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THE HYPNOTIC BIRTHING EXPERIENCE: A QUALITATIVE APPROACH

by

SALLY NIKOLAJ

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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DEDICATION

To Elyse - my inspiration

ABSTRACT

The objective of the present study was to approach an understanding and description of the hypnotic birthing experience. Three couples expecting children were trained to use hypnotic techniques themselves, in preparation for childbirth. The program of instruction included four basic components; relaxation, post-hypnotic suggestion, autohypnosis, and conditioning of the expectant father. An attempt was made to explore the value of hypnosis before, during and after childbirth using a qualitative methodology. The reactions, impressions and recommendations of the participants regarding utilization of hypnotic procedures prior to delivery were accessed through discussion during training sessions. Subsequent to delivery, couples were invited to share their experience of employing relaxation techniques for childbirth and the postpartum period in an unstructured interview with the reseacher. The personal experience of each couple was presented in a case study form. The patterns, themes and characteristics common to all three cases were then used to write a general description of the hypnotic birthing experience. This description exposed features of obstetrical hypnosis that were considered most important to the individuals who used it in childbirth. Many of these features were emotional in nature and related to an active participation in the birth process and a shared involvement between the woman and her

husband. The advantages of this modality most frequently emphasized in the literature did not seem to be of equal importance to the participants in this study. The elements identified by couples as most significant provided guidelines for the continued usage of obstetrical hypnosis. Based upon their experiences and suggestions, the author made recommendations for the use of hypnosis as a method of prenatal preparation designed to meet the needs of the expectant parents.

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Chapter I

Introduction

Introduction to the Study

It is difficult to conceive of any act more integral or basic to humankind than that of birth. Indeed, it is a process that is as old as the human species itself and represents not only our beginning, but also our continuation. Yet, despite this extensive legacy, debate continues over the best way to bear children. The solution to this age old problem is complicated by the fact that what is most desirable in labor and delivery for medical personnel may be very different from what is best for the mother and child.

Today childbirth constitutes a popular and controversial issue as society has begun to recognize and react to the influence that modern medicine has had upon it during the past century. With the movement toward hospital delivery and the routine use of analgesic and anaesthetic drugs, birthing has become less of a natural physiological process and more of a surgical procedure undertaken by doctors and nurses (Alman & Lambrou, 1983; Verny, 1981). There has been a tendency to detach the expectant mother from the birth process and reduce her role to that of a functioning object (Werner, Schauble & Knudson, 1982).

The current trend has been toward returning control to the woman, allowing her to play a more active part in

the birth of her child. Fathers have also become involved as they attend the labor and delivery and often have a significant role in the birth process. A variety of methods have been developed to help prepare women to give birth in the safest, most natural way possible. Obstetrical hypnosis constitutes one of these methods and was the major concern of the present study.

The History of Hypnosis in Birthing

Recently, the use of hypnosis in obstetrics has been enjoying increased attention and acceptance after having experienced diminished popularity for almost twenty years. Very little writing and investigation has been done in this area in the last two decades with the majority of related literature emanating out of the 1950's and early 1960's. Like many other trends, the use of hypnotic techniques in birthing has seen periodic fluctuations in popularity over the years.

The origins of this modality date back more than a century as first reported by Durand in 1860 (Winkelstein, 1958). However, with the advent of inhalation anaesthesia in the early 1900's, its use in obstetrics experienced a relative decline. It wasn't until the 1950's that people again began to consider the potential role that hypnosis and other psychophysical methods could play in the management of childbirth. Specifically, researchers and clinicians, having established the physical and psychological dangers associated with the use of

chemoanaesthesia and analgesia for both the mother and child, were interested in investigating ways that women could experience a safe, painless and emotionally satisfying labor and delivery without the use of drugs. As Roig (1961-62) wrote:

> With the use and abuse of these drugs, the results have been deliveries from which the mothers wake up hours later having completely forgotten, having an amnesia for the birth experience. This not only breaks the maternal-filial relationship - of fundamental importance in the psychic evolution of the child but it is also detrimental in relation to the organic aspect. (p. 14)

It was this time that saw a proliferation of interest in the so-called psychological approaches to pain reduction in labor and delivery; including natural childbirth, the psychoprophylactic method and hypnotic procedures. However, it was the first two that gained popularity, and as mentioned previously, hypnosis again suffered a decline.

The decrease in hypnosis research and practice relating to obstetrics was largely the result of misconceptions with regards to its use. These being that it requires extensive preparation and application time, it necessarily produces amnesia and loss of control in the patient and, it has the potential for causing psychological damage (Werner et al., 1982). In addition,

The American Psychiatric Association, in a 1961 position paper, suggested extensive training if practitioners were to make safe use of hypnosis in obstetrics. This further discouraged involvement and as Werner, Schauble and Knudson (1982) stated, "With these restrictions, it is not surprising that practicing obstetricians withdrew or chose other psychoprophylactic methods" (p. 164). It is only as these and other myths are challenged and disproven that the use of hypnosis in birthing again begins to gain respect and experience a rebirth. Just as Janet predicted when he wrote; "If my work should not be completed now, it will be later on, when the tide of fashion brings back hypnosis, and this will happen as surely as the tastes of our grandmothers will return" (Roig, 1961-62, p. 15).

Statement of the Problem

In the past, many investigations have been conducted to evaluate the use of hypnosis in obstetrics (Abramson & Heron, 1950; August, 1960; Davidson, 1962; Gross & Posner, 1963; Kline & Guze, 1955; Michael, 1952; Tom, 1960; Williamson, 1975; Winkelstein, 1958). The great majority of these were undertaken by practicing obstetricians who were able to use their patients as subjects for research. A number of advantages and disadvantages of employing this method of preparation have been identified by these studies and, yet, almost all define success in terms of the amount of anaesthetic required during labor and delivery. That is, if a woman is able to give birth with

little or no medication, the hypnosis is considered successful. The amount of anaesthetic or analgesic administered is a conveniently defined, measured and compared dependent variable and therefore lends itself to experimental analysis.

However, in accepting a decrease in medication as the only determinant of positive outcome, other important variables that are more difficult to observe or measure are given less attention (Speigel, 1963). Colaizzi (1978, p. 51) said that this represents a familiar dilemma in psychological investigation, where often, in the name of objectivity, only variables that can be witnessed, duplicated and quantified are considered to be valid. The resulting bias has led to an absense of human experience variables in social science research, as they generally do not conform to rigorous operational definitions and are therefore not thought to be legitimate psychological content. Such a rigid approach to psychological inquiry must be reconsidered if the researcher hopes to gain an understanding of complex human events, emotions and processes.

Of particular interest in the present study are the personal experiences of women and men who have employed hypnosis in the birth of their children - a topic which has not been approached directly in previous investigations. The information and insights that they can provide both during training and after birth of their

child, will contribute to an understanding of obstetrical hypnosis and are of potential value to those involved in its use.

A second area that will be considered in this study involves the methods employed in obstetrical hypnosis. The traditional strategy is very dependent upon instruction given by the obstetrician throughout the pregnancy and, upon his presence at the birth. Generally, he hypnotizes the expectant woman when she comes for regular visits, and trains her in useful hypnotic techniques in preparation for her confinement. During the labor and delivery, he is then solely responsible for trance induction and appropriate suggestions and guidance. While this approach has the advantage of creating a close and personal relationship between the woman and her doctor, it also makes her very dependent upon him. Dependence of this nature may not be practical or desirable at a time when physicians often arrive just in time to deliver their patients' babies or when unknown physicians must preside over the birth.

Other approaches, however, allow for more independence and personal control on the part of expectant parents who choose to use hypnosis in birthing. Alman and Lambrou (1983), Ambrose and Newbold (1980), Kline and Guze (1955), Malyska and Christensen (1967) and Schneck (1952) are among those who advocate the use of self-hypnosis as a training or conditioning procedure in obstetrics.

Self-hypnosis has the woman take control of the induction and maintenance of her own trance state and the choice of any hypnotic techniques she may employ in giving birth. Ambrose and Newbold (1980) also suggest conditioning of the expectant father or the labor coach, so that he is responsible for inducing the trance and making related suggestions during labor and delivery.

Roig's (1961-62) hypnoreflexogenous procedure is different again in that formal trance induction is not generally necessary. Rather the woman progresses through the labor and delivery in a state of vigil. That is, she remains awake and comfortable throughout, guided by post-hypnotic suggestions made during her training. In addition, a study by Pascatto and Mead (1967) indicated that these post-hypnotic suggestions could be made by a person other than the obstetrician and not even present at the birth.

The present author believes that all of these methods are valuable, both technically, and in the independence they afford the expectant couple. They can be used alone or in combination to develop a training program suited to the needs of the individual couple - a program which will ideally prepare them to manage this facet of the labor and delivery on their own.

Purpose of the Study

The objective of this study was to evaluate the personal experiences of individuals who use hypnotic

techniques in childbirth. Three women in their third trimester of pregnancy were taught to use hypnotic techniques in preparation for labor and delivery. Their husbands or chosen labor coaches attended the training sessions and were actively involved in the process. Instruction was aimed at preparing the couple to manage the hypnotic procedures by themselves without external guidance. The amount and type of training given was similar for all couples but ultimately dependent upon their personal needs and characteristics.

Attempts were made to assess the experience of using obstetrical hypnosis before, during and after labor and delivery. Information was collected during the training period which reflected the participants' progress and reactions as well as their concerns and suggestions. In addition, subsequent to the birth, guided interviews were conducted with the couples to arrive at a personal description of their experiences during childbirth and to determine some of their retrospective thoughts and feelings regarding the event. Pre-labor and post-labor interview questions explored the proposed characteristics, advantages and disadvantages associated with this method of preparation. Concentration was also given to other possible aspects of the experience that have not been mentioned in the literature, but, rather became apparent during the interviewing process. An opportunity was

provided for the sharing of information that could lead to new insights.

Information gathered before and after the labor was then systematically analyzed for common themes, patterns and generalizations. The presentation of these commonalities along with unique findings specific to each couple, allowed for a description and greater understanding of the experience of using hypnosis in birthing.

The study was qualitative in nature, aiming at a subjective evaluation and description of the use of hypnosis in birthing. The findings are presented in the form of case studies. In addition, a description of the experience in question is given.

Importance of the Study

The present study investigated the use of obstetrical hypnosis from the perspective of the men and women who employed it in the birth of their children. The research is significant in a variety of ways.

1. The results helped to determine the usefulness of this method of prenatal preparation - including the specific indications and contraindications of its usage, during training, childbirth and post-partum periods, from the point of view of those who have experienced it first hand.

2. Feedback from participants exposed particularly effective and ineffective components of obstetrical

hypnosis as well as ways in which the approach can be amended or improved.

3. Information gathered is of value to those who practice or advocate the use of hypnosis in prenatal preparation.

4. Findings may lend support to the natural childbirth movement and to all those who desire an alternate means of encountering a natural birth that is both safe and meaningful for those involved.

Definition of Terms

For the purpose of this study, the phrase hypnosis training is synonomous with relaxation training. As a result of stage hypnotists, the mass media and the popular press, the layman commonly has a poor understanding of hypnosis. The word conjures up thoughts of witchcraft and mysticism (True, 1954) and is often thought to involve mind control and surrendering of the will. Conversely, the idea of relaxation training is unintimidating and carries with it little societal stigma (True, 1954). For this reason, it is accepted as an alternate phrase that may be more appropriate for some individuals.

The medical terms used in the present thesis are defined below:

adnexa - fallopian tubes and ovaries.

anaesthetic - an agent that produces insensibility to pain or touch.

analgesic - a medicine which relieves pain.

anoxia - deficiency of oxygen.

asphyxia - a decrease in the amount of oxygen and a increased amount of carbon dioxide in the body as a result of some interference with respiration.

cervix - neck of the uterus.

confinement - the process of childbirth and immediate recovery from it.

dilatation - the process of cervical opening to allow the baby's head to pass through.

episiotomy - surgical incision through the soft tissue outlet of the birth canal to complete delivery.

parturition - the act of giving birth.

perineum - the soft tissue outlet of the birth canal.

transition - conversion from pre-labor to active labor.

uterus - an organ of the female for containing and nourishing the embryo and fetus from the time the fertalized egg is implanted to the birth of the fetus.

Chapter II

Literature Review

Introduction

The purpose of this chapter is to provide an overview of the literature and research relevant to an understanding of obstetrical hypnosis which served as a foundation for the present study. Consideration is first given to the pain experience of labor and delivery and its physical and psychological determinants. A description and comparison of the various alternatives available to women in coping with the discomfort of childbirth is then presented. The prosposed advantages and disadvantages of obstetrical hypnosis are outlined with emphasis placed upon research which both supports and questions their validity. Finally, the procedures, techniques and training methods which have been and continue to be employed in hypnotic birthing are explored.

The Pain Experience

The issue which is commonly of greatest concern to expectant mothers with regards to their labor and delivery is the pain associated with this event. Like concerns are reflected in the objectives of researchers and clinicians to eliminate this pain whether through the use of drugs, hypnosis or natural childbirth methods. Roig (1961-62b) summarized this general sentiment along with his biases when he wrote:

> Motherhood being the most blessed act of nature that it is, should not be accompanied by pain. Thus the means for painless childbirth should have been within man's reach ever since the first woman became a mother, and should be found in nature itself, in the human mind, source of energy and power which properly guided, can accomplish much. (p. 14)

The late 19th century saw increasing recognition of pain reduction in childbirth as a desirable and morally acceptable achievement for all involved (Hilgard & Hilgard, 1975; Kline & Guze, 1955). It was at this time that certain individuals finally "dared to challenge the ancient edict 'In sorrow thou shalt bring forth children'" (Kline & Guze, 1955, p. 142).

It is, however, puzzling that a process as integrally basic and natural as childbirth should be so painful (Hilgard & Hilgard, 1975). Sauter went so far as to say that there is no other normal physiological act that is as routinely accompanied by pain (cited in Roig, 1961-62a). It is this apparent incongruity which has led many to question the discomfort experienced during confinement and to suggest that it may have a large psychological component (Hartland, 1971; Hilgard & Hilgard 1975; Kroger, 1977; Michael, 1952; Read, 1953; Roig, 1961-62a,b). Hartland (1971) wrote:

> It is generally believed that women suffer great pain and discomfort during childbirth. Indeed, the

> average woman has had this fact dinned into her so consistantly throughout the years that she is bound to suffer pain at her confinement because her mind has been conditioned to it. (p. 305)

Roig (1961-62a) referred to labor pain as a "biological habit" established by hearing that labor and delivery are painful. He quoted Carballo who described the expectation of pain as "a transmission through generations, not of prejudices, but of biological habits, which are passed from mother to daughter, almost with the same incorruptible force of the genes" (p. 2). It would seem that in our civilization we are conditioned to believe the pain naturally and necessarily accompanies labor, and it is this anticipation that is at least partly, if not entirely responsible for the degree of pain experienced (Michael, 1952).

Abramson and Heron (1960) suggested that painful childbirth, like many of the difficulties and ills that humans suffer, is caused by societal traditions and customs. Their claims are supported by widely held beliefs that women in other parts of the world do not experience undue discomfort during labor and delivery because they have no cultural expectation of painful childbirth.

True (1954) also acknowledged the role that suggestion and expectation play in the perception of pain but cautioned against accepting labor pain solely as a

product of modern civilization. He cited the findings of studies which indicated that, contrary to popular thought, women in contemporary primitive societies also experience discomfort in childbirth but tend to be more subdued in their response to it. True concluded that their apparent freedom from pain is therefore more of an expected cultural response than an actuality.

Other theorists place greater emphasis on the possible physiologic determinants of labor pain (Danforth, 1971; Pritchard & MacDonald, 1980). Danforth (1971) pointed out that because pain is clearly associated with the occurance of uterine contractions, "the words contraction and pain have come to be synonymous" (p. 519). He reviewed a number of theories that have been advanced to account for uterine pain in childbirth: "...causes of pain in labor may be stretching of the cervix; traction upon the peritonium, adnexa, and supporting ligaments; distension of soft parts before the advancing head; and pressure upon the urethra and bladder" (p. 520). Limited recognition was also given to psychologic factors that are influencial in the perception of labor pain. Danforth, however, concluded that there still is no good, complete explanation for the discomfort experienced in labor and delivery.

Hartland (1971) also recognized both a physiological and a psychological component to the pain of labor and

delivery. The discomfort, he said, is caused by two factors. First, the contractions of the uterus and the stretching of the birth canal as the baby is being expelled, and second, "a psychological overlay of fear, anxiety and tension arising from expectation and belief" (p. 306).

Yet labor is a natural physiologic process (Pritchard & MacDonald, 1980) and theoretically should hurt no more than any other normal function of the body (Michael, 1952). This is not to say that childbirth is necessarily easy. Just as the word "labor" suggests, it involves hard work, effort and some natural discomfort which can seldom be avoided. Perhaps, however, the fear, anxiety, tension and their related pain can be reduced (Hartland, 1971; Kroger, 1977).

Chemical anaesthetic agents have been used for years to deal with labor pain without complete consideration of its origins. As Hartland (1971) reasoned, "Since the causes of pain during childbirth are largely psychological, it is obvious that the most effective method of dealing with them must also be psychological" (p. 305). In addition, Pritchard and MacDonald (1980) pointed out that because of inherent difficulties, there exists no completely safe and satisfactory method of relieving the pain of labor and delivery. These ideas coupled with knowledge of the risks to maternal and fetal health associated with the use of chemical anaesthetic

agents certainly indicated a need, and motivated a search for different methods of dealing with obstetric pain. True (1954) lent support to this search stating that "Good obstetric practice should concern itself more with the preparation of a woman's mind and less with the administration of noxious drugs" (p. 375).

Winkelstein (1958) described the ideal anaesthetic and analgesic agent for obstetrics:

> It must be one having no toxic effects on either mother or child; one which selectively eliminates the pain sensation; one which promotes a maximum of voluntary co-operation and yet allows the mother the total experience of childbirth. (p. 152)

He also emphasized that;

> It must maintain and not destroy the rapport between mother and baby which is set up at the time of the separation of the two as distinct individuals. It must insure the fact that the delivery experience carries with it most of the pleasant and few of the noxious features of parturition. (p. 157)

Chemical anaesthesia at best only meets a few of these albeit optimistic requirements. In seeking to secure a method which comes closer to fulfilling these conditions, an individual is faced with a variety of alternatives. These are generally referred to as psychological methods for the management of childbirth and acccording to Gross and Posner (1963), fall into five

different catagories: 1. The Read method of Natural Childbirth, 2. The Psychoprophylactic or NeoPavlovian method, 3. Schultz's Autogenous training, 4. The Lamaze method, and 5. Hypnotic training. Jacobsen's Progressive Relaxation has also been included among these by some authors (Davenport-Slack, 1975). For the purposes of the present discussion, however, consideration will be given to the most popular of these: 1. Natural Childbirth as introduced by Grantley Dick-Read and 2. The Psychoprophylactic method of Velvovski, popoularized by Ferdinand Lamaze, and the ways in which these approaches are similar to, and different from obstetrical hypnosis.

