knot that was taking in oxygen. She stated that the knot in the tree looked like a yoni, the most sacred part of both the tree and the mother, and that she felt as though you were looking into the most sacred part of the tree and the woman in this image. “I decided to turn the tree into a woman since it’s the strength of us, and it has to create life,” she shared. She likened the rings of the tree to the

stretch marks many women have from giving birth, and described the symbiotic relationship between tree and pond, similar to the relationship between mother and baby. Brianna also realized that, when discussing the art, it looks as though the woman/tree is ready to dive into the water. She said, "There's always that moment [in birth] when you're in that 'hold your breath and dive'."

Celeste, babies 4, 5, unassisted birth and home water birth. Key Experiences: Connection with Baby, Spiritual.

"I can clearly do it on my own, but I think I did feel some relief when they [the midwives] were here" (Celeste).

Celeste's story was unique, in that it encompassed three births over the course of four years. We focused on the two most recent births, which were six months and two years prior to the interview. Celeste felt the birth of her two-year-old daughter was more spiritual and profound than the birth of her six-month-old son. Throughout the pregnancy, Celeste felt spiritually connected with her daughter and shared that "the whole pregnancy was really neat, because it was like we were communicating the whole time." She dreamed she was carrying a girl and then dreamed the entire birth. "And that was exactly how it turned out," she said. Her daughter was born at home without the help of a midwife or doctor, commonly referred to as an unassisted childbirth (UC). After three previous positive birth experiences, Celeste said she did not feel fearful of birthing unassisted, but felt that her desire to know that everything would be okay was the reason for her dreams of the birth.

In her next pregnancy, Celeste had a similar feeling of knowing what she and the baby would need, and this time she chose to have a midwife attend the birth. "It was

really odd that something was telling me that she should be there," she said. Celeste mentioned that it felt like it was a "step back" to hire a midwife after having an unassisted birth, yet the nagging feeling that she would need the midwife continued. Shortly after giving birth, when Celeste stood up to get out of the birthing tub, she fainted. This was her confirmation that her feelings had been accurate. Having the midwife present for this moment was critical, as the midwife and her assistant were able to tend to Celeste and stabilize her. She says she cannot say where the "knowing" came from, only that she knew. "It was just a feeling, I guess, but something would have to tell me, I suppose, to have that feeling." Listening to her instincts was a profound element of Celeste's birth experiences.

Figure 11. Art image created by Celeste.

The womb in Celeste's art is both a literal and figurative representation. She described this image as both dreaming of the impending birth and what she imagined while visualizing her daughter during labor. She also stated that the colors were both the colors of her dreams and the aura surrounding her baby. Celeste's father died weeks before her daughter was born, and while she found it difficult to articulate exactly how he was connected to her birth experience, she says that she felt "his spirit was there somewhere" and has remained connected to her daughter in some way. The colors/aura in her art represent her father as well.

Christy, baby James, home birth. Key Experiences: Spiritual, Personal Strength/Transformation.

"I had to be okay with whatever happened" (Christy).

Going into labor at 37 weeks was challenging for Christy. Like most mothers, she had expected to have more time to prepare for her birth. She spent much of the early labor period coming to a place of acceptance. "I have that, 'Great, I guess I'm having a baby today!'" she said. The early hours of birth did not follow a pattern that had been typical of her previous births, so Christy spent time worrying about what might happen. When she surrendered to things unfolding in any way they might, her labor became more active and progressed faster.

Christy spent some of her active labor alone in her room, which she felt was instinctive to her. "I just get really inside my head, and I have to be in a really spiritual place, really be centered and zoned, and I just go with a surrender and my body just does what it does." It was in a moment of solitude that Christy heard herself say, "I can't do

this anymore," and she knew that birth was imminent. Her body began pushing during that contraction, and baby James was born within minutes.

Another profound moment for Christy was after the birth. She described to me the expectation in her family to have four children, and the sting of hearing her husband say, after the birth of their fourth, that they were finished. "I never felt like I was done, ever," Christy stated. She had not been trying to get pregnant when she conceived James, but she felt that "if there was a spirit around or whatever, that was the one chance for someone to jump in and be my child." She described the journey to birthing her fifth child as one that centered and completed her. "When you feel the intensity of birth, it rocks your mind, your body, your soul, and every part is shaken to the core. Here you are, centered, and you walk back from that…It will change your life, just having been there, because you get the knowledge that whatever comes your way, you're gonna make it through." This feeling of being centered, and of feeling that she did what she was meant to do (having five children instead of four), left Christy feeling empowered and as though life is more meaningful.

Figure 12. Art image created by Christy.

Both Baby James and Christy are represented in the art that she created. The way they are holding hands was exactly what she found herself doing shortly after his birth. She left their faces out of the image, because "it's more of a spiritual feeling and connection." Even though the details felt more subtle to Christy, she also felt the powerful, colorful and intense emotions of birth, and represented them with the bright

flowers. She described both the art and the birth as bold, vibrant, and wonderful rainbow type energy. Christy hoped to capture the perfect moment of birth in her art, while capturing the peace and clarity of being enveloped in the intensity of the experience.

Dana, baby Reed, home birth. Key Experiences: Relationship with Others, Personal Strength/Transformation, Spiritual.

"We did a lot of work on releasing and just telling Reed I trusted him. It was his time to come" (Dana).

Giving birth to an eleven-pound baby, at home, was a transformative experience for Dana. Her previous birth, four years earlier, had left her feeling anxious, nervous and distraught. She described it as feeling "broken wide open," as though nothing she knew was true. Dana felt, from the time Reed's spirit came to her (approximately two and a half years before his birth), that this birth would be a healing experience and would bring resolution to the experience of giving birth to her daughter. The intensity of labor pushed Dana to her threshold and thinking, "This is not a healing experience! This is bad!" She repeated several times that she felt like she had reached the limit of what she could tolerate.

At the peak of reaching these limits, Dana decided that she wanted to transfer to a hospital for pain relief. Her description of her three birth attendants (midwife, doula, and photographer) is both intense and comical. "So all these little women, and I'm a big woman, I started walking to the door and they got up and got in front of me." Many women reach a state of being irrational during labor, and Dana had definitely reached that state. Her midwife began by focusing on having Dana put on clothing, or at least wrap herself in a sheet, for the drive. Within a few minutes, the midwife had calmed Dana

enough to do an internal exam and explained that Dana was so close to having a baby that a drive to the hospital would most likely result in birth in the car.

Most profound of all was Dana's willingness to trust the midwife through the process. "Previously, I had the type of personality, like, 'Why would I trust someone else's opinion of me over my own?' That was the most transformative aspect…that I listened to somebody else, that professionally, personally, spiritually, they thought, they *knew* that I was fine and I was okay, and that they were not going to support me in making a decision that didn't feel like was in my best interest." Dana realized that without the trust she had in her midwife, she would have gone to the hospital, reinforcing the anxiety and nervousness she felt after her daughter's birth. "Life's a lot better when you're not going it alone," Dana stated.

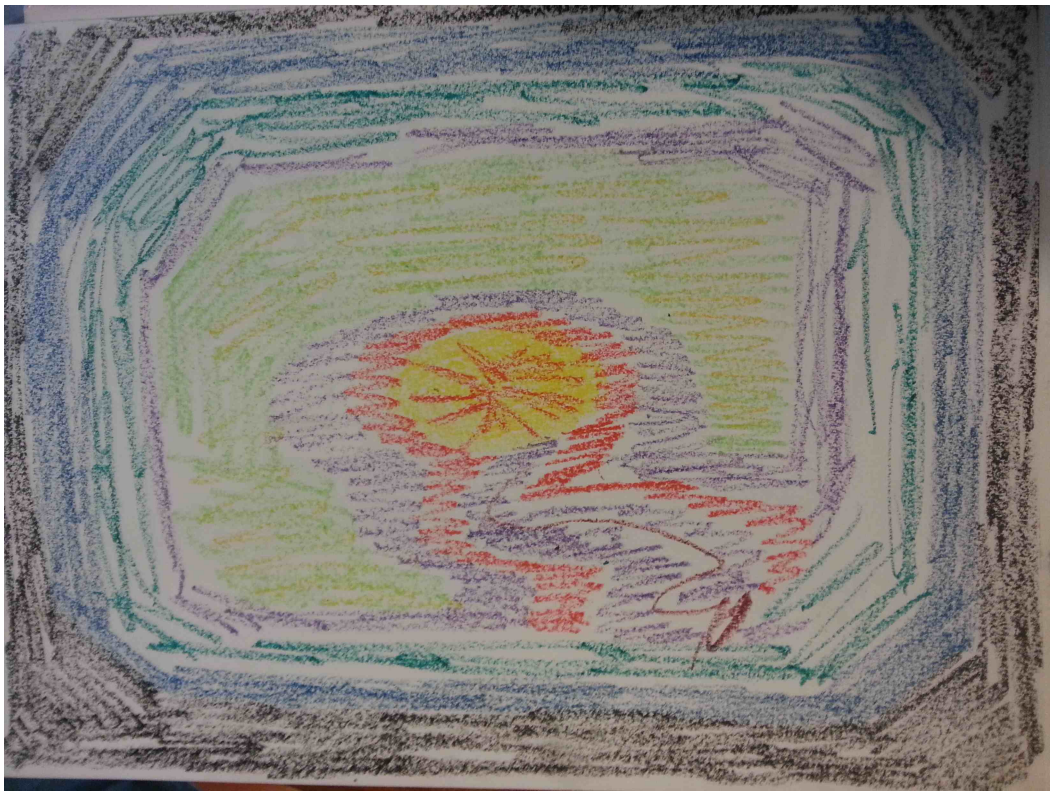

Figure 13. Art image created by Dana.

Dana stated that she sees things in shapes and blocks of color, so this drawing was typical of something she would create. The yellow and orange in the middle represent herself and baby Reed, and the brownish line was actually added by her four-year-old daughter. "It's really funny that J put that in there, because it really is like, that is her, like 'I'm here too!'" The black outer layer, Dana explained, was who she was and where she had come from, with the other colors representing what it has taken to get to who she is now. Each color also represented a specific person she felt was crucial to her journey: blue is her husband, green and purple are two friends who were present, and the other colors represent the other people who attended Reed's birth. She described these people and colors as both surrounding and witnessing her, woven around her but also in the background.

DawnStar, baby Juniper, home birth. Key Experiences: Relationship with Others, Personal Strength/Transformation, Spiritual.

"That moment when the baby was born… that moment of seeing this sort of, 'Oh, there's a real baby!'" (DawnStar).

DawnStar had what she described as a traumatic fourth pregnancy, ending in a relatively uneventful birth. Low energy, difficult life circumstances, and physical exhaustion all contributed to DawnStar's feeling stressed and tired for the entirety of the pregnancy. For this reason, she says it was hard to believe that her daughter was really here after the birth. She describes the most transformative moment as catching the baby herself and realizing, "I really *do* get a baby out of this!"

There were profound moments during the birth as well. She appreciated that her husband was able to be supportive and do what she needed while she labored. "It's just

what our relationship is like… you just do what needs to be done." Turning her attention from negative to positive thoughts was also a turning point for DawnStar. "I started saying 'Ow' which isn't really a very productive thing for me to say, and the midwife said to me, 'You're doing okay.' And I started saying 'okay' instead of 'ow', which was good." She feels that saying or thinking something that is positive and true, rather than negative, is helpful to her.

When baby Juniper was born, DawnStar noticed that the cord was coming up over one shoulder and around her neck. "In my head it looks like a stole which is symbolic to me because I'm a religious professional. I don't actually wear a stole, but it's the shape of it, which is neat to me." For DawnStar, her religious background gave meaning to this symbolic arrangement of Juniper's cord.

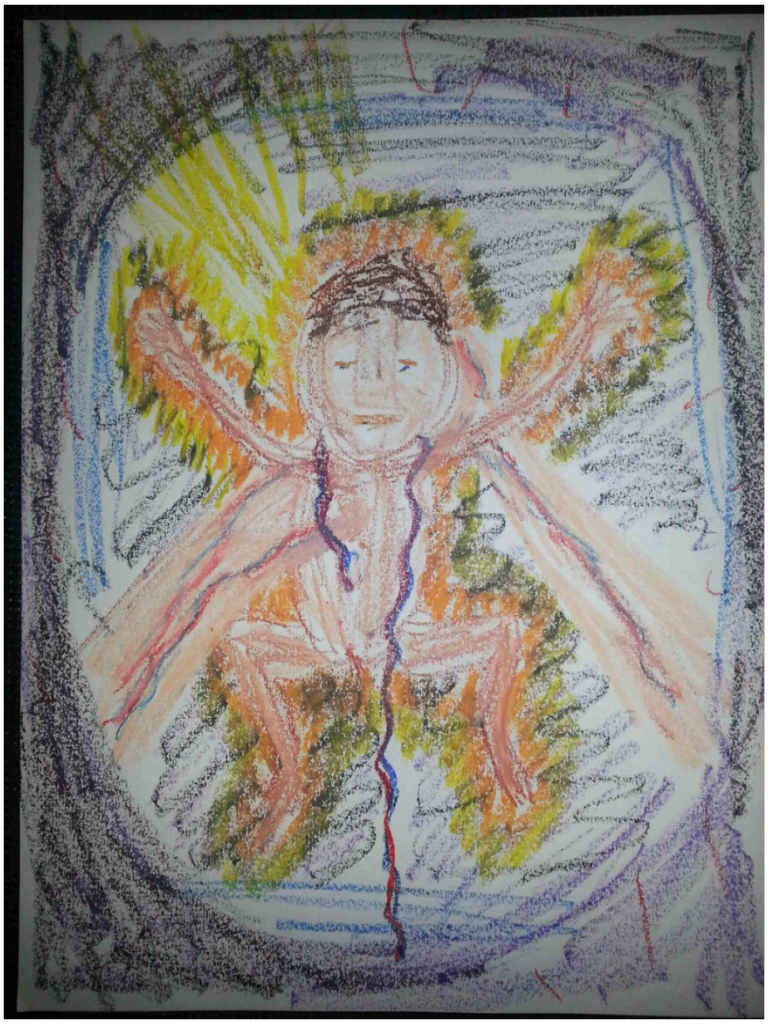

Figure 14. Art image created by DawnStar.

The dark colors on the edges of DawnStar's art image represent both the literal darkness of the late hour at which her baby was born and the atmosphere she felt she had been in throughout her pregnancy. She described the drawing of baby Juniper as more of an archetypal baby than a specific, detailed representation of her child. She is holding the baby in the image, which she stated was because she caught Juniper when she was born. The colors surrounding the infant are a symbolic spiritual aura. "I didn't see an aura when I was catching her, but just on an emotional and spiritual level, that's what it felt like," she explained. The light in the drawing, especially on the top left, also represented light

from the headlamps that the midwives were using to see the baby, but DawnStar felt it also was a reminder that there were helpful people in her personal experience of darkness. Creating this art deepened the moment of DawnStar's story for her. Specifically she stated, "I would never say the baby had an aura around her, it's just not my style somehow…but there's no way I would draw the picture without putting it in there." It was something that was definitely a part of her story, yet she would not have included it in the telling of the story.

Eliza, baby Teegan, home water birth.[3] Key Experiences: Personal Strength/Transformation, Spiritual, Relationship with Others.

"So many women don't ever get to have that spiritually profound, life-changing experience" (Eliza).

Eliza's story started with the birth of her four-year-old son. Joel was born at 33 weeks, approximately seven weeks premature. Eliza attributes the stress she was under in an abusive marriage to the early birth of her child. When her water broke at 33 weeks, she realized that the home birth she had planned was no longer in the cards. During the birth, she asked the hospital staff to leave her alone as much as possible and spent hours meditating and visualizing herself on a beach or at home. "I just chose to be somewhere else. I chose not to be under fluorescent lights. I chose not to be in a sterile environment. To just be somewhere else." Even though Joel spent a month in the neonatal intensive care unit she describes the experience as magical and beautiful.

Several years later, Eliza had married her wife Kelly. They decided to have a baby that Kelly would carry, using Eliza's brother's sperm. Eliza spent the pregnancy caring

[3] Note: While Eliza did not give birth to baby Teegan, I chose to include her story, as it is a beautiful example of the healing power of birth.

for Kelly, ensuring she ate enough protein and preparing herself for birth. Eliza, who is now a student midwife, was able to work with the midwives they hired throughout the pregnancy in a greater capacity than most expecting parents. During the birth, Eliza gave Kelly everything that she had wanted, but not gotten, in her previous births. She hung affirmations on the wall, provided food and drink, and got into the tub with Kelly to support her in any way she was asked. When Teegan was born, Eliza was in the pool catching the baby while the midwives looked on. "I just think how grateful I was that she got to have this instead of the garbage that I had. She got to experience that empowerment, and she got to know what she was capable of."

While Eliza was not the one giving birth in the case, she still felt that this birth healed the wounds of her previous experience. "That's why I say vicariously that I got to have my perfect birth, and it was very healing for me. It was healing to give her what I had needed so much." The love and connection Eliza feels with Kelly is palpable throughout her story—she refers to *we* far more often than *she* or *I*. "We started having contractions," she would say, or "We gave birth in such a normal way." Eliza feels that the strength Kelly gained in giving birth has strengthened their marriage and changed her life because she gets to be married to such a strong woman. Referring to Teegan, Eliza says, "She is my daughter and I love her completely, just like I love all of them."

Figure 15. Art image created by Eliza.

Eliza and I did not get a chance to talk about her art creation due to time constraints. The power of the image that she created is evidenced in the bold lines, and

the lotus on the mother's belly is a common archetype used in birth art to represent both softness and opening.

Kate, baby Jude, home birth. Key experiences: Personal Transformation, Conducive Environment, Spiritual.

"From, like, the point of when I started pushing there was, like, this clarity and calmness, which was amazing" (Kate).

Giving birth at home with her partner, two midwives and a doula, was an empowering experience for Kate. Having attended about 15 births as a doula, Kate felt prepared for the physical side of birth but had been concerned about feeling out of control. Previous panic attacks were a worry for her, but she felt very relieved when she realized that while the physical experiences were intense, she felt both lucid enough to move through the sensations and as though the more rational side of her brain had gone into an observational mode. Her experience of Jude's birth left her with a feeling of knowing that she could trust her instincts and trust her body. "The only way I know how to describe it is I felt so in control and out of control at the same time," Kate stated. "It was like a small part of my brain was kind of watching what the rest of my body was doing." While Kate did not report having an out-of-body experience, this kind of language—feeling as though one is watching what is happening in one's own body—is often used to describe out-of-body experiences. Kate also reported that she felt her birth might have gone more quickly if her midwives had come sooner. Having them present was a factor for her in having an environment that was conducive to birthing.

Figure 16. Art image created by Kate.