Psychological Methods of Prenatal Preparation

The Read Method

Although interest in psychological methods for the management of childbirth existed early in the 20th century, their popularity waned as the utilization of drugs became more routine. Kline and Guze (1955) credited Grantley Dick-Read with the reintroduction of interest in this area. They described him as the leader of a new movement toward recognition of labor and delivery as a comfortable process for women trained in relaxation.

Read's approach is founded upon his belief that unbearable pain should not exist in labor and that any discomfort experienced is the result of muscular and

nervous tension caused by a fear of childbirth (Hilgard & Hilgard, 1975). He made an important contribution with his explanation of the fear-tension-pain reverberatory cycle (Roig, 1961-62a). His theory identified fear as the main determinant of pain in childbirth - "fear which is a product of society's view of childbirth as a terrifying experience" (Werner et al., 1982, p. 161). This fear in turn leads to tension which ultimately produces pain (Hilgard & Hilgard, 1975). Read introduced to obstetrics the idea of dealing at a psychophysical level with the fear in order to break the circuit, changing the woman's attitudes, and thus reducing or avoiding labor pain altogether.

Read's Natural Childbirth methods included "factual instruction regarding childbirth; physiotherapeutic practices, especially relaxation and breathing exercises; and psychological methods that inspire confidence and carefully incorporate suggestion [but avoid hypnosis]" (Hilgard & Hilgard, 1975, p. 105).

The Lamaze Method

Interest and popularity enjoyed by Read's approach was partly upset by the introduction of the Psychoprophylactic method to North America. Psychoprophylaxis, or Lamaze as it is commonly known, is based upon the blocking of conditioned reflexes of pain, in a Pavlovian sense, through the provision of a counter stimulus (Lamaze, 1958; Werner et al., 1982).

According to Bing (1969), the Lamaze method also has its foundation in the belief that women experience two types of pain during labor and delivery. One is physiological pain and the other is anticipated pain which is the result of fear, ignorance and prejudice. Lamaze deals with the second type of pain through an educative process which is described well by Hilgard and Hilgard (1975):

> Teaching includes what happens in the course of a normal pregnancy; the Pavlovian thesis of relieving pain by eliminating fear; respiratory exercises; neuromuscular control, through relaxation; and the appropriate responses during labor and delivery. An important aspect of the process is the participation of the expectant mother throughout. The training commonly includes the father who becomes a participant also. (p. 106)

It is interesting to note that Lamaze has its origins in hypnosis; specifically the hypnosuggestive method promoted by Platanov, a Russian psychotherapist during the 1920's and 1930's (Alman & Lambrou, 1983; Hilgard & Hilgard, 1975). Success with the use of this hypnotic procedure for the delivery of babies led to its refinement by Velvovski, resulting in psychoprophylaxis. After being exposed to this method during a visit to Russia, Ferdinand Lamaze introduced the ideas of Velvovski to France, England and North America with his book Painless

Childbirth (Hilgard & Hilgard, 1975).

A Comparison

Although followers of both Natural Childbirth and Lamaze recognize the existence of suggestion in their training, they vehemently deny that hypnosis is involved (Hilgard & Hilgard, 1975; True, 1954; Werner et al., 1982). This is in part because of the misconceptions and stereotypes surrounding its use. As Ambrose and Newbold (1980) explained; "When Grantley Dick-Read began his work, the word 'hypnosis' undoubtly conveyed a suggestion of something sinister in the minds of many" (p. 263). In reality, there are many features that Lamaze, Read's Natural Childbirth and obstetrical hypnosis share in common. These include the emphasis placed upon relaxation, focused attention, controlled breathing and suggestions that women will be able to handle the stresses involved in childbirth (Hilgard and Hilgard. 1975).

There are many authors who have suggested that the relaxation techniques employed in the Lamaze and Read approaches are indistinguishable from hypnotic techniques (August, 1960; Mandy, Mandy & Farkas, 1952). Samuelly (1972) specifically addressed the similarities between Lamaze conditioning and hypnosis. He pointed out that these methods have the same necessary and sufficient requisites. Both depend upon the narrowing of an individual's field of attention and the focusing of one's

attention on a specific activity. Based upon the results of his single case investigation of these two methods of prenatal preparation, Samuelly concluded that "there is little in the Lamaze method which is not hypnosis" (p. 138).

Davenport-Slack (1975) in her comparison of obstetrical hypnosis with all other types of antenatal childbirth training found that, even in terms of outcome, it is impossible to distinguish between these approaches. Hilgard and Hilgard (1975) however cautioned against assuming that because these methods overlap in their techniques and their psychological consequences, they are necessarily identical. They acknowledged the similarity and compatibility of these approaches and yet suggested that hypnosis is actually superior to the Lamaze and Read methods in that it allows for greater flexibility in terms of the techniques that can be used and their scope of applicability.

An historical review would suggest that the Read and Lamaze methods represent extensions or modifications of a much older hypnotic approach. Although extensive research has proven them effective, they both have the disadvantage of requiring elaborate education and instruction and commonly long sessions of physical and respiratory exercises (Roig, 1961-62a). It is not however the intention of this discussion to suggest that hypnosis is

better than other types of childbirth preparation, only that it constitutes a viable and practical alternative.

Advantages of Obstetrical Hypnosis

The positive indications for the use of hypnotic techniques proposed in the literature are certainly extensive. Perhaps the most elegant, however, is the tendency for women, with or without antenatal training, to spontaneously enter a mild hypnotic trance during labor (Ambrose & Newbold, 1980; Werner, 1963-64).

Generally, hypnosis has been considered an appropriate and useful technique for birthing because it is a relatively simple, uncomplicated procedure which does not require great amounts of skill or training for application (Kroger & DeLee, 1943;Williamson, 1975). In addition, no apparatus or undue expense is involved, making it ideal for hospital or home delivery (Kroger & DeLee, 1943). Mosconi and Reda (1958-59) described obstetrical hypnosis as having a double advantage in that it benefits both the mother and infant. For this reason, the additional advantages of using hypnosis in labor and delivery will be considered in terms of the positive results this training has for the mother and the positive results it has for the child.

Advantages for the Mother

Relaxation.

The greatest value of hypnosis in birthing is often felt to be its ability to produce mental and physical

relaxation. This increase in relaxation and concomitant decrease in tension provides an ideal state from which to reduce the fear associated with childbirth (DeLee, 1955; Williamson, 1975). As mentioned previously, it is the fear and related mental and physiological anxiety which have been established as causal factors in the production of pain (Hilgard & Hilgard, 1975). Therefore, the interruption of this cycle constitutes an important corollary to reduction in the subjective experience of pain (August, 1961; DeLee, 1955; Kroger, 1977).

Mental relaxation is also felt to produce muscle relaxation which in turn produces cervical and uterine relaxation, thereby reducing associated pain and facilitating dilatation of the cervix (Roig, 1961-62a). According to Davenport-Slack(1975) however, the data which would support this assumption are lacking. She introduced an alternate explanation that perhaps concentration on relaxation actually serves to direct focus of attention away from the discomfort rather than to reduce it. Davenport-Slack also questioned suggestions that hypnosis results in a decrease in subjective perceptions of pain given the obvious difficulties in measuring such a nebulous entity.

During Pregnancy.

Hypnosis is not only of value to the woman during labor and delivery but also may be very useful during her pregnancy in the alleviation of various accompanying

symptoms (Roig, 1961-62b). Ambrose and Newbold (1980) listed a number of antenatal disturbances that can be improved through hypnotherapy. These include heartburn and flatulence, nausea, backache, pruritis, insomnia, hypertension, and in some situations, even threatened miscarriage. Hypnosis has also been found useful in dealing with Hyperemesis Gravidarum, a condition of excessive vomiting that may be experienced by some pregnant women (Hartland, 1971; Roig, 1961-62b).

Reduction in Medication.

Obstetrical hypnosis has been shown in many studies to significantly reduce the use of anaesthetic and analgesic drugs during labor (Davidson, 1962; Gross & Posner, 1963; Kline & Guze, 1955; Kroger, 1977; Moya & James, 1960; Pascatto & Mead, 1967; Williamson, 1975). In Kline and Guze's (1955) investigation of 30 hypnotically conditioned expectant women, 57% received no drugs during delivery. In the opinion of delivering obstetricians, of those women who did require supplementary drugs, 17% utilized less than average dosages, 23% utilized average dosages, and only 3% needed more than the average dosage.

Gross and Posner (1963) included a control group in their investigation of obstetrical hypnosis. Their findings showed that 62% of the hypnotically trained women (194 cases) were able to manage their delivery with no

chemoanaesthetic agent. Whereas, all but two of the control group subjects (196 cases) required some type of anaesthetic. Closer inspection of patient characteristics indicated that the hypnosis was more successful for women who had given birth previously than for first time mothers.

The results of a study conducted by Williamson (1975) also indicated that women using hypnosis were given the smallest amount of analgesic drugs. She compared 70 patients trained in autohypnosis with matched groups of 70 patients given physiotherapy relaxation training and 70 patients given no antenatal training. Fifty-nine per cent of hypnotically prepared subjects had no analgesic drugs compared with 0% of the women in the physiotherapy group and with 1.4% of the women who had no training.

Because with the use of hypnosis, the amount of medication administered is generally reduced, the related risks of maternal damage are lessened if not eliminated. In addition, the woman's labor is likely to progress normally not having been altered by sedative and anaesthetic agents which tend to have a depressant action upon uterine contractions (Ambrose & Newbold, 1980; DeLee, 1955; Kroger & DeLee, 1943). The recovery from birthing is usually smoother as there is also a decrease in the undesirable post-operative effects brought on by drugs (DeLee, 1955).

Hypnotic Anaesthesia.

Some women are able to achieve complete anaesthesia through hypnotic training, although it is generally believed that this is possible in only 20% of selected patients (Kroger, 1977). Hypnotically induced anaesthesia is understandably superior to that induced by drugs considering the safety of its administration and the increased ease with which hypnotic anaesthetic is controlled (Williamson, 1975). Hypnosis does not require injections (Kroger & DeLee, 1943), does not cause any depression of respiratory or circulatory functions (Hartland, 1971), and its effects may be imposed or withdrawn at any time, unlike chemoanaesthesia (Kroger & DeLee, 1943; True, 1954). Individuals capable of hypnotic anaesthesia are not only able to apply this skill during labor and delivery, but also to provide anaesthesia for the abdominal and perineal area should an episiotomy or any other surgical procedure be necessary. Hypno-analgesia is also ideal for women unable to use analgesic or anaesthetic drugs (Williamson, 1975).

Composure and Control.

It has been reported that women who employ hypnotic techniques in birthing are generally composed (Pascatto & Mead, 1967), calm, relaxed (Williamson, 1975) and cooperative (DeLee, 1955; Michael, 1952). They are therefore better able to assist the obstetrician when necessary (Ambrose & Newbold, 1980; DeLee, 1955). These

women are considered to have go control over contractions (Kroger, 1977), and often an immediate awareness of the second stage of labor (Werner et al., 1982). That is, unlike unprepared women who commonly push prematurely, they seem to know naturally when the cervix is dilated enough for the birth of the child and at this point, experience an unmistakable urge to bear down. They apparently have more control over the expulsion of the head and shoulders which reduces the risk of perineal damage (DeLee, 1955).

Reduction in Operative Techniques.

Obstetrical hypnosis has also been credited with a decrease in the need for operative techniques during labor and delivery (Kroger, 1977). Gross and Posner's (1963) research showed that hypnotically prepared subjects had more spontaneous deliveries than their control group counterparts, and therefore enjoyed a concomitant reduction in operative deliveries. Davidson (1962) and True (1954) also reported a decrease in perineal damage and the need for episiotomies among women trained in hypnosis.

Recovery.

Since women trained in hypnosis do not become as fatigued, there is less occurance of obstetric shock during labor and delivery (Ambrose & Newbold, 1980; Hartland, 1971; Kroger, 1977). The raised resistance to fatigue helps facilitate a normal process of labor,

thereby lessening maternal exhaustion especially during the often lenghty first stage (DeLee, 1955). Women who use hypnotic techniques in giving birth also tend to enjoy a rapid, uneventful recovery, free from complications (Alman & Lambrou, 1983; Ambrose & Newbold, 1980; Hartland, 1971; Kroger, 1977; Mosconi & Reda, 1958-59). Gross and Posner (1963) reported a marked improvement in the postpartum course of the hypnotically prepared subjects in their study. An investigation by Pascatto and Mead (1967) using post-hypnotic suggestion to prepare unwed mothers for labor and delivery also found superior postpartum recovery in the hypnosis condition compared with a matched control group. Specifically they noted less post-labor insomnia, headaches and breast discomfort.

Buxton (1962) pointed out the routine experience of postpartum depression among women who use chemical anaesthetic in birthing (cited in Werner et al., 1982). If hypnosis is able to reduce the use of drugs with this effect, it may indirectly lessen postpartum depression. It is also possible to stimulate lactation (August, 1960) and ease of breast feeding through the use of post-hypnotic suggestions, both of which improve the postpartum period (Davidson, 1962; Hartland, 1971; Williamson, 1975).

Labor Length.

Another feature that is commonly cited as an advantage of using hypnosis for the mother is the

shortening of labor length (Abramson & Heron, 1950; Cheek, 1957; Kroger, 1977; Kroger & DeLee, 1943; Michael, 1957; Williamson, 1975). Kroger (1977) estimated that the first stage of labor is decreased by as much as three hours in a first pregnancy and by more than two hours in subsequent pregnancies. Abramson and Heron (1950) compared labor length of 100 hypnotically prepared women with 88 control subjects and found a statistically significant difference in the mean length of the first stage. The average for experimental subjects was 8.32 hours as compared with 10.31 hours for women in the control condition. Michael's (1952) research also showed a difference in duration of the first stage, although not statistically significant. The mean length for the hypnotic subjects was 13 hours 30 minutes, versus 17 hours 22 minutes for control subjects.

There is however controversy with regard to claims that obstetrical hypnosis leads to shorter labors. It seems that the measurement of labor length is confounded by other variables such as means of establishing when labor begins (Roig, 1961-62a; Werner et al., 1982). Obviously, determination of the onset of labor will influence its recorded duration. Some researchers depend upon the degree of cervical dilatation, while others rely upon the woman's self report as to when labor began (Davenport-Slack, 1975). Winkelstein (1958) reasoned that "since it is difficult or almost impossible to determine

the onset of labor, the starting point, (in his study), was the patient's admission to the hospital" (p. 154).

Certainly, this inconsistency in measurement jeopardizes any general conclusions. If the woman is simply asked when she went into labor it is not hard to see how hypnosis could act as a distortion of reality. That is, if indeed hypnosis facilitates relaxation, comfort, and an elevated pain threshold, the trained individual may not be aware that she is in labor (Gross & Posner, 1963). Therefore, it may seem as though her labor is shorter when in fact this is only an artifact of the preparation (Werner et al., 1982).

A study undertaken by Davenport-Slack and Boylan (1974) compared labor length determined by cervical dilatation with that established through self report. They found that the length of labor was twice as long (8 hours) if verbal report was used than with cervical dilatation of 2.5 cm. (4 hours). Among the self-report subjects, prepared women did report shorter labors than non-prepared women. However, when cervical dilatation was used as the criterion of onset, variability in labor length for both prepared and non-prepared groups was reduced. The findings of this investigation suggested that the preparation itself was not responsible for reducing the duration of labor.

Roig (1962-62a) pointed out that hypnotic deliveries are actually not outstanding for their rapidity. They

often take place at a later date than expected and include a prolonged first stage. Werner's (1963-64) question seems appropriate here; "Why would labor be hurried and intense" (p. 19) especially when it involves a relaxed, fearless and happily expectant mother?

Emotional and Psychological.

Perhaps the greatest advantages of using hypnotic techniques in giving birth are emotional or psychological in nature. These benefits are often undervalued by researchers more interested in the amounts of anaesthetic or analgesic administered (Spiegel, 1963). Women who are hypnotically prepared are able to actively participate in the birth process. Davenport-Slack (1975) suggested that it is this ability to be actively involved that is most responsible for positive childbirth experiences. She explained that "the amount of control a woman has over her own labor seems to be a central factor in accounting for a successful childbirth outcome" (p. 276), and that "perhaps the greatest contribution of childbirth preparation is that it enables women to have far more satisfying and rewarding childbirth experiences" (p.275).

Because the woman experiences the delivery more completely, she enjoys a greater feeling of accomplishment and fulfillment (Alman & Lambrou, 1980). Mosconi and Reda (1958-59) noted a "particular state of euphoria" among these women, which they attributed to successful use of hypnosis in delivery. Williamson (1975) stated that the

majority of these women remember their labor as a pleasant and happy experience to be enjoyed again. In her follow-up questioning, she found that 70% of subjects who were hypnotically trained described labor as a pleasant experience, compared with 23% of subjects who received physiotherapy (breathing) preparation and 33% of subjects who had no prenatal training. Michael (1952) suggested that the mother-child relationship may actually be enhanced since the mother does not have unpleasant memories of childbirth and therefore does not consciously or unconsciously blame her child for the suffering she may have experienced.

It has been found that regardless of the success of hypnotic deliveries, most individuals support hypnosis and wish to employ it in subsequent pregnancies. Based upon his study, Tom (1960), who opposes the routine use of hypnosis in obstetrics, noted that "regardless of the results, all but one of the patients thought hypnosis was worthwile and a great help during labor and all wanted to use hypnosis again for the next delivery" (p. 224). The psychological benefits of this method of preparation are also recognized by Kroger (1977) who stated that hypnotic childbirth is an "intensely gratifying experience for well adjusted mothers" (p. 229), and by Roig (1961-62a) who added that "the mother really feels she has given life to her child, seeing him and enjoying him from the first moment of birth" (p. 11).

Advantages for the Child

Physical Well-being.

There are also a number of potential health benefits to the child when hypnotic techniques are used in birthing. The most important of these relates back to the reduction in the use of chemical anaesthetic and analgesic agents associated with this method of preparation. These drugs have been directly linked to depression of circulatory and respiratory functions of the unborn infant because they incur some degree of oxygen deprivation to the fetal brain (Ambrose & Newbold, 1980; Clark, 1956; Gross & Posner, 1963; Hartland, 1971; Kroger, 1977). Related fetal anoxia or asphxia may also result in cerebral damage (Kroger, 1977; Williamson, 1975).

Moya and James (1960) reported that "some degree of biochemical asphyxia of brief duration occurs as a result of the birth process and is a normal finding in newborn infants" (p. 2026). Recovery from this asphyxia is one of the first adjustments the infant has to make. They compared the full term babies of 21 hypnotically trained women to a matched group of babies born under a variety of anaesthetic regimens. The hypnosis group showed a significantly greater ability to recover from asphxia than non-hypnosis infants. Similar results were found in Pascatto and Mead's (1967) investigation. They noted the superiority of infants born under hypnosis in establishing and maintaining effective ventilation. None of these

infants required oxygen after delivery, whereas, 5 out of 15 control infants did.

In deliveries where women are hypnotically prepared and therefore able to manage their labor with little or no medication, there is a related decrease in the incidence of infant delivery trauma. These children may enjoy additional long range benefits since the nature and quality of obstetrical drugs potentially have serious and long lasting effects on the development of the child (Werner et al., 1982).

Because hypnotized women are in a relaxed state not only emotionally but also muscularly, there is also a reduced risk of fetal injury. Infants are less likely to suffer intracranial damage when being born (Ambrose & Newbold, 1980).

Prenatal.

The relaxation and general suppression of fear and anxiety experienced by women who have been trained in hypnosis during pregnancy is also thought to benefit the fetus in utero (Roig, 1961-62a). Tension in the pregnant woman very likely has a negative influence upon her unborn child. Recently, there has been much more research dedicated to understanding to what extent babies are being educated and impacted before birth. Verny (1981), in his book The Secret Life of the Unborn Child, recommended that the mother nurture her unborn child by taking care of herself, thinking good thoughts, interacting with him

through words and touch, listening to relaxing music, etc. - basically providing a warm, caring environment for physical and psychological growth.

Although, the effects of music, speech and parental emotions on the unborn have not been clearly established, there is evidence that the endocrine and hormonal mechanisms involved in maternal tension have a negative influence upon the fetus. Chronic anxiety in mothers has been linked to irritability, restlessness, diarrhea and intolerance for food in newborns (Sontag, 1954). The general calm experienced by hypnotically prepared women, even during their pregnancies is therefore of potential value to the health of their child.

Recovery.

Mosconi and Reda (1958-59) stressed that in considering the value of obstetrical hypnosis "one must notice the condition of the infant at birth who is always vigorous without any sign of suffering or difficulty in breathing" (p. 39). Ambrose and Newbold (1980) stated that "it is the rule for babies born under hypnosis to cry lustily and breath normally as soon as they are separated from their mothers" (p. 269). Mothers of these children reported that their babies usually do not have restless nights (Roig, 1961-62a), and the majority of them sleep through almost immediately (Werner et al., 1982). Roig (1961-62ab) described these infants as quiet with an unusual nervous equilibrium and explained that "these

babies enjoy the best maternal-filial relations because they are products of deliveries which are pleasant memories for the mothers - of fundamental importance for the future evolution of the psyche" (p. 17).

The significant increase in emotional and physical comfort experienced by the mother has positive implications for the baby, especially in terms of maternal bonding. In addition, women who have learned to use hypnosis for relaxation are better prepared to deal with future familial stresses, an ability which can be of considerable value to the emotional life of the family and newborn infant (Werner et al., 1982).

Disadvantages of Obstetrical Hypnosis

There are relatively few disadvantages associated with the use of hypnotic techniques in labor and delivery and those that exist are largely logistical in nature.

Time.

In one of the earliest controlled studies of obstetrical hypnosis, Schultze-Rhonhof concluded that the shortcomings of this approach are those of time and the availability of qualified hypnotists, both of which he felt could be easily overcome (cited in True, 1954). Still, hypnotic training is considered to be very time consuming, and to require long hours of preparation. This time requirement is often cited as a negative aspect of employing this method (August, 1960; Fening, 1961; Tom, 1960). Although the number of sessions necessary to

adequately prepare a woman for hypnotic delivery differs depending upon the individual woman, as well as the clinician involved, patients are generally seen at least six times prior to delivery (Ambrose & Newbold, 1980). Kroger (1977) suggested that the number of sessions may actually range anywhere from one to 20 or more.

This problem of time can be partially avoided by training women in groups, especially at the beginning stages, and supplementing with individual treatment when necessary. Hilgard and Hilgard (1975) advocated group training not only because it conserves time but also because pregnant women tend to have similar concerns and in a group setting they may enjoy a mutual support generated by the sharing of a common experience.

Temporal concerns are not however an issue for all practitioners as many recognize the cost-efficiency of time expended in light of the advantages (True, 1954; Werner et al., 1982). Davidson (1962) stated that "the time spent antenatally and the personal attention involved are well worth while to produce such objective and subjective benefits to the pregnant woman" (p. 953).

Stereotypes.

Certainly the myths and misconceptions that abound with regards to hypnosis in general may pose an additional problem (Kroger, 1977). There exists a prejudice (Hartland, 1971), or stigma (Williamson, 1975) against the idea of hypnosis itself. As Abramson and Heron (1950)

explained, "The difficulty has always been that the lay person has felt that there is something mysterious about the procedure and as a result has been fearful about submitting himself to it" (p. 1070). Even if a woman using obstetrical hypnosis is able to see past the superstitions and stories perpetuated by the popular press, she may have to deal with a hospital staff who are ignorant as to the true nature of hypnosis (Hartland, 1971). They may not understand the process involved and, therefore, disrupt the woman's efforts.

Susceptibility and Depth.

Another factor that is often considered to limit the usefulness of hypnosis in childbirth is the finding that some individuals are not susceptible to hypnosis. However, the percentage of these people may represent as little as 5% of the population (Williamson, 1975). In addition, the validity of such claims have been challenged. Wolberg (1948) believed that eventually all people would respond favorably to hypnotic suggestion if attempts at induction were consistant enough.

Among those individuals who can go into trance, only about 20% reach sufficient depth to achieve complete anaesthetic (Hartland, 1971; Kroger, 1977). Winkelstein (1958) however, found no coordination between depth of trance and successful management of delivery, and Mosconi and Reda (1958-59) wrote that "it is not necessary to reach a state of profound trance; a light trance is

sufficient" (p. 37). Abramson and Heron (1950) also questioned the importance of depth in hypnotic training. Instead, they emphasized the phenomenon of relaxation which can be easily induced in a lighter trance state.

Psychosis.

Although obstetrical hypnosis constitutes a favorable method of antenatal training for most interested women, it is contraindicated for individuals who are deeply disturbed or psychotic (Williamson, 1975). These people tend to be difficult to hypnotize (Kroger, 1977) and the hypnotic state may percipitate the onset of a psychotic episode (Ambrose & Newbold, 1980).

Training

The main objective of antenatal hypnotic training is to teach the pregnant woman to become completely relaxed, both mentally and physically; to achieve a trance state; to remove fear and apprehension and to encourage confidence and well-being (Hartland, 1971). Hilgard and Hilgard (1975) explained that practitioners who wish to teach hypnotic techniques for childbirth are faced with a variety of choices regarding the specifics of the training they will provide. Their decisions in this respect largely reflect personal preferences and local customs.

Such things as the ideal time to commence training will differ from one theorist and practitioner to another. Werner (1959) suggested attempting the preliminary induction at the end of the woman's fifth month of

pregnancy. Whereas, Tom (1960) began preparatory sessions during the seventh month and Mosconi and Reda (1958-59) recommended the beginning of the eighth month. Third trimester instruction is also supported by Hilgard and Hilgard (1975) and Clark (1956) because of their belief that a woman's anticipation and motivation are greatest at this stage in her pregnancy. August (1960) even induced trance in some women for the first time during their labor, however, this practice is generally not advised unless the woman is particularly receptive or very fatigued (True, 1954).

Ambrose and Newbold (1980), Davidson (1962), and Hartland (1971) differed in that they advocated training throughout pregnancy, stating that it is important to schedule the first visit as soon as possible after confirmation. There are a number of reasons why early training is favorable. First, the sooner in the pregnancy that myths, fears, anxieties and tensions are removed, the more likely it is for the woman to have a positive attitude toward her labor and delivery and to look forward to it with pleasant anticipation. Secondly, as mentioned, hypnotic techniques can be employed quite successfully in the prevention and improvement of common discomforts during pregnancy (Hartland, 1971). Ambrose and Newbold (1950) mentioned an additional advantage being the opportunity of the hypnotist to discover the best approach and techniques to use with specific clients.

The operator must also decide whether or not hypnosis should be attempted with the woman during the first interview. Hartland (1971) wrote that never, under any circumstances would he induce trance during the initial meeting. Others see no harm in the induction of superficial hypnosis at this time (Hilgard & Hilgard, 1975). Any acceptable method of trance induction is suitable for obstetrical hypnosis (Abramson & Heron, 1950; Michael, 1952). Again, these particulars represent individual choices that depend upon the woman involved and the style of the hypnotist. This flexibility also applies to the number of visits necessary for adequate training as well as their scheduling. Generally, however, it is advisable to see the woman quite often at the beginning, while rapport and the hypnotic state are being established. Sessions may then become less frequent, and then more often again in the last six weeks of pregnancy (Ambrose & Newbold, 1980; Hartland, 1971). Research has shown that most women can be trained in five to eight sessions (Clark, 1956; Gross & Posner, 1963).

The specifics of training are obviously the choice of the hypnotic operator and their client. Still, there are a number of things that most theorists agree should be included in the first session. An attempt should be made to put the expectant mother at ease, to establish rapport and to gain her confidence and trust (Kroger & DeLee, 1943; Michael, 1952). It is useful to assess her

attitudes towards pregnancy and childbirth and to deal with any fear and apprehension by reassuring her that birthing is a perfectly normal physiologial process that need not involve any undue discomfort or pain (Hartland, 1971; Michael, 1952). A general description of the dynamics of labor is important as well as an explanation of what role hypnosis can potentially play in this process (Michael, 1952; Roig, 1961-62a; Werner, 1959). This explanation may take place when the woman is conscious or in a trance state.

Expectant mothers should also be told that if they require medication during labor, it will be available and that they should not consider themselves a failure if this is necessary (Werner, et al., 1982). As Kroger (1977) wrote "It should be stressed again and again that the purpose of hypnosis is to minimize, not to eliminate drug requirements" (p. 231). Participants should not feel they have to "sign a pledge" against the use of anaesthetics.

Cheek (1957) emphasized the importance of incentive in a successful hypnotic delivery. He suggested that the percentage of good hypnotic patients approaches 100% when the hypnotist is able to impart incentive and motivation in the client. Fostering of motivation should also begin during the inital session and be maintained throughout training.

Subsequent meetings generally concentrate on teaching the woman to relax and to repeatedly attain the deepest

possible state of hypnosis. She is given post-hypnotic suggestions that exalt motherhood that are of positive value to management of pregnancy and the ultimate labor and delivery (Hartland, 1971; Roig, 1961-62). In addition, the woman may be taught a variety of other hypnotic methods for use during birthing which depend upon the personal approach of the practitioner. Many of these techniques will be described below.

Techniques

Suggestion

The variety of useful suggestions that can be made once a woman is in trance are limited only by the creativity of the hypnotist. Some of the ones which are recommended most commonly in the literature are as follows;

-Childbirth is a joyful experience.

-You will continue to keep fit and well throughout your pregnancy.

-Labor is a perfectly normal process of the body.

-Because labor is a normal physiological process, it should be no more uncomfortable than any other function of the body.

-You will look forward to the birth of your child with feelings of confidence, pleasure, and happiness, rather than with fear and apprehension.

-Your labor will be painless. The only sensation that you will feel will be a tightening or pressure in the lower abdomen and lower back during uterine contractions. (NEVER use the phrase "labor pains").

-You will experience your contractions as relatively pleasant sensations.

-Contractions will be experienced as pressure, comparable in every way to normal physical exertion. (Care must be taken not to abolish sensation altogether or the woman may not be aware that she is in labor).

-You will remain calm and relaxed during contractions.

-The moment that a contraction is gone, you can forget about it.

Suggestions can also be very useful in encouraging postpartum adjustments and recovery. For example;

-You will feel fit and well after the birth of your child.

-After the birth of your child, your breasts will produce plenty of milk and you will be able to breastfeed without difficulty.

-Your breasts will be full and heavy but not painful.

-You will experience numbness in your perineum during the entire hospital stay.

-You will pass water without being catheterized, you will move your bowels without enemas.

-You'll have a good appetite.

-The entire hospital stay will seem like a pleasant vacation.

Autohypnosis

The ability for a woman to put herself into hypnotic trance can prove to be a very valuable asset regardless of the depth attained. A two year experimental study conducted by Kline and Guze (1955) indicated the general effectiveness of self-hypnosis in childbirth for most of the people who used this method of preparation. Malyska and Christensen's (1967) investigation combined self-hypnosis and prenatal preparation classes. Based upon their results, they concluded that "training in autohypnosis during prenatal classes helps any nurse or doctor serve his patient better and helps almost every patient during the whole pregnancy - before during and after labor" (p.191-92).

When using autohypnosis, the woman is responsible for putting herself into trance, and is therefore less dependent upon the practioner, whether this is an obstetrician, nurse or a psychologist (Kline and Guze, 1955). The production of physical and mental relaxation produces an analgesia that is due to a reduction in fear and anxiety rather than direct suggestion. This technique should be taught to the expectant mother early in the training so she has the opportunity to practice at home and gain confidence in her ability (Hartland, 1971).

Hypnosis can be self-induced during labor in two ways. The woman can put her self into trance at the beginning and maintain it for the majority of the labor, or she can self-induce trance at the start of each contraction and maintain it only until the contraction ends (Ambrose & Newbold, 1980; Hartland, 1971). Hartland outlined a procedure for teaching autohypnosis through post-hypnotic suggestion;

> In a few moments...when I count up to seven...you will open your eyes and be wide awake again. After I have wakened you up, I shall talk to you for a minute or two. You will then put yourself straight off to sleep again...into a sleep, just as deep as this one. You will lie back, comfortable...fix your eyes on a spot upon the ceiling and count slowly up to five. As you count...your eyes will become more and more tired...you will feel drowsier and drowsier ...and, the moment you have reached five...your eyes will close immediately...and you will fall immediately into a sleep, just as deep as this one. (p.318)

Glove Anaesthesia

Glove anaesthesia is a useful means of relieving pain and is attained through direct suggestion. First, anaesthesia is produced in the hand by stroking it and suggesting that it is becoming numb. The woman practices producing the glove anaesthesia and then transferring it

to other areas of the body. The side of the face is usually first, and then the abdomen and perineum (Ambrose & Newbold, 1980; Kroger, 1977), all in rehersal for relieving the pain of contractions during labor. The trainer generally tests for the degree of anaesthesia with a pinch or a pinprick. Kroger's (1977) verbalization for glove anaesthesia is as follows;

> And now you will go into a deep, hypnotic state, way down deeper and deeper! You are going to produce glove anaesthesia. As I stroke this hand, it is going to get numb, heavy, and woodlike. When you're sure that your hand has become numb just as your gums would be after your dentist injected procaine, you will then transfer this numbness to your face. With every movement of your hand toward your face, it will get more numb and woodenlike. When it touches your face, press the palm of your hand close to your face, and when you are certain that the numbness has transferred from your hand to your face, drop your hand and your arm....(p. 232)

Substitution

A minor or secondary symptom can be substituted for a pain experienced during labor in the same location where the discomfort was originally felt. Although the feeling is completely relieved, it is replaced with a less painful, perhaps innocous sensation, i.e. light tingling (Hilgard & Hilgard, 1975).

Displacement

In this technique, the symptoms of the contractions are displaced to other areas of the body. The rhythmic contractions of the uterus may be transferred to the hands, for example, thus shifting attention away from any abdominal discomfort (Hilgard, 1975).

Dissociation

Dissociation may take a number of forms. Donald Coulton (1959-60) developed a technique known as partial body trance or partial physical dissociation, in which he had the woman divide her body into upper and lower halves. She was then taught to bring her upper body out of trance while leaving her lower body, including the uterus, in a limp, inert, insensitive trance state. In another form of dissociation, the woman is asked to notice a person sitting across from her whose description corresponds to her own. When she can see the person, the hypnotist attempts to anaesthetize this dissociated self. The woman is encouraged to accept that her hallucinated image is anaesthetized and then to let the image disappear. At this point, it is very common to discover the patient has herself been anaesthetized (Werner, 1959).

Hallucinations

Ralph August popularized this method of imaginative separation in which the woman's attention is diverted away from labor to a pleasant activity - one which has been previously established as part of the person's experiental

history. She is encouraged to experience some pleasant fantasy or to undertake some activity in her mind. The personal preferences of the individual can be determined to aid in development of the hallucination. It is best to choose events which take place over time rather than fleeting ones, because of the often lengthy duration of labor. Some common examples are swimming, dancing, playing the piano, watching television, or taking a long car trip, with activities involving physical movement being particularly effective (August, 1960-61).

Time Distortion

The ability to learn time distortion can be very useful to the woman in labor. Some degree of temporal distortion is common for most people in a trance state, however this can be further enhanced by direct suggestions (Coulton, 1959-60). The perceived duration of labor can be shortened using this technique. In addition, it is possible to make the contractions seem to last only a few seconds and the interval between them to seem like a fifteen to twenty minute break (Coulton, 1959-60; Werner, 1959).

The Journey (The author's title)

This technique was mentioned in Great Expectations (July, 1983), a magazine for expectant parents. It involves educating the woman as to the dynamics of birth concentrating specifically on the delivery path. Illustrations are extremely useful as they show where the

baby is at each stage and what position they are in. This aids the woman in visualizing the event. She is encouraged, while hypnotized to make this journey with her child and to appreciate what a wonderful and happy experience it is. This technique seems particularly powerful in that it allows the woman to feel she is protecting and guiding her child through its birth.

Conditioning the Expectant Father

Certainly, childbirth has emotional significance not only for the expectant mother, but also for the father. Some primitive cultures even practice a ritual participation of the father during pregnancy and confinement referred to as couvade (Crasilneck & Hall, 1975, p. 253).

In modern society, it has become the norm for the expectant father to participate in childbirth by accompanying the woman into the labor and delivery room. In the case of hypnotic birthing, it is possible to involve him in the process by putting him en rapport with the woman, as described by Ambrose and Newbold (1980). This is usually accomplished by having the hypnotist suggest to the woman while she is hypnotized that she will accept the instructions of her husband to go into trance. A cue or signal is then established, such as a shoulder touch or counting to five. The husband is then invited to attend sessions and attempts to hypnotize his wife using

the cue. The procedure is repeated several times in order to give the husband confidence in his ability.

This approach has obvious benefits when the woman cannot attain autohypnosis or when the hypnotist will not be attending the birth. However, its greatest value is that it allows the husband to actively participate in the birth of his child and fosters a feeling of cooperation and a team effort in labor.