Kate drew herself in her bathtub. She explained that the faucet was oversized because it became a focal point for her during labor. The sound of the water coming out, she said, was calming. She also stated that she felt self-contained and powerful at the moment she depicted. “Our bathroom is tiny. I think that is very primal to get into this tight, safe little spot,” she said. In the background are her partner, midwives, and doula. The background of the picture was also important to Kate. She drew her shower curtain not only because it was there when baby Jude was born, but also because it was a symbol of empowerment and strength for her.

Lisa, baby Ruby, home birth. Key experiences: Body/Physical, Relationship with Others, Personal Strength/Transformation, Fighting Against Norms.

"I have never felt a more triumphant or transcendent moment in my life" (Lisa).

Lisa worked hard to surround herself with people, stories and information that set up a profound birth experience. Connecting with her husband, Scott, during labor was one of the many beautiful experiences she shared. "We had this very sweet time of just being together," Lisa stated. Scott also caught the baby when she was born, which Lisa said was one of her favorite parts of the birth experience.

Several people in Lisa's community had less than ideal birth experiences during her pregnancy. "So many people told me I could not do it [give birth at home, un-medicated]," she said. She felt somewhat fearful of having a similar experience, and during labor she asked, "Are you sure it's too late to go to the hospital? Are you sure it's too late for drugs?" Having a supportive birth team was critical for Lisa in those moments.

Lisa described the physical aspect of birth, especially the pushing stage, as excruciating. "I feel like my body is being fucking ripped in half," she told her acupuncturist. When the acupuncturist confirmed, "Yes. That is what birth feels like," Lisa felt validated and was able to refocus and continue. Knowing that the pain was normal, and had a clear purpose, was enough for her to carry on.

Ruby was Lisa's first child, and she does not plan to have another. Knowing this, she says, "I knew that I had this one shot to have this experience." The feeling of triumph, of having done something that others told her was not possible, left her knowing

that she could be a good mother. Lisa feels that she can trust her instincts and her inner voice.

Figure 17. Art image created by Lisa.

"I didn't realize until I was drawing it, like how that moment, I just felt like everyone else just ceased to exist," said Lisa. She explained that the drawing is just the two of them because, at the time of the birth, she felt as though they were the only people in the room. The light symbolized the intensity of the feelings she was having. "It was like the warmest, brightest, most loving light was shining on me," she said. Lisa also described feeling like a warrior, a dragon mama who was empowered by the intensity of the experience. Like other mothers, Lisa said she would not have described much of these feelings in words, but in image she was able to capture those thoughts.

Meagan, baby Charlotte, hospital birth. Key Experiences: Body/Physical, Relationship with Others, Spiritual.

"You think you know, but you have no idea" (Meagan).

Meagan described her pregnancy as a nine-and-a-half-month meditation. She dealt with questions such as "Who do I want to be? What kind of mom, what kind of woman, what kind of version of myself?" Her mother, a certified midwife, came into town a few days before her due date so that she could attend the birth. Having the support of her mother, the nurses, and her midwife was pivotal for Meagan. Her mother provided support, herbal concoctions, and guidance, and the voice of a nurse telling her, "You're doing it and you're doing awesome," gave her the encouragement she needed to keep going.

The primal aspect of birth overcame Meagan at several moments. After receiving a dose of Pitocin to increase contractions, she described herself as feeling like a tiger and as though she was breathing fire. "It was the strongest, most bad-ass I've ever felt in my life. I wanted that pain because it was mine. I didn't want to run away from it. I wanted to own it. And I wanted to conquer it, and I wanted to slay it." Accepting the pain led to the most spiritual moment of Meagan's birth experience. "All of a sudden the pain stopped. I was just leaning on the hospital bed and I closed my eyes and I could see this baby's face. It felt like I was looking into my birth canal." She described that moment as feeling safe, connected with her baby, and connected with her body.

Meagan described natural birth as "the greatest gift a woman can give herself." For her, giving birth naturally was empowering and normal. She feels that birth made her a

stronger person, more capable of setting boundaries for herself, and able to be the kind of mother she wants to be.

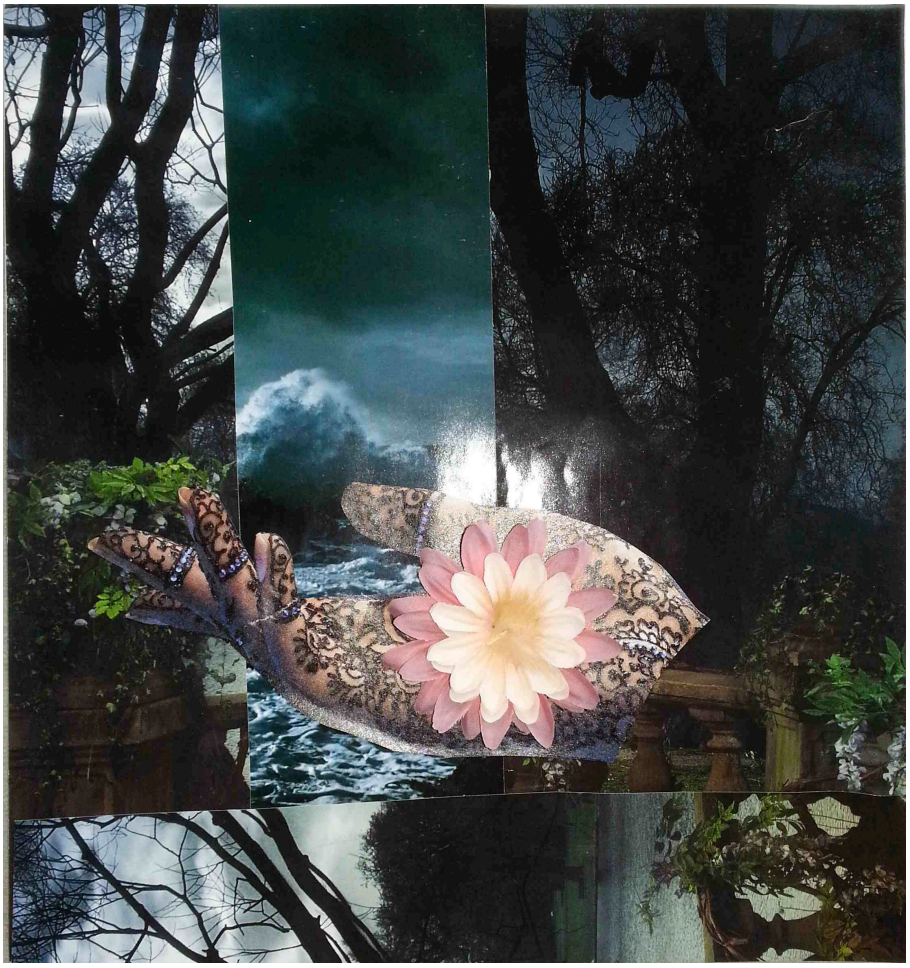

Figure 18. Art image created by Meagan.

The darkness and waves in Meagan's art represented, for her, the difficult contractions caused by the Pitocin, from which she was not getting a break. When she closed her eyes, however, the experience changed: "I saw this little, tiny baby. And it was peaceful, and the darkness was peaceful, and it was all okay." The hand in Meagan's art felt to her to be old and spiritual, representing her mother and grandmothers and other women who have endured pain for birth. It was also an image that reflected the womb

holding her baby, safe and peaceful even in the midst of the darkness, the intensity, and fear. The idea of being lost in a forest was described by Meagan as scary, until the moment of seeing light and knowing that all was well.

Natalie, baby Judah, hospital birth.[4] Key Experiences: Body/Physical, Fighting Against Norms.

"I felt like Gollum holding his ring, like 'Get away from my baby!' I was growling at everybody" (Natalie).

Natalie's planned home birth ended in a hospital transfer after more than 50 hours of labor. Her experience as a doula gave her the knowledge that things were fine but also that her exhaustion was beginning to get the best of her. After receiving a shot of morphine, but missing the nap she had hoped for due to an ultrasound, Natalie began a battle against hospital policies. She finally convinced the doctor on-call to break her water (something she had asked her home birth midwife to do twice) and baby Judah was born two hours later. Natalie had several negative interactions with the doctor and with a midwife who was also on-call. Rather than respecting her wishes, Natalie felt that both women were rude and angry about her decisions to labor naturally and delay cord clamping. "I was this big Amazon woman trying to labor, and I was mad at that point. I was just like, this is ridiculous."

One goal Natalie had for this birth was catching her baby herself. She said it was a wonderful feeling to reach down and catch him and to then create a wall around herself and Judah so that no one could cut his cord too early or try to take him away. "I was in the perfect position to catch him… 'Who delivered, who delivered for you?' No, I did. I

[4] No image available. See Procedures for Data Collection & Analysis section for details.

caught my baby; my body did that." She felt a trust in her body and the process of birth after laboring for several days and still birthing a healthy, happy baby.

Natalie's image included two rainbows, with Baby Judah between them. Both the baby and her arms are red and glowing, and the picture is surrounded with darker colors. She said that her arms were red because she had been working so hard and that the red represented the heat off her body. "He's glowing, and I'm still kind of glowing, but then there's all this dark around because that's…where we were was kind of a darker, darker place than I would have chosen to birth him," Natalie said. Judah, she explained, was the "bright light out of the whole story," and catching him herself, after such a long and unplanned labor, was the light at the end of the experience.

Raegan, baby Genevieve, unassisted home birth.[5] Key Experiences: Personal Strength/Transformation, Connection with Baby.

"I just had a lot of confidence that I didn't need the midwife there" (Raegan).