The Hypnoreflexogenous Method

A discussion of techniques used in obstetrical hypnosis would not be complete without consideration of Santiago Roig-Garcia's (1960-61a) contribution. Roig's Hypnoreflexogenous method is actually more of a total approach to birthing than just a technique. His method represents a combination of the Pavlovian concept of conditioned reflex and hypnosis. It is based upon Roig's belief that suggestion is the most basic and typical reflex in humans. He uses suggestions, very similar to the ones mentioned earlier, to alter the conditioned reflex of associating pain with labor. This may not sound much different from techniques already discussed, however it is unique in that "Roig is concerned with managing delivery in a state of 'vigil', a state of wakefulness." (Werner, et al., 1982). Traditional obstetrical hypnosis usually involves the use of trance during labor and delivery. That is, as soon as the woman is uncomfortable, either she, her husband, or a hypnotist induces a trance

state that is then maintained for the majority of the labor. Roig's approach does not require that the woman be in trance during her confinement. Rather, she remains awake and comfortable, guided by post-hypnotic suggestions made during training. Roig explained:

> The low excitability of the cortex obtained by deep psychological sedation of the organism, the abolition of the negative emotions which is fear of delivery, and the substitution by the contraction of the pain response constitutes the tripod on which our method sustains itself fundamentally. (Roig, 1960-61a, p. 5).

Labor in vigil s[illegible] an ideal way for women to experience the birth of their child and if nec[illegible]y it could be supplemented by other hypnotic techniques i.e. trance induction.

Chapter III

Methodology

Rationale

The present research utilized a qualitative case study methodology in the investigation of obstetrical hypnosis. The primary goal was to develop a greater understanding of the phenomenon of hypnotic birthing and to provide a subjective description of the experience of using hypnosis as a method of prenatal preparation. The objectives of this research were best met through a qualitative approach - a methodology in which the aim is exploration, differentiation and understanding (Peavy and Hunnisett, 1983).

This type of research was also considered appropriate because it follows an inductive, discovery oriented process. The researcher begins with specific observations and moves towards general patterns and theories (Stainbeck & Stainbeck, 1984). The discovery aspect arises in the ongoing redefinition of the experience in question as new data are collected, examined and incorporated into the definition (Peavy and Hunnisett, 1983). In addition, the participants are considered to be the actual experts in this approach. It is the information, perceptions and feelings that they share that ultimately lead to an understanding of the experience being studied. For this reason, they assume the status of co-researchers (Colaizzi, 1978). Polkinghorne (1979) explained that "the

informant is not treated as a subject being observed as part of an experiment, but as a full participant in the search" (p. 20).

Components of the case study approach as outlined by Good (1966) were also included in the design because they allowed for presentation of the participants' history, characteristics and training as well as their personal accounts of the experience. All of these factors provided organization, and detail which potentially led to greater understanding of the phenomenon.

Qualitative research methodology attempts to determine "the subjective aspects of people's behavior" (Bogdan & Bilken, 1982), and is therefore very dependent upon the particular behavior or experience being studied. As a result, there exists no clear-cut design for collecting or analzying data when doing qualitative research. Rather, the literature on the qualitative and case study approaches gives only recommendations for conducting this type of research, outlining components which should generally be included. The researcher is then responsible for using these general guidelines to develop a design which best satisfies the objectives of their investigation. In addition, Peavy and Hunnisett (1983) pointed out that qualitative research design is usually flexible and tends to evolve in complexity as the data are collected and considered.

Procedure

The design of the present investigation incorporated various elements suggested by Colaizzi (1978), Good (1966), Peavy and Hunnisett (1983) and Polkinghorne (1979), as well as additional unique stages that were necessary in conducting this particular research. A detailed description of the specific steps followed in this study of obstetrical hypnosis are outlined below.

1. At the outset, it was important to identify the unit of investigation. As this occurred prior to the pilot studies, the definition of the experience under study was understandably vague and unrefined, and yet served as a initial guideline for the early stages of research.

2. General research questions were generated based upon the characteristics and description of obstetrical hypnosis proposed in the professional literature, as well as upon the presuppositions of the researcher.

3. Three pilot studies were conducted with voluntary participants in order to explore issues addressed in the research questions. In addition, through pilot research, the investigator gained experience in using hypnosis as a method of prenatal preparation and identified important components of the training and experience that would be applied later in the study.

4. The unit of investigation being studied was

reconsidered and redefined based upon the findings of the pilot studies.

5. Research questions were reformulated and additional research questions were generated.

6. A training program for the use of hypnosis as a method of prenatal preparation was developed. This program included the basic components of instruction to be employed with all research participants. The methods and techniques used were based upon the professional literature, the results of pilot studies and the personal expectations of the researcher.

7. Three couples were selected as participants for research. No attempt was made to use a standardized sampling procedure or to have the participants be representative of all couples expecting children. Rather, their involvement was dependent upon their personal interest in learning hypnosis and using it in the birth of their child. In addition, the expectant woman was required to be in her third trimester of pregnancy and the couple was asked to make a commitment to attend training sessions and follow-up interviews together.

Pertinent personal and life history data was collected on all couples. Concentration was given to information that was relevant to both training and an understanding of their experiences.

8. Between six and eight one hour training sessions were conducted with each of the couples individually. The

number required depended upon their personal needs and characteristics. During these sessions, each couple was taught to use hypnosis in preparation for childbirth. Meetings were scheduled roughly one week apart and all took place at the University of Alberta Education Clinic. Specific details of the training are described in Chapter V.

9. During each session, time was allocated to discussion, both before and after the actual training. This provided an opportunity for interaction between the researcher and the participants. The couple was invited to ask questions, voice concerns, react to the procedures and give advice. In turn, the researcher was able to check out the progress of training and the validity of emerging patterns.

10. Following each session, careful notes were made outlining the techniques and procedures used and their apparent effectiveness, the reactions of the couple to these techniques, and their general behavior and attitude during the session. In addition, the researcher documented topics of discussion including the concerns, impressions and questions of the couple as well as the themes, generalizations, patterns and metaphors that became apparent in conversation.

11. At the beginning of each meeting, the content of written summaries from the previous sessions were reviewed

with the couple. Revisions and clarifications were made as necessary.

12. Within a month following the birth of their child, an open ended interview was conducted with each couple during which they were invited to share their experience with obstetrical hypnosis. An unstructured, nondirective type of interview was considered to be superior to standardized questionnaires or rating scales for the collection of data as the objective was to allow participants to freely express their personal thoughts and feelings regarding the use of hypnosis in birthing. Questionnaire or scale items would unlikely have accessed individual insights or awarenesses as they would be based on the expectations of the author regarding the characteristics of the experience. Stainbeck and Stainbeck (1984) support this point of view. They stated that "the unstructured, open-ended approach allows the subjects to answer from their own frame of reference rather than from one structured by prearranged questions" (p.405).

During the interview, the researcher initially asked each couple to describe their own experience. An attempt was made to seek answers to research questions when such information was not offered in the description. However, emphasis was placed upon eliciting the subjective reactions of the participants rather than verification of

characteristics proposed in the literature. All follow-up interviews were taped with the consent of participants.

13. Notes were made from the taped interviews.

14. A case description of each couple was written using information gathered both during training sessions and follow-up interviews.

15. An analysis of pre-labor and post-labor notes was undertaken in search of common themes and patterns, generalities, consistancies and inconsistancies. Experiences specific to particular couples were also identified and noted.

16. The resulting themes, patterns and generalities were integrated.

17. A description of the experience of using obstetrical hypnosis was written identifying the essential elements and pattern of the structure.

Role of the Researcher

The researcher was responsible for all facets of the present investigation including; development of the training program, recruitment of participants, training of participants, and conducting follow-up interviews.

Chapter IV

Preliminary Research

Introduction

In Chapter III the evolving nature of the qualitative research methodology was introduced and described. It was explained that as researchers collect new data during the course of this type of investigation, their understanding of what is being examined undergoes elaboration, amendment and redefinition. The design of a qualitative study and the questions it addresses are also flexible and are often revised to suit changes in the investigators' understanding of the experience being studied. In this chapter, an attempt will be made to reflect the evolution of the present study and its growth in specificity as new information from pilot research was considered and intergrated.

Prior to Pilot Studies

Before pilot research was conducted, the researcher's general definition of the unit of investigation was;

> The experience of using hypnosis during labor and delivery for the woman giving birth.

The related research questions were based upon descriptions provided in the professional literature and upon the investigator's expectations. They were as follows;

1. Can women benefit from the use of specific hypnotic techniques in giving birth?

2. Does hypnosis produce mental and physical relaxation during labor and delivery?

3. Does the use of hypnosis influence the woman's subjective experience of and reaction to labor pain?

4. Do women trained in hypnosis enjoy feelings of control and composure during childbirth?

5. Is childbirth an emotionally satisfying and rewarding experience for women who use hypnosis?

Subsequent to Pilot Research

Training of and interaction with pilot participants exposed many new awarenesses regarding hypnotic birthing, which lead to revisions in the researcher's understanding of the experience. These revisions, in turn, resulted in changes in the approach to research and in the objectives of the present study.

General changes included (a) viewing the use of hypnosis within a wider scope - considering its influence not only upon labor and delivery, but also during pregnancy and the postpartum period, (b) placing more emphasis upon the involvement of the father in hypnotic training, delivery and early parenting, (c) consideration of the potential influences of obstetrical hypnosis on the infant, before, during and after delivery, and (d) greater recognition of the emotional, psychological and interactional facets of using hypnosis in birthing.

It was necessary to amend [redacted] of investigation in order to reflect the above [redacted] orientation.

The unit of investigation was then defined as;

> The experience of using obstetrical hypnosis, before, during and after childbirth for the mother, father and infant.

The research questions were reformulated and expanded as follows;

1. Is the woman influenced before, during and after delivery by training in and use of hypnotic techniques - specifically relaxation, post-hypnotic suggestion, autohypnosis, and trance induced by husband?

2. Does the woman enjoy prenatal benefits such as the ability to relax, bodily comfort, energy, ability to sleep, pleasant anticipation of childbirth, feelings of preparedness etc., when she practices hypnosis during pregnancy?

3. Does the use of hypnosis produce mental and physical relaxation during labor and delivery?

4. Do women trained in hypnosis enjoy feelings of composure and control during childbirth?

5. Does the use of hypnosis influence the woman's subjective experience of and reaction to the discomfort of birthing?

6. Do women who use hypnosis feel they have played an active part in the birth of their children?

7. Is childbirth an emotionally satisfying and rewarding experience for the women who use hypnosis?

8. Do hypnotically prepared women experience a rapid recovery from childbirth?

9. Are hypnotic techniques of value to women after childbirth?

10. Can the father play a role in the use of hypnosis, before, during and after delivery?

11. Is it beneficial logistically to involve the father in training and make him responsible for particular facets of the process?

12. Does the father's involvement contribute to a rewarding and satisfying pregnancy and childbirth experience for the couple?

13. In the parent's opinion, is the infant influenced by the use of hypnosis, before, during and after delivery?

The findings of pilot research also led to changes in the approach to training resulting in the development of a specific program for instruction. This program will be described in Chapter V.

Chapter V

Training Method and Participant Preparation

Introduction

In the present chapter, the training procedure employed with all research participants is described. First the essential characteristics of both the initial contact with participants and their first session with the trainer are outlined as these are important to the ultimate success of training. A description of the components of instruction used by the researcher is then detailed.

First Contact and Meeting

During the initial contact with potential participants, the researcher provided a brief description of the study and its objectives. The requirements of involvement were explained and related questions were answered. In addition, the couple was asked to check with the woman's obstetrician to determine if he or she supported participation and to provide their doctor with the researcher's name and phone number should the physician desire more information.

The setting for the first session and all subsequent meetings was a large room which comfortably accomodated three adults. Couches, conventional chairs and hypnosis chairs (high-backed with body support) were all available for use. Because many pregnant women are actually more comfortable in a reclining position than sitting, they

were given the opportunity to decide where they would prefer to be induced. Husbands were also invited to sit where they wished. The room was dimly lit in order to create a relaxing atmosphere.

The first session included many of the components recommended in the literature as well as some unique features. The researcher attempted to establish rapport and initiate a relationship with the couple. This was accomplished, in part, through discussion of and reaction to their feelings and expectations regarding pregnancy, childbirth and the use of hypnosis. Related fears, apprehensions and misconceptions were seriously considered and relieved when possible.

The process of labor and delivery was reviewed and relevant terms were introduced and defined, i.e. confinement, episiotomy, transition, etc... Participants were familiarized with the concept of childbirth as a natural physiological function that theoretically should be no more uncomfortable than any other other bodily process (Michael, 1952). The use of drugs in labor and delivery was also discussed. Couples were encouraged to recognize that although reduction in the use of medication is an admirable goal, it is not as important as having a healthy baby and a safe and meaningful childbirth experience. It was stressed that they should not feel they had failed if some anasthesic or analgesic was required for labor and delivery. Personal information was

also collected from participants some time during the first meeting. This early discussion had an additional function in that it allowed the researcher to assess the couple's relationship as husband and wife and to anticipate any conflicts they might have regarding childbirth.

The expectant woman was then given the opportunity to experience hypnosis as her husband observed. Trance was induced gradually for the first time through a progressive relaxation technique. The woman was encouraged to concentrate on different parts of her body (beginning typically with either her feet or her head) and to notice relaxation spreading slowly throughout, replacing tension. This process was continued until the woman was completely relaxed and in trance. Hypnotic trance was confirmed with an arm levitation.

Trance was deepened further through a pleasant fantasy initiated by the operator. This fantasy involved anything from a walk in the park to a hot air balloon ride. An attempt was made to appeal to all senses in order to determine which were most powerful for the woman.

Positive suggestions were made for the continued good health and fitness of the participant during the remainder of her pregnancy. In addition, it was suggested that she could enjoy deep relaxation during childbirth. Finally, a cue was established with the woman so that she would be able to enter trance more quickly in the future. This cue

consisted of the operator firmly grasping her shoulder and slowly counting to three. The woman was conditioned to enter a deep trance when these events occured together and when it was her genuine desire to do so. She was then brought out of trance and the remainder of the first session was devoted to discussion.

Training Program

The program employed in preparing participants to use hypnosis in childbirth incorporated a variety of components which will be detailed below. Again, many of these are mentioned in the professional literature and are traditional in obstetrical hypnosis, whereas others are unique to the present investigation.

Three Deep Breaths

This technique is similar to the Natural Childbirth strategy of "deep cleansing breaths" in that the woman thinks of herself inhaling relaxation and exhaling tension - in essence, cleansing her body. However, in its present usage, the woman was also encouraged to visualize the event. She was first asked to simply become aware of her breathing and then to shut her eyes and try to see the "breath of relaxing air" coming up through her feet, along the back of her body, up over the top of her head, and down the front of her body, literally pushing out tension and anxiety. The woman was told to inhale to the count of 10 and exhale to the count of 10 and it was suggested that each breath would leave her more completely relaxed.

Certainly this technique represents a skill that requires considerable rehersal. However, with sufficient practice, most women were able to relax their bodies and minds completely in three deep breaths. The conditioning cue of a shoulder grasp and counting to three established during the first session was then applied in order to formally put the woman in trance, although, on many occasions, she was already in trance at this stage.

Deepening Trance

Generally, deepening of trance was necessary only in the first few inductions while the cue for trance was being strengthened. Yet, most women expressed enjoyment with this facet of the session. For this reason, it was continued, in one form or another, throughout training. Perhaps, however, its function changed from that of deepening to provision of a pleasurable excursion.

It was discovered in pilot research that fantasies involving water were very powerful for labor and delivery. They were therefore used in deepening of the hypnotic state. One of two different fantasies was generally used by the trainer although actual verbalizations were never identical from one session to the next. The first of these had the expectant woman standing beneath a gentle waterfall. She was asked to concentrate on the sensation of the water as it poured down over her body, draining away any discomfort, tension or anxiety. She was encouraged to think of herself gradually becoming part of

the water as she floated weightlessly out to sea. The second fantasy was very similar but began with the participant laying on a sandy, tropical beach. As the tide came in, it would creep slowly up the length of her body, and again would drain away tension pressure and fear when it retreated back over the sand. She too would be totally encompassed by the water until she felt part of the rushing waves.

The specific language and metaphors used in these fantasies were responsible for the creation of rich images, connections and reactions, and were therefore crucial to the effectiveness of this technique. A sample verbalization is provided below as an illustration.

> Now...I'd like for you to imagine that you're standing on a smooth, cool rock...a smooth cool rock surrounded by water...the rock feels solid and strong beneath your feet and you enjoy how cool and smooth it feels...and now you are aware of a gentle waterfall just above and behind you...and as you position yourself beneath it, you can feel the cleansing water pour gently down...down...down over your body...flowing gently down from your head, along your arms and torso, over the curve of your stomach and down your legs...and the water feels so good, so wonderful and refreshing...as it gently pours down

down...down over the length of your body, it cleanses you, it drains away any pressure, tension, or anxiety that might remain in your body...and you can feel the tension and pressure draining out of your body, being pulled out by the gentle flow of water...leaving you so completely relaxed, so totally relaxed and comfortable...peaceful...calm... and perhaps you can even see the tensions and fears leave you as they accumulate in a pool just beyond your feet...and as this pool grows larger...you feel more and more relaxed...more and more comfortable... calm...peaceful...and relaxed...etc..

Husband en Rapport

Towards the end of the second session, the cue for trance induction was transferred to the husband so that he would also be able to induce his wife. This technique not only allowed the father to be actively involved in labor and delivery but also encouraged the couple to act as a team in achieving a rewarding and meaningful childbirth experience. While the expectant woman was hypnotized, the emotional and logistical advantages of conditioning her husband were explained. She was given suggestions by the trainer to go into hypnotic trance when her husband employed the established cue and when it was her wish to do so. The woman was also told that each time she and her husband practiced this process she would be able to go into trance more easily, more quickly, and more deeply.

The couple was instructed to practice at least twice daily in order to become very comfortable with the process. In addition, the husband was invited to put his wife into trance during sessions with the trainer. He was also encouraged to follow through with storytelling, fantasies and useful suggestions once he had hypnotized his wife.

Autohypnosis

The pregnant woman was introduced to the technique of autohypnosis during the third session. While hypnotized, the advantages of being able to put oneself into trance were impressed upon her. The operator then described the process she would go through (the cue) in order to hypnotize herself. She was told that if she shut her eyes, took three deep breaths, and then began to count slowly backwards from 35, by the time she reached 30, she would be in a deep state of trance. After repitition of the instructions, the trainer actually lead the woman through the process, verbalizing the steps involved. The woman was then brought out of trance and after brief discussion, was asked to hypnotize herself. Assistance was provided when necessary. Once the woman was in trance again, it was suggested that she practice this technique often at home and the each time she did, she would relax more easily, more quickly and more deeply.

Post-hypnotic Suggestions

Although suggestion was used extensively in all elements of training, there were some suggestions that had

very specific purposes. The majority of each session was spent in making these specific suggestions which would ideally have their influence at a later date or over a future period of time. These are outlined below in the approximate order that they occured during training sessions.

For Pregnancy.

Positive suggestions for pregnancy began during the initial session and continued throughout training. Their purpose was to help the expectant women to enjoy good health, comfort, and a positive attitude during the often difficult third trimester of pregnancy. Some of the suggestions use most commonly were;

-You will continue to feel fit and well throughout the remainder of your pregnancy. Healthy, fit and well.

-Despite your increasing size, you'll enjoy lots of energy and have no difficulty conducting your normal daily activities.

-You will feel very proud of expecting a child and will express this in you're interaction with others.

-You will continue to perform normal bodily functions quite easily, without difficulty or discomfort.

For Labor and Delivery.

Suggestions given for the actual labor and delivery also began early in training although they tended to become more directed and specific as the event approached. That is, during early sessions, suggestions concentrated

on allieviating related fears, reframing birthing as a normal physiological process and building the association between relaxation and childbirth. Gradually, more consideration was given to the occurrence of contractions, their function, and how they would be experienced. In the last couple of sessions, a detailed description of the process of labor and delivery was made along with specific suggestions for how the woman would ideally react at that time. Some frequently used suggestions included;

-During the birth of your child you will be just as mentally and physically relaxed as you are at this moment

-You will look forward to the birth of your child knowing that you will be relaxed and comfortable.

-Childbirth is a perfectly normal physiological process...one for which your body is so well prepared...so ready. Because it is such a normal function for your body, it should be no more difficult or uncomfortable than any other normal function...like sneezing or having a bowel movement.

-By relaxing your body... working with it instead of against it...you will relax and go with the rhythmic contractions of your uterus knowing of their very important work.

-You will welcome each contraction knowing that each brings you closer to your goal...closer to the birth of your child... closer to the moment you will hold your baby in your arms.

-There will be no undue discomfort associated with contractions...you will experience them only as a tightening or pressure in your stomach or perhaps in your lower back.

-You will know when you are in labor because you will begin to experience a periodic tightening or pressure in your stomach or lower back...you will be very excited but will remain calm and relaxed and in control.

-Any time during labor when you wish to practice, relax or when you just need a little break, you will use your autohypnosis or will ask your husband (actual name used) to put you in trance.

-As the contractions become more frequent, they will also become more intense...but you'll find that as they get stronger, you will become more relaxed, calm and relaxed.

-When your contractions are 5 to 7 minutes apart, you'll know that it is time to go to the hospital.

-At the hospital you will remain calm and relaxed...co-operating with your doctor and nurses...welcoming each contraction.

-If you'd like to relax more completely or just need a little rest or break while at the hospital, you'll simply put yourself into trance or ask your husband (actual name used) to put you in trance.

-When your cervix is dilated enough for the birth of your child, your doctor will ask you to push or bear down.

It will be very easy for you to comply with his/her wishes. You'll push when asked and stop when asked...relaxed and in control. This will seem very simple and very natural.

For Postpartum.

Post-hypnotic suggestion was also used to improve the postpartum period. These suggestions were given to women in the later part of training and included some of the following;

-After giving birth...you will be very thrilled with your accomplishment...very excited and proud.

-You'll be full of energy and able to get up soon and move about easily.

-You may have a few stitches if an episiotomy was necessary, but these will not bother you at all.

-Your breasts will be full and heavy with milk on the third day after your child's birth or perhaps before...but they will not be uncomfortable.

-You'll enjoy the sensation of full breasts knowing that the milk you produce will nourish your child...you'll enjoy breastfeeding (this suggestion made only if women intended to breastfeed).

-You will be able to urinate easily and will have a bowel movement by the third day.

-You will have a good appetite and will sleep well.

-Your whole hospital stay will seem like a pleasant vacation.

-You'll be able to employ your ability to relax or will ask your husband (actual name used) to help you relax anytime after the birth or your child.

For Future Depth.

During each session, it was suggested to the woman that every time she, her husband or the trainer attempted to induce her, she would go into trance more easily, more quickly and more deeply. This suggestion was generally repeated several times.

For Strengthening Cues.

Both of the cues established for the woman to enter trance were strengthened through post-hypnotic suggestion. This was accomplished by repeating the instructions and verbalizations for these cues each time she was hypnotized and suggesting to her that she would respond to them readily if it was her desire to do so.

tional Features of Training

Allowing Husband to Experience Trance.

It became apparent during pilot studies that the observing husbands were often influenced by the induction of trance with their wives. They expressed frustration with resisting the urge to relax, thinking that it was imperative for them to remain alert. With future couples the trainer gave husbands the opportunity to experience trance along with their wives if it was their wish to do so. This not only allowed the men to become familiar with the process itself but also made them more susceptible to

the instructions and valuable suggestions given to their wives. Husbands were assured that their awareness of what was occuring would actually be enhanced while in trance so they did not have to worry about missing something.

Enhancement of Self-Esteem, Confidence and Security.

The trainer made efforts to build the self-esteem, confidence and feelings of safety of the expectant woman through the use of metaphor, suggestion and the repetition of key words. Again, water images provided a particularly powerful vehicle for this purpose. The characteristics of strength, power, control and calm were emphasized in deepening fantasies, and became key words used in the various suggestions. Images of safety and security were also abundant and had related significance for childbirth as is evidenced in the following passage.

> ...and as you continue to relax deeper and deeper... being cleansed and renewed by the warm, gentle water ...you'll begin to feel very fluid as if you were a part of the water...as if you were water, gently flowing down and down...being carried away to sea on a wave...and you feel so much a part of all that is around you...so comfortable...so peaceful...so familiar...as if you belong...you belong in this place...and you're lulled by the roar of the ocean, by the swish of the surf as it creeps along the sand ...these sounds are so familiar now...so comforting and soothing...just like a lullaby...as you are

rocked to and fro, to and fro...gently rocked by the movement of the waves...as the arms of the ocean embrace you...rocking to and fro...just as a mother would rock her tiny child in her arms...so safe, so very safe and secure...etc..

Again, key words such as safety, comfort and belonging were repeated at different stages of training to strengthen these feelings and provide continuity.

Reframing.

During the course of training, the instructor often encouraged participants to accept a more positive or optimistic perspective when they communicated ideas, attitudes or perceptions which were negative in orientation and potentially counterproductive. This was generally accomplished through a process of reframing. The trainer would suggest an alternate way of viewing the participant's perception with hopes of producing change. Reframing was used both during hypnotic trance and conscious states. Some of the more frequently encountered uses of this technique were;

1. The reframing of labor pain as manageable discomfort (The word "pain" was never used during training or interaction with participants).

2. The reframing of uterine contractions from something dreaded and unpleasant to a functional occurance that would bring the couple closer to their ultimate goal - the birth of their child.

3. Reframing of anxiety, fear and apprehension related to childbirth as natural excitement and pleasant anticipation of the event.

4. Reframing of bodily discomfort and awkwardness often experienced during late pregnancy from a nuisance to a welcomed indication that soon the baby would be born.

Practice.

At the conclusion of each session, the trainer stressed to the couple the importance of practicing the skills they were learning. It was recommended that a specific time be set aside each day for the husband to induce trance with his wife and for her to practice autohypnosis. The scheduling of this rehersal was left to the couple. They were, however, encouraged to attempt inductions in a variety of different settings i.e. the kitchen, the car, the neighbor's house, etc., in order that they not only become proficient with the process but also with using it whenever and wherever necessary.

Chapter V

Results

Introduction

This chapter presents the results of the current investigation of obstetrical hypnosis. First, the experience of each couple is reported in the form of a case study. A general description of the experience in question is then given, based upon commonalities inherent in the case studies. This description will follow the framework outlined by the research questions. Additional, unexpected findings which do not conform to this format are reviewed and incorporated into the account of the experience.

Case Studies

The case study was considered to be an appropriate and useful means of reporting each couple's experience with obstetrical hypnosis. It provided the investigator with organized information from which to approach an understanding and description of the experience in general.

Each case represents a condensation of data gathered during training and follow-up interviews. The author was however selective, including only material which would potentially lead to a greater understanding of the experience. Superficial, redundant and [illegible] was edited. For example, because many of the logistics of, and reactions to training were similar for all

participants, only those aspects of instruction which stood out in their uniqueness or judged importance were included.

Attempts were made to reflect the attitudes and feelings expressed by the participants. Towards this end, their actual responses were incorporated in the description whenever possible.

Just as the findings from pilot research altered the investigator's understanding of the experience in question, so too did information gathered from research participants. Because these couples were trained serially, it was possible to reapply discoveries made with each to the instruction of, and interaction with the next. For this reason, the three cases are presented in the order that they occured. This way the reader can follow changes in the instructor's approach to training based upon the experiences and recommendations of each couple.

The actual names of research participants have been changed in order to ensure their anonimity.

Couple #1

Michelle, 30 and John, 26, became involved in the present study after having heard about it from a colleague of the researcher. Michelle was an instructor in Medical Laboratory Science and John worked as a planner for the Provincial Government. The couple had been married for two years and were expecting their first child. They began training during Michelle's seventh month of

pregnancy and attended a total of seven preparatory sessions spaced roughly one week apart. Michelle and John had completed a prenatal program through a local hospital but were somewhat dissatisfied with the instruction provided. They were both enthusiastic about learning and applying hypnotic techniques for pregnancy and childbirth.

Michelle had previously been involved in hypnotherapy and was therefore familiar with the process. She responded well to initial trance induction and in her opinion achieved greater depth than she had in the past. Throughout training, Michelle often experienced amnesia for the content of sessions while she was hypnotized. During the third session she admitted to the instructor her belief that she was actually falling asleep. Michelle also assumed that because she could not recall all of the suggestions made, she would not benefit from them. The instructor explained that amnesia is a normal occurance for some individuals when hypnotized. It was pointed out that Michelle always returned from trance when the trainer asked her to, which suggested that she was indeed responding to what was being said. In addition, she reacted to many of the post-hypnotic suggestions made in training, indicating her awareness at other than a conscious level.

John seemed very committed to sharing the experience of childbirth with Michelle and becoming involved in the process. He was however somewhat self-conscious and

lacked confidence in employing the hypnosis with her. As a result their initial attempts were not very successful. John often commented that he was not as effective as the trainer. Michelle stated that although she was able to relax when John induced trance, she seldom reached as deep a trance state as during sessions. The instructor encouraged the couple to continue their efforts and stressed the importance of practice.

They did have greater success with induction of trance later in training. They noticed an improvement when John quit trying to imitate the style and verbalizations of the trainer and began to trust his own inclinations. This was especially evident in his deepening of trance. When John used experiences that the couple had in common for this purpose, he felt more comfortable with the procedure and considered himself more effective. In addition, Michelle commented that when John personalized the fantasies, it made the experience more meaningful for her.

Michelle had an interesting reaction during trance when the instructor made specific suggestions relating to labor and delivery. She displayed a noticable twitching of her hands and facial muscles. This was especially true when uterine contractions were discussed. Once out of trance, she was asked how she experience this. Michelle explained a feeling of "coming up" and not being as deeply

relaxed. She also mentioned that she could remember most of the suggestions made during this time.

Both John and Michelle expressed enjoyment with training sessions and their concomitant aftereffects. Michelle reacted positively to suggestions made for ease of pregnancy - especially ones which reframed minor bodily discomforts (ie. backache) and clumsiness as indications that their child would soon be born. Michelle said that she actually began to appreciate the meaning of these sensations and almost looked forward to their occurance. She also noticed a progressive improvement in her attitude towards labor and delivery.

John appeared to gain confidence in the utility of hypnosis for pregnancy with his awareness of Michelle's progress. He also seemed interested in experiencing trance himself. At the trainer's invitation, he allowed himself to go into trance during one session and was pleased with his own ability to relax.

Michelle enjoyed reasonable success with the cue for autohypnosis but believed that it was most useful in producing relaxation - a state she considered to be different from hypnotic trance. She found the Three Deep Breaths and the autohypnosis cue very useful in helping her to relax, attain comfort and fall asleep during the last part of her pregnancy.

Although John and Michelle completed training, they had only limited opportunity to practice as Michelle went

into labor three weeks prematurely. Initially, Michelle was unaware that she was in labor. Retrospectively, however, she recalled having to urinate at regular intervals the previous night. She woke up the following morning feeling "sluggish" with some tension in her back, but went to work as usual. Michelle walked home in the afternoon still not having considered that she might be in labor and only experiencing what she called "twinges". Soon, she recognized that these "twinges" were occuring regularly, every 16 minutes. The interval between quickly decreased to 10 minutes and then to 5 minutes shortly after. Michelle and John still questioned the significance of these sensations as she was having no discomfort.

After a warm bath and a trip to Michelle's office to straighten up, the two proceeded to the hospital arriving at about 9:00 p.m.. An internal examination confirmed that Michelle was in labor with 2 cm. cervical dilatation. She was given a routine preparation including an enema which increased the intensity of her contractions. At 3 minute intervals, Michelle reported that she was then aware of the contractions and experienced them as managable menstral cramps. One hour later, her cervix was 8 cm. dilated. The assisting nurses expressed surprise with the progress of her labor and with Michelle's composure.

At about this point, Michelle found it necessary to lie down and asked John to help her relax. He applied the established cue and then "took Michelle on a journey". John said that it was difficult to continue the fantasy because of interruptions by nurses who wanted to know what he was doing. Michelle was less aware of these distractions. She indicated that the induction helped her to relax but she questioned whether or not she went into trance.

By 10:30 p.m. the contractions were much stronger and more frequent. Michelle still felt very much in control, breathing deeply through each contraction. She accepted a shot of demerol which helped her to relax further.

An hour later, as nursing shifts changed, a new nurse entered the room and asked Michelle how her "pains" were. Michelle reacted very negatively towards the nurse's comment, defiantly stating that she was not experiencing "pains" but rather "contractions". It was at about this time that the couple noticed a change in the progress of labor and Michelle's attitude towards, and management of contractions. She began to experience much more discomfort and was asked if she would like an epidural anaesthetic as it was no longer safe to administer demerol. Michelle refused and instead tried nitrous oxide without much relief of discomfort.

By 2:00 a.m., it became apparent that Michelle's cervix had regressed from 8 cm. to 6 cm. dilatation. The

epidural anaesthetic was again recommended and the couple decided together that Michelle should accept it. After administration of the anaesthetic, she slept for 2 hours until it began to wear off.

Her cervix was fully dilated (10 cm.) soon after and she was asked to begin pushing. This was a difficult task as Michelle had not regained complete sensation below her waist. After 1 1/2 hours of pushing, the obstetrician opted for a forceps delivery. This did not distress the couple. In fact they remembered this time with great fondness and described their mood as excited and euphoric.

Michelle gave birth to a 6 lb. 7 oz. girl just after 10:00 a.m.. The infant was reportedly very healthy but did develop a condition of jaundice, not uncommon in premature babies, and some colic in the weeks following delivery.

Michelle felt she really "bounced back" after delivery. She experienced a "burst of energy" and had no difficulty performing bodily functions. She said "I was literally on a high for days". Although she was aware of increased emotionality, Michelle explained "I cried tears of joy, not depression".

John and Michelle's memories of, and attitude towards the birth of their child were very positive in spite of the difficulty they had. Michelle commented "I never want to forget it. It was just such an exciting thing". The couple believed that Michelle had actually been in labor

for over 24 hours but was unaware of this fact. She said she felt it was just too easy to be the real thing. They both attributed this relative ease to Michelle's physical fitness and to post-hypnotic suggestions made during training. The couple felt that the hypnosis had been most effective in this respect during the initial part of labor. In addition, Michelle considered her training in relaxation to be instrumental in the degree of control and calm she enjoyed even when contrations were more intense.

John said that it was rewarding to be actively involved in the labor and delivery through the use of hypnosis. His responsibilities as the facilitator of Michelles relaxation allowed him to be a contributor in the process and play a "higher emotional role" beyond just being present.

Michelle and John did express some disappointment with the problems they encountered in light of how well they managed the labor up to a certain point. They felt they had not practiced the hypnotic techniques enough beforehand and were not prepared for the distractions present in the hospital environment. They also felt their expectations were both inconsistant and unrealistic. The couple were however excited about having another child and said they would definitely use the hypnosis again in preparation, but would practice more in advance.

The investigator asked the couple if they thought the nurse's reference to pain had any influence beyond

annoying Michelle. They stated that it may have impaired her ability to concentrate on remaining relaxed given that the labor became noticably more difficult for Michelle following the nurse's comment.

Michelle and John were invited to evalutate the utility of their training in hypnosis for childbirth. They indicated that the hypnotic techniques were useful prenatally in promoting relaxation and helping Michelle to sleep. In childbirth, they were especially pleased with the effectiveness of post-hypnotic suggestions made during training for the initial stages of labor. In particular they credited suggestions which encouraged composure and control, and those which described the sensation of contractions as pressures and tightening. However, when the uterine contractions increased in frequency and strength, they felt these suggestions no longer had as much influence.

In the couple's opinion, they were never successful in the induction of trance during labor but believed that their attempts had helped Michelle to remain relaxed and in control. Michelle said that although she had experienced discomfort with contractions, she continued to recognize their purpose throughout and refused to consider them painful.

John and Michelle said that one of the key benefits of using the relaxation techniques in childbirth was the feeling of cooperation it gave them. They felt that

together they were actively working towards a postive and memorable experience.

Michelle also mentioned that the autohypnosis was important to her in the first couple of weeks at home with her new baby. She said that the self-imposed relaxation was very helpful in coping with a colicky baby and her natural fatique.

John and [illegible] made the following recommendations for improvement of hypnotic train[illegible]e of the hypnotic techniques;

1. The husband and wife must be encouraged to practice often in order to become very comfortable with using the hypnosis together. The process should be so well rehearsed that it is almost rote and can be imposed regardless of the surrounding conditions.

2. Training should begin earlier in the woman's pregnancy.

3. The instructor should spend time during training considering the expectations of the participants regarding labor and delivery, and the use of hypnotic techniques in this process.

4. Upon the couple's arrival at the hospital, medical personnel assisting in the labor and delivery must be informed of their intentions to use relaxation techniques during labor. Attempts should be made to enlist their support and cooperation.

The researcher made additional discoveries in the training of and follow-up discussion with Michelle and John.

1. The power of suggestion to create change regardless of the status of the speaker, as evidenced by the apparent effect of the nurse's reference to pain.

2. The importance of the husband taking over from the trainer at some stage, and assuming the role of primary facilitator of relaxation with his wife.