Raegan's birth experience was surrounded by thoughts of knowing that all was well, knowing what to do, and taking charge of what needed to happen. While she had a midwife, she chose at the last minute not to call her and, instead, have the baby with only her husband's assistance. "I just had this total clarity of what I had to do," she said. Reagan was able to give her husband clear directions and felt confident that she did not need the midwife's assistance. "It was the best possible situation to just be by ourselves."

The most spiritual moment for Raegan was feeling her daughter's hair through the amniotic sack before she was born. "I was so close to her, but still on the other side. It was a transcendent moment. I could see out, from outside my situation." The duality of

[5] No image available. See Procedures for Data Collection & Analysis section for details.

feeling present in the moment, while feeling somewhat out-of-body, was illustrated in her connection with Genevieve.

Reagan drew a picture from her perspective, looking down and touching Genevieve's hair. In that moment, alone in the tub with just her baby, Reagan felt certain of herself and trusting of her own autonomy. When drawing, she remembered that after Genevieve's head came out, she asked her husband if the water was still clear (the presence of green or brown fluid can indicate potential distress for the baby). "He didn't understand the question, so I asked him if he could see her face and he didn't understand that question so I took it as a 'no' and go ahead." These details were important to Reagan's ability to birth without a birth assistant and were remembered as she created the art.

Saadia, baby Hassan, hospital birth. Key Experiences: Empowering/Powerful, Fighting Against Norms, Spiritual.

"Then we were saying certain prayers and stuff like that. Everything else was out the window" (Saadia).

Giving birth in the hospital triage area, without her husband, was not Saadia's plan for a natural, empowering birth. She spent her pregnancy planning to birth in the birth center attached to the hospital, hoping that her husband would be able to get there from New York City in time. For weeks before Hassan's birth, she worried her plans would be changed. Due to hospital policies, she was told that if she did not correct her anemia she would not be able to use the birth center. After receiving several doses of IV iron, she was cleared for the birth center. In the end, her labor was quick, and she was not moved in time. "I was really depending on being in the labor pool, having the birth ball… 90%

of them [pain coping techniques] required for me to be in that room." She found that rather than feeling disappointed or upset, she simply felt acceptance. "It's 'Do whatever you need to do,' you know?" Saadia was grateful that most of the staff were respectful of her plan to birth naturally, and that even in a more clinical setting than she had planned, she was able to feel her son being born. "I remember wanting that moment, like really wanting to capture that feeling in my mind, you know, because it's such a unique experience." She finally reached her husband about half an hour after their son was born.

Saadia had two spiritual experiences during the birth. She described the duality she felt while giving birth. "Even though you are very, very present in it, in your body, it's still sort of an out-of-body experience in terms of everything external." There was a second duality that Saadia experienced while connecting to other women giving birth. Saadia said, "While I was thinking about the 11,000 other women giving birth at the same time around the world," she felt connected to feminine energy. She described the experience as being both universal and individual at the same time. Drawing on both her own internal strength and the knowledge that she was not alone was a spiritual experience for Saadia.

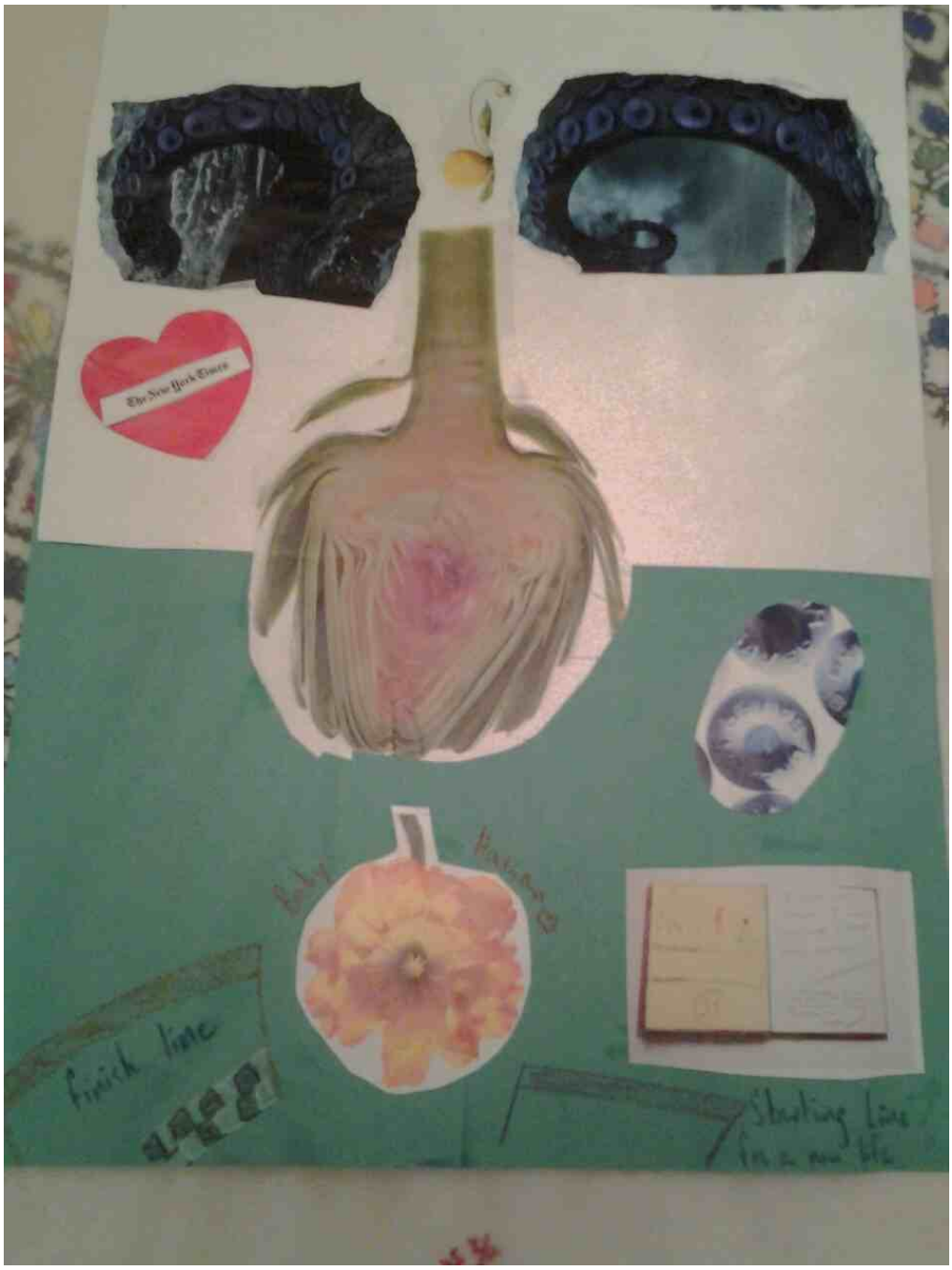

Figure 19. Art image created by Saadia.

Saadia's collage represented for her the experience of pregnancy and birth, including conception and her personal journey. The shapes she chose were meant to reflect the image of ovaries and uterus, including the "seed" of baby Hassan at the top

and the baby Hassan (a flower) at the bottom. The layers of the artichoke, she explained, reminded her both of the lining of the womb and the stages of growth that a baby goes through before being born. For Saadia, Hassan's birth was both an end and a new beginning. Her finish line represented the end of the pregnancy and birth journey, while the starting line represented a beginning of a new family that included her husband, older daughter, and new baby. She also added the breath mints, she said, because she spent much of her first trimester nauseous and sucking on hard mints. Finally, the *New York Times* heading in a heart was important to her because her husband was living away, in New York City, at the time of Hassan's birth. She stated that creating this art piece gave her an even deeper appreciation for her own body, and women's bodies in general, and what we are capable of.

Sally, baby Jena and baby Griffen, hospital birth.[6] Key Experiences: Fighting Against Norms, Spiritual.

"There's two people in there making me crazy. There's a placenta the size of Amsterdam! No wonder I don't feel good" (Sally).

The birth of multiples is considered high-risk in the United States. Most midwives cannot attend the birth of multiples in a home or birth center, and approximately 75% of women carrying twins give birth surgically. Sally knew from her three previous normal, natural births, that she wanted to do things differently. She agreed to give birth in a hospital (her previous births had taken place in a hospital, birth center, and at home) due to the increased risks with multiples, but knew from the beginning that she would do things her way.

[6] No image available. See Procedures for Data Collection & Analysis section for details.

There was also a spiritual aspect to the birth that began early in Sally's pregnancy. She described it as a voice in her head: Whenever she would think to herself "Four kids!" the voice would reply, "Or five…" The whisper of this voice was so loud to her that she often found herself looking around to see where it had come from. Upon finding out that she was having twins, the voice made sense. The feeling of being communicated to, and looked out for, by something she could not identify continued through the birth experience. "I felt so much the hand of God in just making it the best that it could be," Sally said. She felt as though she and her entire family were watched over throughout the pregnancy and birth.

Sally describes her birth as a "badly written comedy screen play," and hearing her story definitely invoked laughter! Hospital policies dictate that birth of multiples must take place in an operating room (OR). When Sally began pushing, a nurse began to wheel her to the OR. Until that point, she had felt supported by the nurses, her mother, her husband, and her doula. "I was so afraid to be in the OR because in my mind, for my whole pregnancy, that's where the knives are." In what Sally referred to as an act of defiance, she pushed out her first baby, Jena, while being wheeled down the hallway. She was still wearing an adult diaper, due to leaking amniotic fluid, and describes the scene: "Finally Jerry [her husband] was the one who had the sense to whip back the sheet, and there was this baby girl squirming out of the side of my Depends."

Adding to the complexity of the birth, the second baby was a double footling breach. Rather than being born head first or bottom first (the safest and easiest way for a breach baby to be born), he presented with both feet first. Sally was fortunate that her obstetrician didn't interfere with the process, telling her that it was up to her to bring the

baby down and out. Approximately 90% of footling breach babies are born by Cesarean section, and even though the first baby had been born vaginally, most doctors would have insisted upon surgical birth for the second baby. Sally is empowered by having done what many would say is not possible: giving birth to two babies vaginally without medication. She shared, "I need everybody on the [hospital] floor here to see that this can absolutely be done in a perfectly safe, respectful and evidence-based way. And that not only can a mother have one baby in a normal way, she can have two babies in a normal way." She hopes that the birth experience, which gave her a sense of calm and triumph, was able to teach others.

Sally drew what she called an "idealized family picture" that included herself, her husband, and her three older children in a protective bubble. Outside of this circle, she wrote, "Mom, doula, OB and nurses" to represent the other people who were involved, and the words *doubt*, *fear*, *respect*, and *triumph* because she felt these were things that were "just barely getting into the circle." Also outside of the circle were elements that Sally said were a part of her birth, but ones she did not want included in the safety of the bubble: the hospital bed with wheels, knives from the OR, and an orderly with an IV. The bubble was drawn in yellow, which Sally explained was like the gold on a trophy, the prize of the safe, protected family inside the bubble. She felt that the birth of the twins solidified the circle of family that they had created and made them all stronger.

Shelley, baby Soren, home birth. Key Experiences: Body/Physical, Relationship with Baby.

"This was like my rainbow baby, healing experience" (Shelley).

For Shelley, birth has always been a quick experience. Her third child was born in half an hour, so of course she anticipated a short labor with her most recent birth. Instead, she had what could be considered a "textbook" labor, with contractions that gradually increased in length and intensity until her son was born about 15 hours later. As a result, her family, including her older children, mother, mother-in-law, and husband, were able to be with her when Soren was born.

Shelley described "waiting" as the most profound part of this birth experience. "I spent a really concerted effort to wait for him, communicate with him when he was in the womb, just, you know, let him come in his own time and cherish that last month when we were together with him in the womb." However, there came a point during the labor when the baby's heart tones slowed dramatically. Shelley felt this was Soren letting her know that he needed more from her. "Oh yeah, now it's my time to not sit back and wait for you but to get what you're communicating to me. 'It's time to go! I'm not kidding Mom!' That's what's really cool." Soren had been wrapped tightly in his cord and was no longer receiving oxygen from the placenta. She feels that his communication with her was critical in his being able to be born safely.

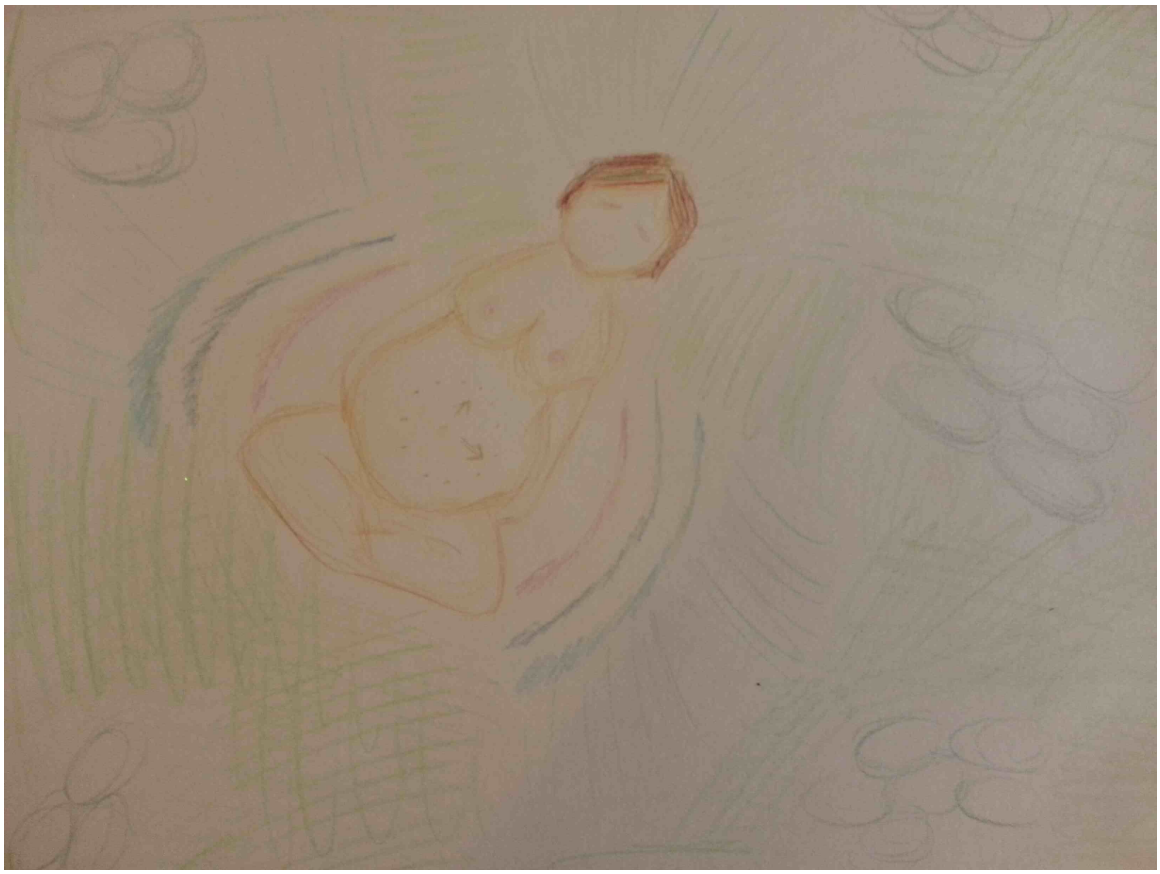

Figure 20. Art image created by Shelley.

For Shelley, the iconic vision of a birthing goddess is what comes to mind when she visualizes herself giving birth. Her art reflected this archetype, in her soft lines and lack of details. The clock, she stated, represented waiting and trusting her intuition. She said, "I just saw a clock in my head for that whole last time, just waiting it out. It's not like watching the clock; it was just the time for me." Shelley felt very connected to others while birthing: She represented people she knew with circles and other women who were strong and birthing at the same time, with lines. The connections she had with friends, both online and in her community, were very important for Shelley during her pregnancy and birth. She states that they contributed to her feeling calm and powerful.

Tonia: baby Dev, home birth. Key Experiences: Personal Strength/Transformation, Relationship with Others, Relationship with Baby, Spiritual.

"I remember thinking this teamwork was great because I felt like Lucy and TJ and even the baby were kind of like cheering me on" (Tonia).

The most profound part of Tonia's birth experience was realizing that she was strong and capable and had joined the ranks of other mothers who were also capable of birthing naturally. Feeling in control of her birth experience made Tonia more confident in herself and her mothering. She also had experiences during the birth of feeling connected to other women giving birth. "I felt, like, someone in the jungles of Africa is doing this right now. Someone in, you know, Antarctica is doing this right now. It was a really awesome connection and I felt like I was in the club, you know? And that was really joyful for me."

Another pivotal part of Tonia's experience was working with her husband, daughter, and baby. She felt as though the four of them were working as a team. At one point, she asked her unborn baby, "What do I do next?" While she reports that she didn't feel as though the baby answered her question, she immediately knew she needed to change position. This was a turning point in her labor when she began to vocalize more. She also began to talk to her baby more, saying, "We're doing this. We're doing this." Feeling this connection to her baby, while having the support and joy from her husband and daughter, gave Tonia strength.

Like many mothers, Tonia felt clearly the juxtaposition between the specialness of her birth experience ("I'm over here doing what is really the most significant thing in our lives.") and the normalcy of the event ("It was just like a normal Monday morning."). She

also felt a healing from this experience, after having had a healthy but (in her opinion) overly-managed first birth. Spending time alone during labor and relying on her own strength contributed to Tonia's feeling of knowing she could be a strong mother to two children and make that transition powerfully.

Figure 21. Art image created by Tonia.

Tonia drew herself and her birth team (midwife, husband, and daughter) surrounded with glowing light, which she said represented their closeness to the experience—her daughter is the person physically closest to her in the drawing. The other circles, she explained, were other people, specifically other women who were birthing or who had given birth in the past. She stated that they were in blue because they were cold, farther away from the experience, while she had to include red in her belly to indicate the warmth that she was radiating. After creating this image, Tonia said she realized that the

other people were a bigger part of her experience than she had initially thought. “I think a big part of it was being able to connect on that level with other women and having them there when I needed them and vice versa,” she said. Baby Dev added to the art as well, contributing the small squiggle in the bottom left.

Jen (the researcher), baby Talysen, home water birth. Key Experiences: Relationship with Others, Spiritual, Body/Physical.

“I began to tune into the energy of women around the world – our strength, our courage, our doubts, our hopes, our excitement to lay eyes on our new babies. It was a palpable feeling, the connection with these other women” (Jen).

When I began my research, I did not know that another baby was in my future. Sometime during my journey, however, I felt a strong pull to have one more child. Birthing in the midst of this research process brought an even deeper consciousness to the pregnancy and the birth experience. The more I analyzed the stories of the mothers who participated in this project, the more I felt the need to include my own story. I felt as though my own birth was colored by the work I was doing, in positive ways. I wrote my son’s birth story, as I had with my previous children, and have utilized it here as though I were interviewing myself.