3. The elegance and utility of reframing postpartum emotionality as joy rather than depression.

Couple #2

Karen, 30, and Ed, 31 became participants in the present study after being told of it by a fellow student of the researcher. Karen worked as an executive secretary before the birth of their child and Ed was employed as a real estate agent. Karen and Ed had been married for two years. They began training late in Karen's seventh month of pregnancy with their first child and attended a total of eight preparatory sessions. The couple were attending childbirth preparation classes simultaneously with their hypnotic training. They shared their belief that the two methods were compatible and would complement each other in labor and delivery.

Neither Karen or Ed had ever been hypnotized before but they did not seem at all hesitant about the experience. Karen had some difficulty relaxing deeply

during the first induction. The trainer suggested that she was probably just proving to herself that she was in control, and having established this, she would likely allow herself to go into a deeper trance during subsequent inductions. This proved to be a useful suggestion as Karen relaxed more completely during the following session and attained progressively greater depth thoughout training. She did however admit that the development of trust in the trainer was critical to her "letting go".

The depth of Karen's trance was influenced during every session when the instructor began making specific suggestions regarding contractions and the process of labor. She said that initially she could feel herself rise out of trance, tense up, and then relax again. Her tension was visable to both the trainer and her husband. Karen expressed some concern with this occurrence when out of trance. The instructor reassured her that she probably just wanted to pay close attention to these suggestions for labor and delivery and therefore "perked up" a bit.

Both Karen and Ed were enthusiastic participants during training sessions. Ed seemed particularly interested in the process and any potential role that he might play. He found himself influenced by trance induction during the first meeting and was therefore invited to relax along with Karen in the future.

The couple seemed quite committed to practicing what they were learning in training. Although they had some

initial difficulties when Ed induced trance with Karen, they soon became successful and seemed to enjoy their newfound skills. Encouragement and praise by the trainer further strengthened their confidence. Ed said that with practice he became more comfortable creating his own fantasies for deepening Karen's trance. He often employed experiences, images, sounds etc. that were familiar to both of them or that they had shared in the past. Both Karen and Ed found these attempts to be effective and mutually satisfying.

It is interesting that Karen and Ed transferred roles when practicing at home. That is, on at least one occasion, Karen induced trance with Ed. Their description of this and other practice sessions led the trainer to believe that they were comfortable with the hypnotic procedures and genuinely having fun with their application.

Autohypnosis was taught to Karen during the fourth session. When the trainer brought her out of trance and requested that she employ the cue just described to her, she stated that she could not recall it. At this point, Ed began to verbalize the procedure without provocation from the trainer. This was thought to be a significant demonstration of his involvement. Karen responded promptly and completely. The cue for autohypnosis was actually more effective for Karen than the one established

for use by Ed and the trainer. At her request, it was used exlusively to induce trance.

Karen also had success relaxing herself with the same cue and practiced as much as twice daily. She said during the sixth session that the skill was already useful to her in producing calm and relieving anxiety. Karen, however, indicated that she was never able to achieve as deep a trance state as when Ed or the trainer helped her to relax.

The water metaphors employed by the instructor in deepening of the hypnotic state were particularly powerful for Karen - so much so that she extended their use to trance induction. When she, her husband, or the trainer applied the chosen cue for trance, Karen experienced a wave rushing in over her body and relaxing her very deeply. Much like the cue itself, the wave became a consistant and dependable feature of her induction. Karen also expressed pleasure with the waterfall fantasy used for deepening. She shared with the trainer, her experience of relaxing very deeply when taking a shower because, for her, it approximated the sensation of the waterfall.

During the final two sessions, the trainer initiated discussion regarding Ed and Karen's expectations of labor and delivery and the role that their hypnotic training would play in childbirth. They were encouraged to continue this discussion at home and consider how and when

they planned to use the hypnosis. Attempts were made to put them in control of the process and application of techniques.

Karen went into labor at 1:15 a.m. on Christmas Day, shortly after her membranes ruptured. At the time, she was two weeks overdue. Initially her contractions were sporadic and did not impede her efforts to sleep. Soon, however, Karen was aware of a stabbing sensation in her back (the word "pain" was never used in her description) which maintained for the duration of labor and delivery. Although the sensation was more or less continous, it was somewhat more severe during contractions. The discomfort she experienced made it difficult to sleep. Ed induced trance three times during the night to help her relax. Karen felt these attempts were beneficial in producing relaxation but said that she was not able to go into a deep trance state, being distracted by the back discomfort.

Karen and Ed went to the hospital at noon on Christmas Day. They were encouraged by nurses to move about throughout the afternoon. Karen said that she had very little awareness of the contractions. She felt only the then continous and intense back discomfort.

By late afternoon, Karen found it necessary to lie down. Ed did not formally induce trance again until early evening. He applied the cue and deepening verbalizations many times with reasonable success, but did not follow

through with lengthy fantasies or suggestions. Ed said that he continued to talk about relaxation right up until their child was born. Karen felt this encouragement from Ed had been important throughout. She said she also appreciated the concentration on breathing made in training as the Three Deep Breaths were invaluable to her in maintaining control.

During the evening, Karen and Ed were told by their doctor that a caesarean section might be necessary given that the baby was in a transverse position and its head was not engaged. It was at this time that Karen said her hypnotic training was the most valuable. "The trance was most effective when I found out I might have to have a caesarean. I turned inward and made everything in me relax. I knew I had to relax. I was really into my body".

Karen began displaying signs of dehydration at about 8:00 p.m... She was therefore put on an intravenous liquid which also contained a hormone for the induction of labor. She was given an injection of demerol at about the same time which relieved some of the discomfort she was experiencing and allowed her to rest between contractions. Karen was however rather disappointed that the demerol made her feel disoriented. She said "I didn't like being out of it. I wanted to be aware of everything".

Shortly after the demerol wore off, Karen experienced an "urge to push". An internal examination confirmed that

her cervix was 10 cm. dilated - sufficient for the passage of the baby. The physician had been successful in moving the baby into proper delivery position making it possible for Karen to give birth vaginally.

Once in the delivery room, Karen was told to bear down during contractions. The couple very much enjoyed this stage of childbirth. Although it lasted for over an hour, Karen said she was full of energy and found it easy to relax between pushes. Her description of her emotional state provided a rather elegant metaphor for the entire event. "It was like all of a sudden I was just born...I just came alive." Karen gave birth to a 7 lb. 15 3/4 oz. baby girl shortly before midnight.

She enjoyed a speedy recovery from childbirth and stated "I really bounced back". Karen was out of bed and moving about soon after delivery. Although she did experience elevated emotionality about three days after giving birth, she explained that she did not consider herself to be depressed, only excited and anxious to take her baby home.

Karen and Ed were pleased with their childbirth experience and proud of how they handled it. The delivering obstetrician had complemented them on their management of what he considered a difficult labor and delivery given that Karen endured over 20 hours of back labor. Ed also commented on Karen's composure and positive attitude throughout. "Karen was so strong and

she laughed a lot." He also considered himself an "important contributor" in the process and felt they had shared in the experience of giving birth.

In evaluating their instruction in and use of hypnotic techniques, Karen and Ed made a number of interesting comments. Ed said that he felt it was very important to recognize the usefulness of the hypnosis not just for labor and delivery, but also before and after. He and Karen reviewed its functionality during pregnancy in helping Karen to relieve anxiety and to fall asleep. In addition, they described their practice of the skills as "something we could share, something we could do together to make our experience a good one."

Ed explained that because they looked at hypnosis as a relaxation technique rather than a pain killer, they were not disappointed with its usefulness. Karen said that although she had some discomfort, she felt her contractions would have been very managable had it not been for the severe stabbing sensations she experienced in her back. She added "I still refuse to use the word 'pain'."

The couple considered the suggestions made during training which reframed pain as managable discomfort and referred to contractions as useful occurances to have been especially effective. They expressed disappointment that they were not able to achieve a deep state of trance during Karen's labor. However, her description of

"turning inward" would seem to contradict this assumption and suggest that a formal induction was not crucial to relaxing deeply.

The couple explained that they regarded the hypnotic techniques as useful tools that they applied to improve the quality of childbirth. They did not consider the hypnosis to have been the underlying process of the whole event. Karen and Ed felt their use of hypnosis would have been more effective if they had been introduced to it earlier in the pregnancy. They were however pleased with the degree of proficiency they had reached and were enthusiastic about using relaxation techniques during Karen's next pregnancy and childbirth.

Karen indicated that she was still actively using autohypnosis to help her relax. She believed this allowed her to be a "calm mom and a better mom", and helped her to cope with her recent lifestyle change.

Ed and Karen felt that the relaxation that Karen enjoyed during pregnancy, as a result of practicing the hypnotic procedures, had been instrumental in their having such a good baby. They described their child as calm and relaxed "just like her mom." They also expressed some pride that through their use of hypnosis and participation in prenatal classes, they had nurtured and cared for their child prior to its birth.

The couple's recommendations to the trainer for the improvement of training were as follows;

1. Although eight sessions were adequate for training, it would have been better to spread them out over the entire pregnancy. Couples could see the trainer once a month in the beginning and perhaps more often towards the end of pregnancy. This would give them the opportunity to practice and become very familiar with the procedures.

2. During training, the instructor should suggest to the couple that they will automatically use the hypnosis as soon as the woman goes into labor. This will lessen the chances of the couple forgetting to apply their skills in the excitement of the occasion.

3. Consideration should be given to the less positive or routine occurances of labor and delivery. Specifically, the couple should be prepared for the possibility of back labor, caesarean section, forceps delivery, epidural anaesthesia, etc.. The trainer should suggest that the couple will remain relaxed and in control in the event that these occur.

Other important findings which were noted by the investigator in Karen and Ed's case included;

1. The importance of the couple developing trust in the investigator, not only as a trainer but also as a person sharing in a very significant part of their life. Rapport is best nurtured through a warm and honest approach and a genuine respect for the participants' point of view.

2. The ability of the trainer to generate enthusiasm, commitment and a positive attitude once trust has been established.

3. The importance of consistancy and structure in all facets of training to provide the couple with feelings of control and security with which to approach a new experience. Consistancy was inherent in the order of events in each training session, the repetition of key words, images, metaphors and fantasies, and the use of established cues. Couples were encouraged to maintain a structure in their own practice sessions which would ideally make the process more automatic, dependable and easily applied to the actual childbirth.

Couple #3

Sharon, 31 and Roger, 32, indicated interest in being participants in the present study after having been introduced to it by the investigator. Sharon was a full-time student doing postgraduate work and Roger was employed as a lawyer. The couple had been married for eight years and were expecting their first child. They began training during Sharon's seventh month of pregnancy and attended six preparatory sessions. The couple were just completing prenatal classes when they began hypnotic training.

Sharon had experienced hypnotic trance on several previous occasions and had seen the instructor once early in her pregnancy for the alleviation of nausea. She

considered herself a fairly good hypnotic subject but mentioned that she commonly had difficulty visualizing the images used by the facilitator and could never really find the abstract "safe place" so often alluded to in relaxation therapy. Much of the first session was spent in helping Sharon to feel safe through the use of a concrete fantasy which appealed to other than her visual senses. She was pleased with the success of this induction stating that she really enjoyed feelings of safety and security. Roger was also positive in his evaluation. He admitted to having been skeptical, and said that he was impressed and intrigued by what he had witnessed. He also experienced an urge to relax himself during this first session. The instructor invited him to go with the urge in future meetings.

During the second session, Sharon admitted to being rather afraid of childbirth in spite of her belief that it was a natural process. She had been experiencing some discomfort in her lower back which seemed to exacerbate her apprehensions. The trainer attempted to reframe Sharon's anxiety as natural excitement and encouraged her to accept the discomfort as a sign that the baby was growing and would soon be born. Related suggestions were made while she was both in and out of trance. Sharon reacted positively to these suggestions. She displayed a progressively more optimistic attitude during training that she and Roger were aware of and pleased with.

Although Sharon continued to experience some back discomfort, she indicated that knowing what it represented made it more tolerable. The instructor continued to work on improvement of the discomfort during sessions and urged Sharon to do the same at home through relaxing. She gradually learned to localize the sensation and keep it from spreading. In addition, she found that when she went into a deep trance, the discomfort would disappear altogether.

Sharon reacted well to many of the other post-hypnotic suggestions made during training. However, she often experienced a temporary rise from trance and a twitching of her hands and forehead when the trainer initiated discussion of contractions, pushing etc.. Once, when the potential experience of an episiotomy was mentioned, Sharon's entire body shook suddenly. She did not recall this reaction when she was brought out of trance but admitted that she was afraid of the procedure and questioned its necessity.

When Sharon attained a deep trance state, she commonly had an accompanying sensation of spinning. She was frightened by this feeling the first time it occured but began to enjoy it on subsequent occasions. The trainer employed this spinning in deepening the trance during one session and had very good results. Sharon said she had never been in a deeper trance and commented "Wow, I went to China." After having been in a deep trance

state such as this one, Sharon explained that she initially experienced disorientation and then a tremendous burst of energy. In her words; "I suddenly feel I can take on the world."

Roger and Sharon were quite concientious and imaginative in rehearsing the hypnotic techniques. Although their first attempt was admittedly clumsy and comical, they stated that it was much more effective than they had expected. With practice, Roger seemed to grow increasingly more comfortable as the facilitator of Sharon's relaxation. On one occasion he even put himself into trance while inducing her.

Roger was especially creative in how he deepened Sharon's trance state. He did such things as describing legal cases he was involved in, reading magazine advertisements, making up nonsense stories etc., with a favorite fantasy being in-depth descriptions of wine tasting. Sharon was not only pleased with the effectiveness of these strategies but also with a creative side of her husband she had not previously been aware of. At the trainer's recommendation, the couple also attempted to induce trance under less than ideal conditions. Again, they were imaginative in their efforts. They practiced, with the radio on, in bright light, in the car during a long trip etc..

Sharon and Roger did have some less successful practice sessions. On one occasion, Roger had Sharon

going for a swim - an activity she enjoys. She, however, began to tense up and experienced a twitching in her legs. Sharon explained "I just wanted out of there." The couple were rather concerned with this occurrence. The instructor downplayed its significance and suggested that Sharon's "twitchy" legs were perhaps a sign of some emotional "twitchyness" at the time. It was pointed out how elegantly the body can reflect a person's feelings.

Sharon reacted similarly on another occasion later in training when Roger made some specific suggestions for labor and delivery. Again, they were disappointed in light of the success they had been having. Sharon was reminded that she often experienced a rise from trance and some tension even when the trainer made suggestions regarding labor and delivery. Perhaps the relatively stronger sensations she felt with Roger were a result of his inexperience with such suggestions and his failure to make smooth transitions from deepening fantasies to discussion of labor and delivery. The couple was reassured, praised for their progress and encouraged to continue practicing. The instructor also suggested that they establish a signal ie. a raised index finger, that Sharon could use during trance to indicate that she was uncomfortable or anxious. That way, Roger would know to switch the emphasis of his verbalizations to something that might be less intimidating.

Sharon was fairly successful in employing the cue for autohypnosis but in her opinion was never able to achieve as deep a state of relaxation as when Roger or the trainer induced trance. Although she seemed pleased with her ability to relax, she questioned whether she ever put herself into trance. Sharon found the autohypnosis especially helpful during the last part of her pregnancy when she would awaken in the night. She said that she did not have difficultly falling back asleep after she began to use the self-hypnosis cue. Roger also commented on the effectiveness of hypnosis in helping Sharon to sleep. This discovery seemed to give the couple more faith in the usefulness of the hypnotic procedures. As Roger stated "This stuff really works. Sharon hasn't slept so well in a long time."

The sixth session was spent in conversation between Sharon and the instructor as Roger was delayed in court. This unexpected occurance provided an opportunity for Sharon to share some of her feelings about training and the use of hypnotic techniques as well as her expectations regarding childbirth. Her change in attitude from the initial sessions was quite dramatic. She displayed an optimism regarding labor and delivery together with realistic expectations of the event. She did not seem to anticipate an easy or simple experience but believed that her preparation could make childbirth both more managable and meaningful for her and Roger.

Sharon also commented on how much she and Roger had gotten out of using the hypnosis together. She felt it had brought them closer to one another. Not only did it provide an enjoyable activity they could share as a couple but also, at times, an intimate and meaningful encounter. She said she could hardly wait until the baby was born so that she could induce trance with Roger. The trainer encouraged her to assume the role of facilitator even before that time, if she wished.

The conversation continued once Roger arrived and included discussion of the potential occurance of caesarean section, back labor and epidural anaesthesia.

Sharon gave birth two weeks early and therefore the couple were not able to attend the final training session planned.

Sharon's membranes ruptured before she actually went into labor. The couple were advised to come to the hospital to protect against infecting the baby. They arrived at the hospital at 1:00 p.m.. Sharon was still not experiencing contractions however. She and Roger spent most of the afternoon walking about the halls. Roger induced trance twice with fairly good results although their efforts were interrupted by medical personnel entering and leaving the room to check on Sharon's condition.

During the afternoon, Sharon asked an attending nurse how she would recognize a contraction. The nurse assured

her that she would know because it would be very painful. Sharon told the interviewer "That really scared the hell out of me. I went in convinced that it wouldn't be anything but fairly uncomfortable and every time I turned around, someone was talking about pain."

At 5:00 p.m., Sharon's obstetrician decided to induce her labor with a synthetic oxytocin administered intravenously. Two hours later, her contractions were 2 to 3 minutes apart but she was still having no sensation of them. By 9:00 p.m., she began to experience a tightening in her stomach and back. The couple decided to do another induction to help her relax. This time, however, they informed the nurses of their intentions and asked for their cooperation.

Roger put Sharon into a trance using the shoulder cue and then went through 45 minutes of various fantasies including soaking in a hot tub and a wine tasting. Sharon said the induction was very effective and that she was able to go into a deep trance.

She continued to experience very managable contractions at 2 minute intervals until about 11:00 p.m. at which point she had "three real hard contractions." Her obstetrician was, however, concerned with her slow progress and therefore increased the dosage of intravenous oxytocin. This had a sudden and dramatic effect on Sharon's contractions. She explained, "I went from

nothing, to three tough contractions, to hard labor, all in twenty minutes."

By 11:30 p.m. Sharon was having a lot of difficulty managing the intensity of her labor. Roger suggested using the hypnosis to help her relax but she refused. Instead the couple attempted breathing techniques they had learned in prenatal classes. Unfortunately, they had a great deal of difficulty with this. Sharon said the rhythmic breathing actually made her breath more quickly and lose control in the process. After 25 minutes, the couple "gave up." By this time Sharon was angry and frustrated. She said "I was fighting every contraction. I lost all focus and control." At this point, she was given an injection of morphine to help her relax although Sharon felt that it had no effect.