My partner and I became very connected during the last few weeks of my pregnancy. I felt an acceptance from him that was much deeper and sweeter than we had ever had before. When I went into labor, he began to get ill. I was very disappointed, as I had been expecting to have his support, both physically and emotionally. “I had a moment of chat with myself, a moment of accepting that this gloriously bonding experience was not going to happen,” I wrote. He would sit with me for as long as he

could, then go into the hall bathroom and get sick. This continued for the first two and a half hours of labor. When I began pushing, which felt much better than the intense active labor and transition I had been experiencing, he instantly felt better. We both knew, instinctively, that he had been energetically taking on some of the pain and intensity of this labor. My son was born in three and a half hours and was posterior (face-up rather than the usual face-down position), creating a lot of back pain. I said to my partner shortly after the birth, "I could not have handled all of that pain. Thank you for taking some of it for me." While that was not the kind of bonding I had envisioned, an even closer connection between us than I could have imagined was created.

Deep spiritual experiences happened during my fourth son's birth. I had a moment where I felt that connection to other women giving birth. I remember thinking, "Think of how many other women are doing this, right now!" I began to tune into the energy of women around the world – our strength, our courage, our doubts, our hopes, and our excitement to lay eyes on our new babies. At the same time, I was also realizing that this was the last time I would ever have this experience. I knew that Talysen would be my last baby, and I said to myself, "This is the last time you are ever going to do this. It won't last long, and when it's over, it's over forever." It was important to me to remember to fully experience these moments, and knowing that it would not last forever gave me strength to endure the intense pain.

Being an expert in the area of birth can sometimes be a hindrance to laboring women, while others use this expertise to support themselves. It is easier to cope with something that you know is normal, for example, than if you are worried about what is happening. My rational brain, however, shut down almost completely. My three previous

births had involved long labors and because this labor progressed so quickly, it was hard for me to comprehend what was happening physically. For example, I wrote, "When I stood up, my legs were trembling uncontrollably. This is a very common sign of transition, which my brain registered but refused to believe. I remember saying (possibly out loud?) 'I can't be in transition yet, it's too soon!'" This happened approximately two hours after my water broke, which was the beginning of my labor. Since I had been expecting to labor for at least 12 hours before giving birth, this didn't make sense to me. By this point, making sense of things was not something I was capable of doing, and so I dismissed the idea of transition altogether.

I also had to connect with my body in a very concrete way as I was pushing my son into the world. As he descended down the birth canal, I felt him get stuck behind my tailbone. This is common of babies who are born posterior, as their heads are designed to be facing in a different direction. I began to speak to him out loud, saying things like "Come on baby, come on down, mommy wants to meet you!" This chant, combined with several very hard pushes, brought him past my tailbone. I had a moment during that time during which I could clearly see where he was, what I needed to do, and what was going to happen if I didn't get him moved. While I damaged my tailbone during this maneuvering, it was necessary for both of us to do so before distress set in.

Figure 22. Art image created by Jen.

I drew myself in the birth tub, with my partner to my left. As I drew, I created layers over previous lines of the drawing. The blue is the birth pool, the grey are the floor tiles, covered in a vibrant pink to indicate the foundation of intense pain upon which I was sitting. The rings around/over the rest of the drawing started as a way to connect all

of the elements but quickly became a representation of the cervical dilation and birth canal. The black at the bottom is my tailbone and the layer of rings also represent what I saw when I knew that I needed to push my son past my tailbone. Also included in the image are the other people present (represented by the floating pink circles) and the women with whom I felt connected (small green circles). Finally, I added a red circle and umbilical cord to represent the baby and several small candles to represent both the candles that were in my bathroom and the candles I had asked friends to light as I labored.

Like many of the mothers, I used bright, vibrant colors in this art piece. My experience was definitely vibrant and intense, and I felt the need to capture that. My son, partner and I are all physically connected in the image, which is something I felt during the end of my labor. The other people, while there, are less connected to us and to the experience. I was mostly not aware of their presence during most of the time that I was in the tub. The feeling of the art and the experience is that there was only me and my baby and partner, and this tub of water into which he would be born. Everything else continued to exist but was irrelevant to us and to our journey.

Analysis of Art

Using Rose's (2006) coding method, the art images were coded. A comprehesive guide to the codes created can be found in Appendix G. These codes are meant to be inclusive of all of the elements from all of the pieces. However, a different researcher could create completely different categories. The codes are meant to show similarities and differences, not to be a comprehensive guide to the elements shown in the art. Unfortunately, due to a technology issue, three of the images were lost, and therefore

there are only 12 pieces analyzed in this section. I did not include an analysis of my own art, as I felt it had been influenced too much by the images created by the other mothers.

Analysis of the group of images resulted in several general observations. Most of the mothers (10 out of 12) used bright, high-contrast colors in their art pieces, indicating an intensity of experience. Also typical of the images was the connection of mother and baby, shown in nine of the 12 images, either because the baby had not yet been born or because the mother was now holding her new infant. However, only eight of the images included a literal image of themselves, and only five of the images included a literal image of the baby.

Generally, the images captured a specific moment of the mother's story. Six of these moments took place immediately after birth, while the other half reflected a time during the birth that the mother felt was significant. These profound moments were often a turning point in the labors, when the mothers felt a new surge of energy, connection, or sense of purpose. Tonia, for example, indicated her connection with other women giving birth with tiny circles surrounding her family, while Celeste showed her baby in the womb that was also an aura, both separate from and connected to herself.

I had hoped to see, in the created images, more aspects of each woman's story. In many cases, this is exactly what happened. Meagan, for example, told a story of looking for a sign while in labor. While on a walk with her mother, an older man pulled up next to them and she thought, "This is my beautiful, nice spiritual moment on this journey." What happened instead was that the man made several sexual comments to them before driving off. She decided she no longer needed a sign, and began to look forward to the birth unfolding however it might. The brightness of the mother (hand) and baby (flower)

depicted in her collage, surrounded by the power of nature (depicted in darkness), brought tears to her eyes as she reviewed her work. In her art we both saw the intensity of contrast between the pain and the beauty of her birth experience.

Images of nature were somewhat common, occuring in five of the pieces. Christy stated that the image she created (herself and baby James surrounded by vibrant, colorful, feminine energy represented with silk flowers) captured a perfect moment. “There’s a few perfect moments in your life, and after you have your children, that’s maybe one of a few, you know? That’s what I was trying to capture,” she shared. Meanwhile, Eliza captured the beauty of her wife in the ink drawing of mother and lotus. The lotus flower is often used to portray maternal energy, while the image of an opening flower is one that many mothers use to visualize the opening of the cervix.

Some mothers took a more literal approach, while others were more interested in creating a representational piece. Kate drew herself in the tub, with her partner, midwife, and the midwife’s assistant watching, and a large faucet, which had become a focal point for her during labor. She even included a detail of her shower curtain, which she said was important because it was the first thing she purchased for herself after her previous relationship ended. It was a symbol of empowerment. In contrast, Dana’s drawing of concentric geometric colors represented the people attending baby Reed’s birth. She described feeling that she needed a room full of people to be there and to witness the experience she was having: “It’s the moment, it’s just that witnessing, the witnessing.”

There were seven pictures that included some sort of *energy field* in the form of spirals or circles as part of the picture and seven that included other shapes. Often these shapes represented people who were either not physically present or who had faded into

the background of the mother's perception. The presence of these energy fields was significant in that more than half of the mothers depicted them in some way.

Eleven of the mothers had themselves connected to their babies as the center of their art. Some of these mothers (four) were holding their new babies, while the rest were still in the womb. Only one mother had her baby as the center of the art. DawnStar had expressed feeling her daughter was not real until she held her, so the image of her newborn infant with her hands visable, but not the center of the art, is understandable.

The presence of faces in art is something art therapists often discuss, especially in the ways that children portray adults. It was interesting that five of the mothers showed clear faces, two showed blurred faces, and four showed no faces at all. This was almost an even distribution of how facial details were portrayed in the art.

One element I found particularly interesting is that the mothers were asked to portray the most profound elements of their birth experiences. Of the 12 pictures, only four showed people other than the mother and baby. Even in these four images, the other people present (midwives, doctors, spouses/partners, other children, friends or other beings) are always in the background, and only in two of the drawings are these other people actually recognizeable as people. Tonia and Kate both drew some faces to represent others who were present, while Dana and Shelley represented people through abstract shapes.

Summary of Findings

Each birth story, and each piece of art, is so personal that it is impossible to draw hard conclusions from this research. However, there were definite themes that emerged in

the short narratives, in the interviews, and in the art. The themes in the birth stories included:

- having a conducive birthing environment.
- having an experience that was empowering and/or powerful.
- experiencing connections with one's body or other physical elements.
- having relationships with others involved in the birth.
- having a relationship with baby during the birth.
- having spiritual or religious experiences.
- deriving personal strength or experiencing personal transformation.
- fighting against the societal norms to create the desired birth experience or outcomes.

Multiple mothers in the short narratives, interviews, and artwork expressed each of these themes. Each of these highlighted areas contributed to these women's profound experiences. Seeing these themes, while recognizing both the personal and universal nature of birth, may help reveal the importance of empowering women in their birth choices and birth experiences.

Chapter 5: Conclusion

> I had a huge difference in my births, with one drastic experience in the hospital and one drastic experience at home…I know that there was a profound difference that I couldn't possibly compare. Nobody told me it could have been different. And I knew some people that had had a home birth or a natural birth when I had my daughter but nobody said anything. And I'm like, I feel like it was kind of stolen from me. That I could have had it [a more profound or peaceful birth] if more women talked about these experiences. – Brianna

Birth is both a profoundly individual and a wholly universal experience. According to the Center for Disease Control (Martin, 2013, p. 1), over 10,800 women give birth every day in the United States. Yet each mother, if interviewed, would have a unique story, told from her perspective. While it was not the intent of this research to draw any hard conclusions about birth itself or the nature of profound experiences during childbirth, there are several deductions that can be made as a result of these interviews.

First, women can be greatly empowered by their birth experiences. Some women are empowered by a newfound trust in their bodies, while others are empowered by spiritual connections or having gone against the norms of birthing culture. Regardless of the nature of the empowering experience, these moments can transform women in profound ways. Every mother whom I interviewed was able to pinpoint ways that her birth experience changed her as a mother and as a person.

Second, the mothers show an ownership of their birth experiences that is not common in the blogosphere of motherhood. The lack of other people shown in the art images seems to reflect the profound, empowering, and personal nature of birth. These mothers own their experiences as their own. This is in high contrast to the nature of birth reflected so often in our society in which the doctor is seen as the hero of the story. Yes, those professionals and loved ones who are present can be critical to the experience, but

for the mothers, in this study at least, the transformative effects are personal and profound in nature.

Third, there is a spiritual element in birth that is different for each mother and dictated somewhat by her belief system. While Sally felt the presence of God, Tonia felt a connection with other mothers who were giving birth, and Kate had a feeling of going out of her own body. Many writers have written about this spiritual element of birth in non-academic writings, and yet it is still largely overlooked by many of the professionals working with birthing mothers. This spiritual element exists and needs more consideration by all who work in the birth field.

Personal Reflections

Speaking to the mothers with whom I had the privilege to interview was one of the most profound experiences of my life. Not only was I honored to be allowed into such intimate conversations, but I found new depth to my own birth experiences. Each of my four sons has given me renewed depths of strength, a greater understanding of myself and others, and a connection with my own spirituality. I found I could relate to each mother's story in different ways, but the reminders I got from them all were amazing insights into my own incredible journey.

Further Research

There are three questions that I would like to explore further. First, I would like to speak to more women who have had specifically spiritual experiences, such as feeling the hands of God or seeing non-physical entities while birthing. I personally find these types of experiences fascinating, and I would like to know more about what these women felt during these moments.

Second, I think the use of art creation as part of the interview process was critical for this research, and I would like to collect more images from mothers of their profound birth experiences. Using a larger pool of images could allow for a more comprehensive understanding of the relationship between image and experience. It could also be useful to collect images from mothers who do not relate to their birth experiences as profound and to compare these two groups using the images.

Third, I asked each mother how she felt her birth experience prepared her to be a mother or changed her as a mother. I believe that there is a correlation between how empowered a mother is by her birth experience and how empowered she is as a mother. This is a topic I will likely devote many years to exploring.

In addition, I believe this research would lend itself to several other inquiries. For example, while the mothers in this study gave birth in different settings (home and hospital), to what degree does that setting make a difference in the profound experiences? Given that the majority of American women give birth in hospitals, it could also be useful to address what factors in a hospital setting could be altered or changed to facilitate profound experiences. Several authors such as Gaskin (2003), Shanley (1994) and Harper (2005) have written about this idea extensively, however I have found no evidence of this being discussed in academic research.

Final Conclusions

Every woman who gives birth becomes a mother. Every woman has a unique story to tell, and every woman deserves for that story to be heard. My hope is that this research will contribute to the growing body of knowledge that birth is more than a physical event. Women need the support of their partners, including those they have hired

to support their births, in making childbirth a rite of passage. There is a colloquialism that says, When you know better, you do better. We can only do our best when we have the knowledge and information needed to make the best choices. The more we talk about the profundity of childbirth and the more we prepare women to make choices that empower their birth experiences, the better we can do for ourselves and our children.

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Appendix A: Committee Members

Dr. Susan G. Carter, Chair

Susan Carter, Ph.D., earned her Ph.D. in Humanities (Philosophy and Religion) at The California Institute of Integral Studies (CIIS), San Francisco, California. Susan is now a full professor (adjunct) at the California Institute of Integral Studies (CIIS) and full-time faculty at Marylhurst University (Portland, OR). She has been teaching at CIIS for 15 years in the School of Undergraduate Studies, the Transformative Leadership M.A. program, the Transformative Studies Ph.D. program, and the Women's Spirituality M.A. and Ph.D. graduate programs. At Marylhurst University she serves as Chair of the Masters of Interdisciplinary Studies program. As a feminist scholar and an avid advocate of volunteerism and community-based learning, Susan is actively involved in the non-profit sector, and has served on a number of boards that promote education and empowerment of underserved populations, cross-cultural understanding, and the arts. She has formed and directed a 501[c][3] foundation, and consults with other Bay Area and Pacific Northwest educational institutions to help promote community service. In addition, she presents nationally and internationally on diverse spiritual and educational topics. Susan currently serves as President of the Pacific Northwest region's American Academy of Religion (AAR) and Society of Biblical Literature (SBL). She is also consultant to and on the speaker's bureau with The Center for Partnership Studies.

Arisika Razak, MPH, Committee Member

Arisika Razak, RN (Registered Nurse), CNM (Certified Nurse Midwife), MPH (Masters in Public Health) has worked for over thirty years in the fields of Women's

Spirituality/Women's Studies/Women's Health, Spiritual Dance, and Nurse-Midwifery. She has achieved local, national and international recognition in these fields as an educator, artist, practitioner, and author. As an educator in the field of Women's Studies/Women's Spirituality, Ms. Razak has been interviewed in the publications: *New Age Journal; Women of Power; Snake Power;* and *Goddessing Regenerated.* She is one of 18 extraordinary women featured in Cathleen Roundtree's book of interviews and photographs: *On Women Turning Forty.* She has articles in three books: *Children of the Dawn: Visions of the New Family; Reweaving the World: the Emergence of Eco-feminism,* and the introduction to *Childbirth Wisdom.* She has been interviewed and featured for her work in Women's Health and Women's Studies both in film and on radio. Arisika has lectured extensively and led experiential and didactic workshops in the overlapping fields of Women's Studies/Women's Spirituality, and Women's Health at San Francisco State University, University of California at Davis, University of California at San Francisco, University of California at Santa Cruz, California State University of Sonoma, the California Institute of Integral Studies, New College of California, JFK University in Orinda, and Educational Programs Associates of Campbell California. Arisika received her MPH in Health Care Administration from UC Berkeley in 1978. She is a Registered Nurse, receiving her BS in Nursing from UC San Francisco in 1976. She is a Certified Nurse-Midwife, received her Certificate in Nurse-Midwifery from UC San Francisco, in 1980. She has worked as a nurse midwife, health care provider, and health care administrator for over 25 years, serving as staff nurse-midwife and director of the Nurse-Midwife Service at Highland Hospital in Oakland; director of the Alameda County

Pre-term Delivery Prevention Project, and Assistant Administrator for Ancillary services at Cowell Hospital, UC Berkeley.

Dr. Robbie Davis-Floyd, Committee Member

Robbie Davis-Floyd, PhD, Fellow of the Society for Applied Anthropology and Senior Research Fellow, Dept. of Anthropology, University of Texas Austin, is a medical anthropologist specializing in the anthropology of reproduction. An international speaker and researcher, she is author of over 80 articles and of *Birth as an American Rite of Passage* (1992, 2004); coauthor of *From Doctor to Healer: The Transformative Journey* (1998); and coeditor of ten collections, including *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (1997); *Cyborg Babies: From Techno-Sex to Techno-Tots* (1998); and *Mainstreaming Midwives: The Politics of Change* (2006). Her latest is *Birth Models That Work* (2009), an edited collection highlighting excellent models of birth care around the world. This collection will be followed by *Volume II: Birth Models on the Global Edge*, co edited with Betty-Anne Daviss (forthcoming). Her research on global trends and transformations in childbirth, obstetrics, and midwifery is ongoing. Robbie currently also serves as Editor for the *International MotherBaby Childbirth Initiative* (IMBCI) and Board Member of the *International MotherBaby Childbirth Organization* (IMBCO).

Appendix B: Study Flier

Profound Experiences in Childbirth: A Study

Please feel free to share this flier with other moms!

Now Seeking Mothers!

Attention Moms:

Did you experience a spiritual, transformational, life-changing, or extra-ordinary event while giving birth to your child? Are you interested in sharing your story with others? We are collecting stories of the profound events that happen during childbirth, and we would love to hear your story!

If you are a mother in the United States between the ages of 18-45, and have given birth in the last year, please log on to: (Website TBD) to complete a short survey and share your story. All surveys are completely confidential. You will be asked to provide an email address, as further interviews will be conducted with some mothers. If you prefer, a survey can be mailed or emailed to you.

Please email spiritualchildbirth@gmail.com for more information.

Appendix C: Survey Monkey Survey for Participant Selection

1. New Mother's Information

Thank you for your interest in participating in the "Profound Experiences of Childbirth" research project! By answering the following questions, you are providing vital information to the research process. Please check the following box before continuing:

___ By completing this online survey I agree that the information given can be used for the purposes of the "Profound Experiences of Childbirth" study. I understand that my identity will be kept completely confidential, and that my participation is voluntary. I also understand that I can choose not to answer any questions in this survey, and that I may choose not to participate at any time while completing the survey.