After another half hour of struggling, Roger asked a nurse for help. She was able to show the couple how to slow down Sharon's breathing. According to Roger and Sharon, the nurse used an approach very similar to the Three Deep Breaths taught in hypnotic training. For this reason, they caught on quickly. Sharon felt that slowing down her breathing really made a difference. "Gradually I began working with the contractions again instead of fighting them."

Once Roger saw the improvement in Sharon's composure he began using various aspects of the hypnosis. He explained, "First I started pacing my voice to Sharon's

breathing. Then, in between each contraction, I tried to get her as much into trance as I could by using the cue." Sharon found this very helpful stating "I went into trance between every contraction. That made the last hour of labor quite managable." She admitted to feeling a lot of pain when she was fighting the contractions but said that once she regained control, the sensation was that of intense tightening and managable discomfort.

By 1:45 a.m., Sharon's cervix was dilated enough for her to begin pushing. She did not however experience an internal urge to do so. The couple was transferred to the delivery room. Sharon pushed during each contraction and Roger attempted to induce trance in the intervals between using his voice and the shoulder cue. After an hour, Sharon said she was fatiqued and very discouraged as she could tell her pushing was not working. Her doctor returned and decided to use forceps for delivery since the baby's head was not descending into the birth canal. Sharon said she did not resist at all because of her trust for the obstetrician.

At 3:20 a.m., Sharon gave birth to a 7 lb. 15 oz. boy. The infant sustained some facial bruises from the forceps but was otherwise in good condition.

Unfortunately, only general suggestions were made for the postpartum period because the couple missed the final preparatory session. Sharon however indicated that in her opinion, the post-hypnotic suggestion which described

postpartum emotionality as joy and excitement was, and continued to be more useful than any other. She said "I felt like I must have been having what they call postpartum depression, but I didn't feel depressed. I felt excited, happy, a little scared, lots of things...but not depressed. Your suggestion really stuck."

Both Sharon and Roger felt their childbirth experience had been a good one. They, however, believed that the induction of Sharon's labor had made their management of childbirth more challenging. Sharon did not experience a gradual build-up in the intensity of contractions, but rather went into hard labor suddenly when the dosage of oxytocin was increased. This made it difficult for her to maintain control.

The couple were very grateful for their hypnotic training, especially considering the problems they had with breathing techniques taught in prenatal classes. Roger referred to their use of hypnosis during childbirth as the "saving grace." And Sharon said "It made the difference between me saying I really want to do this again and I will never have another child in my life." She added that she would handle childbirth better next time because she knew what to expect and had faith in the hypnosis.

Roger said that he enjoyed being actively involved in the hypnotic process. During training he was pleased that he could make things easier for both Sharon and himself.

And he said that during childbirth "I played a very integral part - relaxing Sharon between each contraction, and I got my own rub doing it - I relaxed too." Roger also shared his belief that things would have been much different if he had not been involved in this way.

The couple were a little disappointed that they had not immediately applied their hypnotic skills at the stage in labor when Sharon lost control. Yet, they were pleased that together they were able to get things "back on track."

In evaluating the features of their training that were most important and had the greatest influence, Roger and Sharon first emphasized the positive aspects of using hypnosis before their child was born. The trainer's reframing suggestions were Helpful in improving Sharon's attitude towards pregnancy and childbirth. The couple's practice apparently brought them closer together and provided an important shared activity. In addition, Roger felt that his inductions were helpful in relieving Sharon's tension and anxiety during the last month of pregnancy. The autohypnosis cue was also useful prenatally in helping her to relax and to fall back asleep after awakening in the night.

During childbirth, the couple believed that the relative ease Sharon experienced when she first went into labor was the result of post-hypnotic suggestions made during training which described the sensation of

contractions as tightening or pressure. They also considered their successful induction of trance at this stage to have been instrumental in Sharon's composure. When the contractions became more difficult, the suggestion that each was functional and would bring them closer to the moment their child would be born was particularly effective. Sharon said she found herself naturally repeating this suggestion during contractions and noticed that Roger also emphasized this association in his verbalizations. They were both very pleased and perhaps a little surprised by how well they were able to apply the hypnosis late in labor to relax Sharon between contractions.

Sharon repeated her belief that the most powerful suggestion of all was the one that positively reframed postpartum depression. She felt it made a great difference in her post-labor adjustment. Although, Sharon did not consciously use the autohypnosis cue during childbirth, she told the interviewer that she had employed it many times since in order to rest during the day and fall back asleep after nightime feedings. She stated "I just take the three deep breaths, start counting backwards, and I'm gone."

The couple made a decision to continue using the hypnosis together. As Sharon said "It's something we don't want to lose. We've decided to induce each other once or twice every weekend."

Both Sharon and Roger said they were looking forward to having another child and using hypnosis as a method of preparation. They however recognized the importance of practice and suggested that they would be better rehearsed for the next birth.

The couple's recommendations for the improvement of training and the use of hypnotic techniques were as follows;

1. Training sessions should begin earlier in the woman's pregnancy in order that she and her husband have ample opportunity for practice of hypnotic techniques and enjoyment of their positive sideffects. Sharon indicated how valuable the ability to relax would have been during the initial months of pregnancy.

2. The couple should be encouraged to practice the deepening fantasies used in training in addition to their own original variations, because of their ability to deepen the trance quickly and consistantly.

3. If possible, the couple should be prepared for the potential occurance of panic and loss of control on the part of the woman. Perhaps it could be suggested that they apply a particular cue or follow a sequence of events that would help the woman regain composure and focus.

The investigator made a number of other discoveries regarding obstetrical hypnosis in the training of and discussion with Sharon and Roger.

1. The importance of using smooth transitional bridges between different parts of an hypnotic induction was discovered. This is especially true when the facilitator finishes a deepening fantasy and begins discussion of labor and delivery. Although the trainer made this change as subtlely as possible using metaphor and significant phrases in the transition, husbands were not as inclined to do this. The results were generally negative for their wives and included anxiety, a rise from trance and in Sharon's case, some physical discomfort. If husbands are to successfully take over, and assume all facets of the induction from the trainer, they should be encouraged to make these transitions.

2. Setting aside one session late in training solely for discussion, as an opportunity for the sharing of problems, concerns, ideas, and recommendations was felt to be potentially useful.

3. The husband's ability to take the skills aquired in training and to creatively elaborate, expand and personalize their application was recognized. In Sharon and Roger's case, the interviewer was particularly intrigued by Roger's spontaneous use of his voice timed to Sharon's breathing as a means of initiating relaxation late in labor. This represented a more subtle, almost Ericksonian, approach to trance induction which was elegantly applied by a relative novice.

A Description of Hypnotic Birthing

In this section, a general description of hypnotic birthing is extended based upon the common experiences of the three research couples. Presentation is made within the framework of the research questions, although much overlap occurs from one question to the next. In addition, new discoveries beyond the expectations of the investigator and the boundaries of the research questions will be reviewed.

It is important to remember that the following description is based upon the reflections and subjective feelings of the participants. It is certainly impossible to determine what specific reactions and results the training in and use of hypnosis were responsible for. This is not however considered important. Rather, it is the subjective impressions and attributions of the men and women who used the hypnotic techniques that are being addressed in the present study.

1. Is the woman influenced before, during and after delivery by training in and use of hypnotic techniques - specifically, relaxation, post-hypnotic suggestion, autohypnosis, and trance induced by husband?

There is no question that instruction in, and use of hypnotic procedures had its influence over not only labor and delivery but also the prenatal and postnatal periods. The specific effects within these stages will be discussed in more detail below. It is, however, important to point

out here that while the women were all similarly influenced in a general sense, they displayed a real individuality in their response to the various hypnotic techniques. They reacted quite uniquely to the procedures employed, and not all procedures were equally effective for all participants. In addition, once the woman had discovered which specific techniques, cues, fantasies and suggestions she preferred, she and her husband tended to personalize them even further and make them their own.

Generally, the ability to relax was considered to be invaluable before, during and after delivery, regardless of the woman's individual approach. The post-hypnotic suggestions made in training also tended to be quite effective at different stages of pregnancy; labor and postpartum. Pariticularly useful were those which 1. aimed to improve comfort and attitude during the remainder of pregnancy, 2. reframed birthing as a normal physiological function, 3. reframed contractions as useful and desirable occurances, 4. reframed pain as managable discomfort, 5. stressed control and composure during childbirth, and 6. reframed postpartum emotionality as joy and excitement.

Autohypnosis was most useful to the women in facilitating relaxation. None however believed that they experienced as deep or complete a trance state when they induced relaxation themselves. Trance induced by the husband was another successful facet of the hypnotic

program. It was particularly useful in the promotion of relaxation antenatally and in the management of childbirth.

2. Does the woman enjoy prenatal benefits when she practices hypnosis during pregnancy?

Hypnotic training was clearly advantageous to the woman before childbirth. Many of the benefits experienced were the result of an ability to relax at will, either through the use of autohypnosis or with spouse facilitating relaxation. These benefits included relief of physical and mental tension and the ability to attain sleep late in pregnancy. There were also two psychological advantages common to all participants. First, a feeling of being actively involved in preparation for a safe and meaningful childbirth experience and second, an increasingly positive attitude towards pregnancy and birthing over the course of training.

3. Does the use of hypnosis produce mental and physical relaxation during labor and delivery?

Participants consistantly credited post-hypnotic suggestions made by the trainer during instruction for the relaxation and general comfort they enjoyed early in labor. They considered suggestions which talked about childbirth as a natural function, reframed pain as managable discomfort and described uterine contractions as useful and desirable to have been the most effective in this respect. However, once labor became more intense, a

more active approach to relaxation was required. Again, couples were unique in their application of hypnotic techniques during labor and generally employed personal variations which were most successful in practice sessions. Although not all women felt they actually went into trance, each found that the use of the hypnotic procedures during childbirth helped her to relax.

4. Do women trained in hypnosis enjoy feelings of composure and control during labor?

Again, there was a similarity in the descriptions of the hypnotically prepared women. All communicated feelings of control and composure for the majority of their labor. However, when contractions became frequent and more intense late in labor, they generally experienced anxiety, fatigue and concomitant feelings of decreased control. It was at this point that they considered the hypnotic training to be particularly important because they were able to transfer control to their husbands. The men then assumed responsibility for the facilitation of composure with their wives.

5. Does the use of hypnosis influence the woman's subjective experience of and reaction to the discomfort of birthing?

In the present investigation, the use of hypnosis by no means abolished the discomfort of childbirth. All of the women experienced discomfort, especially late in labor. The hypnotic training and use of hypnotic

techniques during labor were however felt to be instrumental in the woman's ability to cope with this discomfort. Post-hypnotic suggestions which reframed pain as managable discomfort and contractions as useful and desirable were most important. The participants generally avoided the word "pain" in training, accepting that uterine contractions would be quite managable. This orientation was reflected in their descriptions of labor and delivery where they spoke of intense but managable tightening when describing the sensation of contractions. Women also found that through relaxation, they were able to work with the contractions instead of fighting them and thereby lessened the feelings of discomfort somewhat.

6. Do women who use hypnosis feel thay have played and active part in the birth of their children?

As mentioned previously, the women felt they were actively working to improve the quality of childbirth by participating in prenatal hypnotic training. After delivery, they communicated pride and relief that they had consciously decided to be involved in this respect. All believed that their labor would not have gone as well had they not undertaken to prepare themselves and act as active participants. It was also important to them that their husbands were involved and had a role to play.

7. Is childbirth an emotionally satisfying and rewarding experience for the women who use hypnosis?

Regardless of their specific childbirth experiences, all women expressed a very positive attitude when discussing the birth of their children. They described it as a joyful experience they never wanted to forget and shared personal feelings of pride with their own performance. Each suggested a belief that preparation for the event made it a more rewarding experience. In addition, all were anxious to give birth again and employ the hypnosis in preparation.

8. Do hypnotically prepared women experience a rapid recovery from childbirth?

Although all women felt they had "bounced back" after delivery, none directly credited the post-hypnotic suggestions made for recovery as responsible. Hypnotic training was however considered influencial in the labelling of postpartum emotionality. The suggestion which reframed depression as joy and excitement was felt to be especially beneficial in post-labor adjustment.

9. Are hypnotic techniques of value to the woman after childbirth?

This was another topic about which research participants shared remarkable agreement. Without provocation from the interviewer, all expressed pleasure and some suprise with the usefulness of autohypnosis after childbirth. The self-hypnosis cue was employed by the women for two key reasons. First, to attain fast relief from tension during the day in coping with lifestyle

changes and, second, to fall back asleep after nighttime feedings. The women indicated that they wanted to continue using the hypnosis with their husbands. They also shared a belief that they could be better mothers if they were relaxed mothers.

10. Can the father (husband) play a role in the use of hypnosis before, during and after delivery?

The fathers most definitely played an important if not crucial role in the use of hypnosis. They acted as active participants during training, learning how to use hypnosis to achieve relaxation along with their wives. This active involvement seemed to foster a team approach to childbirth both in preparation and the actual event. The men assumed the role of trance facilitator after the cue was transferred to them. By the end of training, they were more effective than the trainer in this respect because of the personal approach they took to induction and the relationship they shared with their wives. Through practice of hypnotic techniques at home, the husbands not only improved their skills and prepared for childbirth, but also benefitted their wives at the same time by producing relaxation.

During labor and delivery, the men were grateful that the hypnosis allowed them to continue playing an active part beyond just being present. They felt their use of hypnotic procedures was integral in childbirth and believed things would not have gone as well if they had

not been so involved. They also felt that they had shared in the act of giving birth.

11. Is it beneficial logistically to involve the father (husband) in training and make him responsible for particular facets of the process?

The most obvious logistical advantage of including the father in the use of hypnosis was that it reduced the role of the trainer as the facilitator of trance. Certainly it was more practical for the husband to be the person responsible for helping his wife to relax as he could apply this skill any time during the day or night. This relationship became even more important in childbirth where the husband was present and ready to play and active part and the trainer did not belong.

12. Does the father's (husband's) involvement contribute to a rewarding and satisfying pregnancy and childbirth experience for the couple?

Many of the psychological benefits of the father's involvement have already been alluded to. Again, both male and female participants enjoyed the opportunity to act as a team, working towards a positive childbirth experience. Rehearsal of techniques during pregnancy provided them with a shared activity that was not only beneficial but also fun. In addition, the husband's relaxation of his wife and use of personal fantasies reportedly brought the couples closer together in an intimate and meaningful interaction.

In discussing labor and delivery, the women all emphasized the importance of their husbands presence and active participation in the birth of their child. Both the men and women shared positive feelings regarding their birthing experience and said they would not have done it any other way.

13. In the parent's opinion, is the infant influenced by the use of hypnosis, before, during and after delivery?

Discussion with participants during training exposed their belief that they were doing something positive for their baby before its birth by preparing for childbirth. There was also some suggestion that the relaxation enjoyed by the woman as a result of using hypnosis was benefiting the infant in utero. Participants did not share any common opinions regarding the influence of hypnosis on the child during or immediately after delivery. However, because mothers were able relax around their new babies in the days and weeks subsequent to childbirth by using hypnosis, the parents felt their newborns were also relaxed. They believed that their personal stress or lack of it directly influenced their child.

There are a number of other findings common to all participants that do not fit within the framework of the research questions. They are however important to an understanding of the experience of hypnotic birthing and will therefore be itemized below.

1. While hypnotized, the women consistantly experienced a sensation of "coming up" or a rise from trance when the trainer or their husbands began discussion of labor and delivery. They also tended to display physical signs of "twitchiness" when specific mention was made of contractions, pushing, episiotomy, etc.. These occurances were accepted as indications of the women's active perception while in trance and became useful diagnostically in determining areas of concern for them.

2. All women expressed some skepticism regarding the achievement of a trance when using the cue for autohypnosis. They generally felt that they could not reach as deep a state of relaxation on their own as when the trainer or their spouses acted as facilitator. It seemed to be important for the women to discriminate between relaxation and trance in this respect.

3. Participants expressed some frustration over the distractions in the hospital environment and the disruption of their attempts at relaxation by medical personnel. They agreed that the doctors and nurses had to be made aware, if not included in the couple's efforts if the hypnotic procedures were to be effective.

4. The women's descriptions of their reactions during labor indicated that their susceptibility to suggestion was elevated while they were in this condition. This seemed to be the case whether the women were in or out of trance.

5. The use of slow rhythmic breathing as initiated by the Three Deep Breaths was particularly useful for the women in producing calm and helping them to regain composure after a difficult contraction.

6. All women accepted analgesic drugs during labor at the recommendation of their doctors. However, this did not seem to be an issue for the participants. None had feelings of failure as a result. They felt only some disappointment that the medication decreased their awareness of what was occuring.

7. Before and after childbirth, all women expressed a wish to act as the facilitator of relaxation with their husbands. In addition, the men said they looked forward to being on the receiving end of an induction. These desires were thought to reflect the couples' enjoyment of hypnosis beyond just a method of childbirth preparation.

8. Participants felt some retrospective disappointment that they had not practiced their hypnotic skills more prior to labor and delivery. All believed they could have been better prepared.

Chapter VII

Discussion

Introduction

In this chapter the results of the present investigation are reviewed and discussed as they relate to previous studies and literature on the topic of obstetrical hypnosis. Recommendations are made for the continued usage of this modality based upon research findings. In addition, the author makes suggestions for future research in the area and considers the limitations of the current study.

Relationship to Previous Research

Traditionally, obstetrical hypnosis has represented a procedure employed almost exclusively by obstetricians. For this reason, the approach and objectives of its use are medically oriented. Concentration is placed upon the alleviation of pain, the production of anaesthesia, the minimization of drug usage and a reduction in labor length. Reports of obstetrical hypnosis are generally written by medical doctors, incorporate medical terminology and appear in professional journals. The theories which have been advanced in the area of obstetrical hypnosis also reflect this orientation. In reviewing them, one is given the impression of a process of obstetricians, by obstetricians and for obstetricians. Hypnosis has seldom been prescribed or promoted as a mechanism to be used by the layman in childbirth.

Although the average person has access to information regarding hypnosis and its use in labor and delivery, he or she would be unlikely to apply it to prenatal preparation for a number of reasons. Included among these are myths and stereotypes surrounding its use, the belief that hypnosis is a complicated procedure for which one must undergo extensive training and, the lack of specific instructions for application. As a result, obstetrical hypnosis is not generally the method of choice in preparation for childbirth unless the woman's obstetrician shows an interest in it and is willing to use it with her. If hypnosis is ever to become a successful and popular method of antenatal training in the same way that the Read and Lamaze methods have, it must undergo some changes. Most importantly, its usage must be extended to the women and men expecting children and its approach must reflect their needs.