You may also be asked to participate in a second stage of the study, involving a personal interview. Your answers to these questions are completely confidential. Your email address is being collected only to contact you for participation, and will not be shared with any other person or entity. Should you be contacted to participate further in this study, the information you provide will be used for the study's purposes only; you will not be personally, directly identified in any written materials, with the exception of a confidential consent form. Again, thank you for your willingness to participate!

1. Demographic Information

First Name:

City/Town:

State:

Email Address:

2. What is your current age?

What is your current age?

- 18-24
- 25-30
- 31-35
- 36-40
- over 40

3. How recent was your most recent birth?

How recent was your most recent birth?

- Less than 6 weeks ago
- 6-12 weeks ago
- 3 - 6 months ago
- 6-9 months ago
- 9-12 months ago
- More than 1 year ago
- Less than 2 Years Ago

4. Would you describe your birth experience as traumatic, disturbing, upsetting, or distressing?
YES NO

5. Briefly describe the experience you had while giving birth that you would define as profound, spiritual, transformational, or empowering. Your answer only needs to be a few short sentences; further details will be necessary only if you participate in the next phase of the study.

Page 2: Personal Information

Many of the questions on this page are often optional when filling out surveys. However, because this research requires a diversity of participants, these answers are essential to the research process. All information will remain confidential, and will be reviewed only by the researchers.

1. What is your current educational level?

- Some high school
- High school graduate/GED
- Some college
- 2-year college degree (Associates)
- 4-year college degree (BA, BS)
- Advanced degree (MA, MS, PhD, etc)

2. What is your total household income?

- Less than $19,999
- $20,000-$39,999
- $40,000-$59,999
- $60,000-$79,999
- $80,000-$99,000
- $100,000-$149,000
- $150,000 or more
- prefer not to answer

3. What is your current marital status?

- Single, never married
- In a domestic partnership
- Married
- Divorced
- Widowed

4. What is your primary religious affiliation?

- Protestant Christian
- Roman Catholic
- Evangelical Christian
- Jewish
- prefer not to answer
- Muslim
- Hindu
- Buddhist
- Spiritual/non-religious
- none

Other (please specify)

5. What is your ethnicity? (Check all that apply)

- White/Caucasian
- Hispanic
- African-American
- Asian
- Native Hawaiian/Pacific Islander
- Native American
- Alaska Native
- prefer not to answer

6. What is your sexual orientation?

- Heterosexual
- Bi-sexual
- Trans-gendered
- Lesbian/Gay
- Queer
- prefer not to answer

Appendix D: Sample Consent Form

California Institute of Integral Studies

Transformational Studies Department

Childbirth as a Profound Experience: Exploring narrative and image of experiences during birth

Researcher: Jen Schwartz Dissertation Chair: Susan G. Carter, PhD

[phone and email withheld for privacy] [email withheld for privacy]

Jen Schwartz, a doctoral candidate at the California Institute of Integral Studies in San Francisco, is conducting a study on the nature of profound and transformational experiences that women have while giving birth.

Participation in this study involves a series of audio recorded interviews totaling about three hours, and participation in the creation of a piece of visual art that expresses the experiences discussed. In the first part of the interview you will be invited to share your birth story. The interviewer may ask questions for clarification. You will also be invited to discuss the elements of your birthing experience that are extra-ordinary or transformational in nature. This part of the process will proceed like a conversation. In the second part of the interview, you will be invited to create a piece of visual art with the medium of your choice – you do not need to be artistic to complete this part of the research! You will be led through a short, guided imagery process, and will be asked to create a piece of art that expresses the experiences you had. Finally, you will be asked to speak briefly about the art. It is expected that this process will take anywhere from one to three hours (depending on the number of interruptions and the amount of time you spend making the art).

Participation in this study is voluntary. During the interview, you will be free to answer, or refuse to answer, any questions that the interviewer may ask. You are also free to stop the interview at any time, and withdraw your participation. All of the information from the interview will be kept confidential, within the limits of the law. All data will be kept in a secure place in the researcher's locked office, and only the researcher and (if needed) the faculty supervisor mentioned above will have access to this information. Upon completion of this project, all data will be destroyed or stored in a secure location, and no data will be stored for more than 5 years after completion. You may choose to be identified by a pseudonym if you choose; participants will only be identified by a first name, last initial, and demographic data such as age, location, ethnicity, sexual orientation, relationship status, and educational status.

There is no guarantee that you will benefit by participating in this study, however it is expected that participation in this research will be an enjoyable experience, and may provide new insights for you into the birthing experience. In the event that you find the interview or art creation process to be disturbing, you have the right to contact _____, a psychiatrist who specializes in trauma. S/he will be happy to speak with you to resolve any issues that arise during the interview. S/he can be reached at _____.

Participant's Agreement:

I am aware that my participation in this research is voluntary. I understand the intent and purpose of this research. If, for any reason, at any time, I wish to stop the interview, I may do so without having to give an explanation. I also understand that I may choose to not answer any questions posed during the process.

I am aware that no direct benefit, either monetary or resulting from the experience itself, is offered or guaranteed. I understand that I may, however, find the process interesting and thought-provoking. I also understand that the information that I provide will benefit the understanding of childbirth from a non-medical perspective.
I am aware the data will be used in a doctoral thesis that will be publicly available. The data gathered in this study is confidential with respect to my personal identity unless I specify otherwise.

If I have any concerns or questions regarding my rights as a participant in this research, or if I feel that I have been placed at risk, I understand that I may report this -- anonymously, if I wish-- to the Chair, Human Research Review Committee, California Institute of Integral Studies, 1453 Mission Street, San Francisco, CA 94103, [phone and email withheld for privacy].
By signing below I acknowledge that I have received a copy of this consent form that I may keep for my own reference.

I have read the above form and, with the understanding that I can withdraw at any time and for whatever reason, I consent to participate in today's interview and research process, exploring the mystical and transformational experiences of childbirth. In addition, by signing this statement, I am stating that I have received a copy of the Statement of Confidentiality and the Participants Bill of Rights.

_____

Participant's name

_____ _____

Participant's signature Date

_____

Interviewer's signature

If you would like to receive a written summary of the results of the study, please provide an address where it can be sent to you.

_____

Street City State Zip

Appendix E: Statement of Confidentiality

Statement of Confidentiality

Your privacy with respect to the information you disclose during participation in this study will be protected within the limits of the law. However, there are circumstances where a researcher is required by law to reveal information, usually for the protection of a patient, research participant, or others. A report to the police department or to the appropriate protective agency is required in the following cases:

1. if, in the judgment of the researcher, a patient or research participant becomes dangerous to himself or herself or others (or their property), and revealing the information is necessary to prevent the danger;
2. if there is suspected child abuse, in other words if a child under 16 has been a victim of a crime or neglect;
3. if there is suspected elder abuse, in other words if a woman or man age 60 or older has been victim of a crime or neglect.

Appendix F: Participant's Bill of Rights
(FOR PARTICIPANTS IN PSYCHOLOGICAL RESEARCH)

You have the right to...

- be treated with dignity and respect;
- be given a clear description of the purpose of the study and what is expected of you as a participant;
- be told of any benefits or risks to you that can be expected from participating in the study;
- know the researcher's training and experience;
- ask any questions you may have about the study;
- decide to participate or not without any pressure from the researcher or his or her assistants;
- have your privacy protected within the limits of the law;
- refuse to answer any research question, refuse to participate in any part of the study, or withdraw from the study at any time without any negative effects to you;
- be given a description of the overall results of the study upon request;
- discuss any concerns or file a complaint about the study with the Human Research Review Committee, California Institute of Integral Studies, 1453 Mission Street, San Francisco, CA, 94103.

Appendix G: Codes for Art Images

Color:
- C1. Dark
- C2. Light
- C3. Bright
- C4. Muted
- C5. High contrast
- C6. Low contrast
- C7. Shining Light

Images Present:
- I1. Mother
- I2. Baby
- I3. Spouse/partner
- I4. Other children
- I5. Midwife/doctor
- I6. Other support (doula, etc)
- I7. Other family
- I8. Other friends
- I9. Other beings
- I10. Furnishings
- I11. Medical equipment
- I12. Nature (trees, flowers, grass, etc)
- I13. Water
- I14. Umbilical Cord
- I15. Animals
- I16. Body Parts (not attached to beings)
- I17. Text
- I18 Literal Image
- I19. "opening" – of cervix, yoni

Other Present:
- O1. Energy Field (spiral, circling, etc)
- O2. Shapes
- O3.

Art Medium Used:
- A1. Pastels
- A2. Paints
- A3. Collage
- A4. Pen/Pencil
- A5. Crayon
- A6. 3-D items (ribbon, silk flowers, beads, etc)

Relationship:
- R1. Mother connected to baby (in utero)
- R2. Mother connected to baby (after birth)
- R3. Mother separate from baby
- R4. Mother touching others
- R5. Mother separate from others

Center:
- S1. Mother center of art
- S2. Baby center of art
- S3. Connected pair center of art

People:
- P1. Faces clear
- P2. Faces blurred
- P3. No faces

Appendix H: Supervising Psychologists and Therapists

Sara Bingaman, MFT, California

Dr. Elizabeth Bonet, Florida

Dr. Keith Magnus, Indiana

Dr. Lynne Nugent, Pennsylvania

Dr. Aparna Ramaswamy, Maryland

Dr. Julie Rosenberg, Oregon

Dr. Ruth Smith, Texas

Dr. Kimberly Wagner, Ohio