The objective of the present investigation was to evaluate the personal experiences of individuals who used hypnotic techniques in childbirth, and in so doing, to approach a greater understanding and description of the experience in general. Towards this end, it was necessary to develop a program of instruction for training men and women to use relaxation techniques - a program which put control and responsibility for application in their hands. By training the participants and then requesting their subjective impressions of using hypnosis in birthing, it

was felt that new and important information could be accessed. The researcher hoped to identify the features of obstetrical hypnosis which were of particular value to the users. This was accomplished, in part, through an active interchange with participants during which they were invited to share concerns, ask questions and make recommendations. The training program was constantly amended in order to accomodate their needs.

It is important to discuss the findings of this study as they compare and contrast with previous research and professional literature pertaining to obstetrical hypnosis. Certainly validation or invalidation of the results of other studies is impossible given the different objectives of and methodology used in the present research. However, it is reasonable to consider how the findings of this investigation relate to those which have preceded it.

Perhaps the most interesting discovery made was that the features of obstetrical hypnosis, which have previously been identified as its greatest advantages, hold less relative importance for the actual participants. Above all, the literature emphasizes the ability of hypnosis to reduce the need for analgesic and anaesthetic agents. Other benefits stressed include production of hypnotic anaesthesia, decreased labor length and reduction in operative techniques. These constitute the major concerns and criteria for success in the investigations

and writings of Abramson and Heron (1950), August (1960), Davidson (1962), Gross and Posner (1963), Kroger and DeLee (1943), Michael (1952), Mosconi and Reda (1958-59), Roig (1961-62ab), Tom (1960), True (1954), Williamson (1975), and Winkelstein (1958) - indeed the great majority of researchers and theorists in the field. Again, this perspective reflects the medical orientation of these writers. Their interest in these areas is certainly not without foundation. Realization of such benefits in childbirth would be beneficial to both the woman and her doctor. However, based upon the findings of the present study, they do not appear to be of tantamount importance to the women giving birth or their spouses.

It is this author's belief that if the success or failure of obstetrical hypnosis continues to be evaluated in terms of its ability to produce the above effects, it is unlikely that it will ever become a viable method of prenatal preparation. Expectations of how obstetrical hypnosis is beneficial definitely influence the characterisics of its use. The advantages which have been emphasized in the literature and the resulting approach simply do not coincide with those aspects valued by participants or their requirements in application, as identified in this study.

A number of common benefits of using hypnosis in birthing were exposed in discussion with research participants. Many of these are emotional or

interactional in nature. Such qualities seem to be undervalued or downplayed in the literature perhaps because the women involved were not generally asked to evaluate their experience. Gross and Posner (1963) suggested that although emotional or psychological benefits can not be numerically assessed in a statistical sense, they are not without significance.

The most important features of using hypnotic techniques in birthing, according to the people who employed them in the present study, are as follows;

1. Use of hypnosis prenatally allowed the expectant parents to be involved in preparation for childbirth. Couples believed that they were making a conscious and active effort to improve the quality of their birthing experience through their training in and practice of hypnotic procedures.

2. The husband was included in all facets of training and was given specific responsibilities in the use of hypnosis. This made it possible for the husband and wife to work as a team both in preparation for childbirth and during labor and delivery. The importance of spousal involvement concurs with Samuelly's (1972) discovery that women have a strong emotional need to share the birth experience with their husbands. When this opportunity is not available, the experience is less satisfactory. Davenport-Slack (1975) also suggested that women find childbirth more rewarding when they are allowed to have

their husband present. This is a characteristic which has long been recognized by proponents of Lamaze (Hilgard & Hilgard, 1975; Lamaze, 1958). Not surprisingly, it is also important in the use of hypnosis.

3. Rehearsal of hypnotic techniques provided a shared activity for the couple that was not only enjoyable and useful, but also fostered feelings of closeness and intimacy. According to Samuelly (1972), this closeness has traditionally been an advantage that the Lamaze method, which has always included the husband in training, has had over obstetrical hypnosis.

4. Training in and use of hypnosis was useful to the woman prenatally in the relief of tension and anxiety, and in the attainment of sleep. Through positive post-hypnotic suggestions, women also enjoyed improvement in their general attitude toward pregnancy and childbirth. The value of hypnosis in relieving the symptoms of pregnancy was described previously by Ambrose and Newbold (1980), Hartland (1971) and Roig (1961-62b). However, it was not introduced as something that the couple could do themselves.

5. Utilization of hypnotic tecniques also allowed for active participation during childbirth - a factor which had considerable emotional significance for both the husband and wife. This characteristic was emphasized by Davenport-Slack (1975) as a positive side effect of prenatal preparation. She suggested that the ability to

participate in the birth of one's own child is more responsible for a positive experience than the specific techniques taught in preparation. She wrote "It seems likely that any factor which facilitates participation in childbirth will also function to foster positive and rewarding childbirth experiences" (p. 275).

6. Women enjoyed feelings of composure and control over contractions for the majority of their labor. Similar benefits were proposed by Pascatto and Mead (1967) and Williamson (1975) who stated that women who use hypnotic procedures are generally composed, calm and relaxed during labor.

7. Although women did experience discomfort during labor, they found that the use of hypnosis helped them to cope with it. Post-hypnotic suggestions made during training successfully reframed labor pain as manageable discomfort. This achievement alone made participants more optimistic and relaxed about childbirth. Suggestions were also effective during labor and delivery in helping the woman to think of contractions and their accompanying discomfort as functional occurances. In addition, women found that the use of hypnotic techniques during labor actually lessened the discomfort experienced.

The belief that the discomfort of birthing involves psychological causation has been extended by many theorists in the area (Hartland, 1971; Hilgard & Hilgard, 1975; Kroger, 1977; Michael, 1952; Read, 1953; Roig,

1961-62a,b). The results of the present investigation would tend to support this idea since the use of hypnosis decreased negative anticipation of pain and also reduced subjective feelings of discomfort in labor. The author, however, supports the positions of Bing (1969) and Hartland (1971) who proposed that there is both a physiological and psychological component to the discomfort of childbirth. Participants communicated a perception of natural, unavoidable discomfort associated with contractions which was worsened by their physical and mental tension.

Recognition of actual physical discomfort does not necessarily mean that women will experience untractable, intolerable pain. Relaxation clearly provided a vehicle for managing the discomfort of childbirth. However, suggestions in the literature that all unpleasant sensations associated with childbirth can be allievated through the use of hypnosis do seem rather optimistic - at least given the approach utilized in the present investigation. As Davenport-Slack (1975) suggested, concentration on relaxation may actually function to direct focus away from discomfort rather to reduce it.

8. The women involved did not experience postpartum depression. Although they felt an elevated emotionality in the first few days following childbirth, they labelled it as joy and excitement rather than depression. This benefit was considered to be the result of a specific

suggestion made during training which positively reframed the common feelings of depression in new mothers. Buxton (cited in Werner et al., 1982) also suggested a reduced occurance of postpartum depression among women who use hypnosis in childbirth. He, however, attributed it to a decrease in the use of anaesthetic drugs.

9. Training in relaxation continued to be of value in the postpartum period. Autohypnosis was used by new mothers in the days and weeks following delivery. They employed it primarily to help them relax during the day and to fall asleep at night. Couples felt that the relaxation enjoyed by the women had concomitant benefits for the newborn infant lending support to Werner et al.'s (1982) suggestion of the same nature.

Recommendations for Continued Usage

When the parents are actively involved in using hypnotic techniques for birthing, the resulting description of the experience is quite different from that which is documented in the literature. Most notably, the participants emphasized different features of its usage as being important. In addition, they exposed advantages of this method which have not previously been reported. If hypnosis is to be employed successfully as a method of antenatal preparation, the aspects which are valued by participants must be recognized and should guide its usage.

Based upon the findings of the present study, the author makes the following recommendations for using hypnosis as a method of prenatal preparation.

1. Obstetrical hypnosis should represent a method that the woman and her spouse or chosen labor coach can learn, practice and utilize together as a team.

2. Instruction must involve a manageable training program that is within the abilities of the common person. It should be adapted to the individual needs and requirements of the participants and its application should be simple and straightforward.

3. Consideration should be given to the value of hypnotic techniques before, during and after childbirth. The training program should incorporate features which are aimed towards improvement of these different stages in the birthing process.

4. The objectives of the participants in using hypnosis in birthing must be respected.

5. Obstetrical hypnosis should be considered as a means of producing relaxation which will ideally provide a more manageable, comfortable and meaningful childbirth experience.

6. The approach to hypnosis must fit within mainstream obstetrics to be effective. It should be seen as an aid or adjunct to traditional labor and delivery practices rather than an alternative or threat. It's

usage should not be intended as a panacea for obstetrical delivery.

Future Research

Very little research has been undertaken which contributes to an understanding of the experience of using hypnosis in birthing. Additional studies are indicated in confirming the findings of this investigation and in exploring their reliability when variations exist in the characteristics of participants and the specifics of the approach.

All participants in the present study were expecting their first child. It would be interesting to see if couples who have already had a previous childbirth experience react in a similar fashion to the use of hypnotic techniques.

There was great agreement among participants that training should have begun earlier in the woman's pregnancy. Research could be conducted to determine whether this change would make the couple feel more comfortable and proficient with the procedures and better prepared for childbirth. One might also discover additional prenatal advantages with early onset of training.

The general techniques of relaxation, post-hypnotic suggestion, autohypnosis and husband en rapport were chosen to make up the present training program because of their relative simplicity and ease of application. It

would however be beneficial to train participants in some of the other hypnotic procedures such as glove anaesthesia, time distortion, dissociation, displacement etc., in order to determine their effectiveness and practicality.

A study which trains participants in groups rather than individually would also be advantageous. A similar training program as utilized in this study could be applied to several couples at once. In addition, a combination of individual and group instruction could be investigated. Research is definitely required in the area of program development relative to using hypnosis as a method of prenatal preparation.

Limitations

There are a number of limitations inherent in the present investigation which must be taken into consideration when applying the results. Because the methodology was qualitative in nature, it is impossible to draw any causal relationships between the use of hypnosis and the effects and benefits mentioned by the participants.

The three couples which served as research participants volunteered to take part in the study. No attempt was made to choose people who were representative of all couples expecting children. For this reason, the results cannot be generalized across this population. In addition, the description of the experience of hypnotic

birthing was based upon commonalities and patterns present in the experiences of only the three couples and therefore applies to these people alone.

Finally, although the investigator made no attempts to lead participants to verify research expectations, it is possible that they responded in a way which they felt would please the researcher or cast them in a more positive light.

Conclusion

The experience of hypnotic birthing as generalized from the descriptions and reactions of the three research couples would suggest that hypnotic techniques are of value in antenatal preparation. The methodology employed allowed the researcher to determine which features of the experience were considered most important to the participants.

The resulting structure was very different from that which is documented in the existing literature on obstetrical hypnosis. This was very likely because the present investigation approached understanding from a different perspective - that of the expectant parents.

The information and insights they shared are not only important to an understanding of the hypnotic birthing experience but also provided some basic guidelines for its development as a viable method of prenatal preparation. In addition, the successes enjoyed by participants contribute to a restoration of faith in the utility of

hypnosis and encourage a rebirth of its usage in obstetrics.

References

Alman, B., & Lambrou, P.T. (1983). Self-hypnosis - A complete manual for health and self-change. San Diego: International Health Publications.

Abramson, M., & Heron, W.T. (1950). An objective evaluation of hypnosis in obstetrics. American Journal of Obstetrics and Gynecology, 59, 1069-1074.

Ambrose, G., & Newbold, G. (1980). A handbook of medical hypnosis. London: Cassell Ltd..

August, R.V. (1960). Obstetrical hypnoanaesthesia. American Journal of Obstetrics and Gynecology, 79, 1131-1138.

August, R.V. (1960-61). Hallucinatory experiences utilized for obstetrical hypnoanaesthesia. American Journal of Clinical Hypnosis, 3, 90-94.

Bing, E. (1969). Six practical lessons for an easier childbirth - The Lamaze method. New York: Bantam.

Bogdan, R., & Bilken, S. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon.

Cheek, D.B. (1957). Effectiveness of incentive in clinical hypnosis - Report of three cases. Obstetrics and Gynecology, 9, 720-724.

Clark, R.N. (1956). A training method for birthing utilizing hypnosis. American Journal of Obstetrics and Gynecology, 72, 1302-1304.

Colaizzi, P.F. (1978). Psychological research as the phenomenologist views it. In R.S. Vallee & M. King (Eds.), Existential-Phenomenological alternatives for psychology. New York: Oxford University Press.

Coulton, D. (1959-60). Hypnosis in obstetrical delivery. American Journal of Clinical Hypnosis, 2, 144-148.

Coulton, D. (1966). Prenatal and Post-partum uses of hypnosis. American Journal of Clinical Hypnosis, 8, 192-197.

Crasilneck, H.B., & Hall, J.A. (1975). Clinical hypnosis: Principals and applications. New York: Grune and Stratton.

Danforth, D.N. (1971). Clinical prodromes and course of normal labor. In D.N. Danforth (Eds.), Textbook of Obstetrics and Gynecology. New York: Harper and Row.

Davenport-Slack, B. (1975). A comparative evaluation of obstetrical hypnosis and antenatal childbirth training. The International Journal of Clinical and Experimental Hypnosis, 23, 266-279.

Davenport-Slack, B., & Boylan, C.H. (1974). Psychological correlates of childbirth pain. Psychosomatic Medicine, 36, 215-222.

Davidson, J.A. (1962). An assessment of the value of hypnosis in pregnancy and labor. British Medical Journal, 2, 951-953.

DeLee, S.T. (1955). Hypnotism in pregnancy and delivery. Journal of the American Medical Association, 159, 750-754.

Fening, W. (1960-61). Brief clinical reports: What is the value of hypnosis in childbirth? Americal Journal of Clinical Hypnosis, 3, 203-205.

Good, C. (1966). The individual and case study: Diagnosis and therapy. In Essentials of educational research; Methodology and design. New York: Appleton-Century-Crofts.

Gross, H.N., & Posner, N.A. (1963). An evaluation of hypnosis for obstetrical delivery. Americal Journal of Obstetrics and Gynecology, 87, 912-920.

Hartland, J. (1971). Medical and dental hypnosis(2nd ed.). Baltimore: Williams and Williams.

Hilgard, E.R., & Hilgard, J.R. (1975). Hypnosis in relief of pain. Los Altos: William Kaufmann Inc.

Keddie, P.J. (1983). Hypnoanaesthesia in childbirth. Great Expectations, July, 23-26.

Kline, M.V., & Guze, H. (1955). Self-hypnosis in childbirth: A clinical evaluation of a patient conditioning program. Journal of Clinical and Experimental Hypnosis, 3, 142-147.

Kroger, W.S. (1977). Clinical and experimental hypnosis in medicine, dentistry and psychology (2nd ed.) Philadelphia: J.B. Lippincott.

Kroger, W.S., & DeLee, S.T. (1943). The use of the hypnoidal state as an amnesic, analgesic and anesthetic agent in obstetrics. American Journal of Obstetrics and Gynecology, 46, 655-661.

Kroger, W.S., & Freed, S.C. (1951). Psychosomatic gynecology. Philadelphia: W.B. Ssunders.

Lamaze, F. (1958). Painless childbirth. London: Burke.

Malyska, W., & Christensen, J. (1967). Autohypnosis and the prenatal class. The American Journal of Clinical Hypnosis, 9, 188-192.

Mandy, A., Mandy, T., & Farkas, R. (1952). Is natural childbirth natural? Psychosomatic Medicine, 14, 431-438.

Michael, A.M. (1952). Hypnosis in childbirth. British Medical Journal, 1, 734-737.

Mosconi, G., & Reda, P. (1958-59). Painless childbirth through hypnotism. The British Journal of Medical Hypnotism, 10, 35-39.

Moya, F., & James, S. (1960). Medical hypnosis for obstetrics. Journal of the American Medical Association, 174, 2026-2032.

Pascatto, R.D., & Mead, B.T. (1967). The use of posthypnotic suggestion in obstetrics. The American Journal of Obstetrics and Gynecology, 9, 267-268.

Pe[illegible]R.V., & Hunnisett, R. (1983). Qualitative research and counselling. Unpublished manuscript, University of Victoria, Victoria.

Polkinghorne, D.E. (1979, Summer). The practice of phenomenological research. Paper presented at a seminar on phenomenological research at the Saybrook Institute, San Francisco, CA.

Pritchard, J.A., & MacDonald, P.C. (1980). Analgesia and Anaesthesia. In J.A. Pritchard & P.C. MacDonald Williams Obstetric, New York: Appleton-Century-Crofts.

Read, G.D. (1953). Childbirth without fear. New York: Harper.

Roig-Garcia, S. (1961-62). A new procedure in obstetrical psychoanalgesia. American Journal of Clinical Hypnosis, 4, 1-13.

Roig-Garcia, S. (1961-62). Hypnosis in obstetrics. American Journal of Clinical Hypnosis, 4, 14-21.

Samuelly, I. (1972). Lamaze method of childbirth, conditioning or hypnosis. The American Journal of Clinical Hypnosis, 15, 136-139.

Schneck, J.M. (19523). Self-hypnosis and obstetrics: Case report and comment. British Journal of Medical Hypnotism, 2, 1-3.

Sontag, L.W., & Frank, L. (1954). Differences in modifiability of fetal behavior and physiology. Psychosomatic Medicine, 6, 151-154.

Spiegel, H. (1963). Current perspectives on hypnosis in obstetrics. New York State Medical Journal, 63, 2933-2941.

Stainbeck, S., & Stainbeck, W. (1984). Broadening the research perspective in special education. Exceptional Children, 50, 400-408.

Tom, K.S. (1960). Hypnosis in obstetrics and gynecology. Obstetrics and Gynecology, 16, 222-226.

True, R.M. (1954). Obstetrical Hynoanalgesia. American Journal of Obstetrics and Gynecology, 67, 373-376.

Werner, W.E.F. (1959). Hypnosis from the viewpoint of obstetrics and clinical demonstration of the training of patients for delivery under hypnosis. New York State Journal of Medicine, 1561-1566.

Werner, W.E.F. (1963-64). The use of the hypnoreflexogenous technique in obstetrical delivery. American Journal of Clinical Hypnosis, 6, 15-21.

Werner, W.E.F., Schauble, P.G., & Knudson, M.S. (1982) An arguement for the revival of hypnosis in obstetrics. American Journal of Clinical Hynosis, 24, 149-173.

Williamson, J.A. (1975). Hypnosis in obstetrics. Nursing Times, 71, 1895-1897.

Winkelstein, L.B. (1958). Routine hypnosis for obstetrical delivery. American Journal of Obstetrics and Gynecology, 76, 1523-159.

Wolberg, L.R. (1948). Medical Hypnosis. New York: Grune and Stratton.