

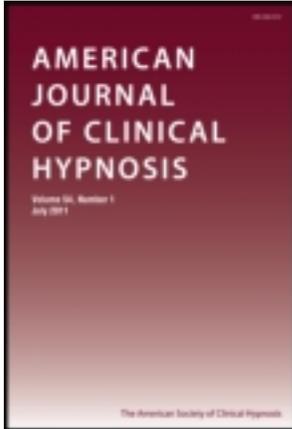
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## The Obstetrician and Hypnosis

R. V. August<sup>1</sup>

This is a report on the use of hypnosis by the author in his private practice. From November 1, 1957 to September 29, 1958, 361 patients were delivered. Hypnosis was used in 295, 80%, of the cases. It was successful when used alone in 94% of these cases, and it failed to provide total adequate anesthesia in 6% of the cases (18 of the 295). No attempt will be made here to review the literature. Only our philosophy and methodology will be presented.

Our obstetrical patient, when first seen, relates her complete medical history to my secretary. I review her history and do a pelvic examination to confirm the diagnosis of pregnancy. Following this, we first review and then advise on the care of any special noxious problems, such as hyperemesis. Then we give her a booklet on obstetrical care and a prescription for prenatal capsules. A complete physical examination, including pelvic mensuration, blood and urine analysis, is done at her second visit. At this time she is advised on the frequency of subsequent visits, which will occur at monthly intervals until the eighth month when she will be seen twice, and the ninth month when she will be seen weekly. At this time we also discuss the various analgesics and anesthetics. We permit our patient to make her own choice of sedation to be used. We promise to adhere to her decision, barring any possible medical contraindication.

We will now concern ourselves with the patient who selects hypnosis. Our next visit consists of one to two hours spent with her, seven other similar patients, and their husbands. At this time, we advise our patients that the primary purpose of good obstetrics is a normal healthy mother and a normal healthy baby, and that the second purpose of our care is a maximum of comfort for the mother and a minimum of sedation for the infant. Next we teach our audience the fundamental facts about hypnosis and then proceed to induce hypnosis in the women. Finally, we encourage discussion in a question and answer period. Subsequent routine obstetric checkups are combined with practice hypnosis in groups of six to eight. Husbands no longer attend, as they are invited only to the first class.

We utilize varying methods of trance induction, deepening techniques, and maintenance of hypnosis. We use the permissive, authoritarian and/or the cooperative approach as indicated.

Our patients were hypnotized for delivery in one of the following manners:

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1. Post hypnotic suggestions. The patient achieved a satisfactory trance state in my office. She retained suggestions of well-being when she was admitted weeks later to the hospital. These sufficed for a comfortable labor and delivery.
2. Emphasis on relaxation or sleep. She was taught to relax and simulate sleep on repeated occasions. She was requested to do likewise after labor began.
3. Rehearsal for delivery with an explanation leading to an understanding of contractions without discomfort. The physiology of labor and delivery were explained to her before and during the trance. While still in the trance, she was advised to welcome the physiological phenomena of labor and to look forward to each contraction because "each contraction brings your baby closer to you." She was told that the contractions would continue stronger and stronger and would appear closer and closer, but that they would seem to be lighter and lighter and that she would be resting longer and longer between contractions.
4. Production of limited area anesthesia in the "birth canal" region. Skin anesthesia was first obtained on the upraised arm with the patient in the trance. This was repeated at each visit. Each time the patient was told more positively that this same anesthesia would be induced in the "birth canal" region, and that the arm was used only for the sake of convenience of demonstration.
5. Production of a dissociated personality and a dichotomy between mind and pelvis. This patient cooperated both physically and verbally. She spoke almost continuously, advising herself (by name) to cooperate with me. I added infrequent suggestions in order not to interrupt her.
6. "On the spot" hypnosis with either simple limitation of the field of attention or separation of her body into tense and relaxed areas.

Over 10% of the women we delivered were other physicians' patients, whom we had never met before. We termed 6% of our hypnosis attempts failures because these patients required additional anesthetic agents, such as local or general medications. This includes all operative deliveries.

Obstetric sedation, when it involves hypnosis, must conform with the patient's desire and with her capacity for accepting suggestions. The grown-up "spoiled child" who accepted the hypnotic trance in my office time after time was a most dramatic failure when she went into labor and demanded deep ether anesthesia long before complete dilatation. She got it. The girl whose divorce was pending, the girl whose father died recently, the girl with the unwanted child were all poor subjects for hypnosis. We have been sufficiently fortunate to be spared patients of extremely subnormal mentality. We believe that hypnosis in the aforementioned patients is just as unwarranted as ether anesthesia or saddle block or any other single form of sedation would be for routine use in every patient. Fortunately, hypnosis is ineffective or at best most difficult where contraindicated. Unfortunately, this is not true of other anesthetic agents in obstetrical use.

The patients we have delivered with the aid of hypnosis fall into three categories:

1. Most of them have had an indoctrination class plus three to twelve practice classes in groups of four to thirteen. We have found six to eight in a group to be the most satisfactory number. We have experimented with commercially available records and with a tape recording of my voice obtained at a previously satisfactory session with another group. The record and tape have been discontinued as being unsatisfactory in our hands.

2. A few patients have had indoctrination with the group and subsequent private classes by their own request. The reasons have been hearing difficulty, psychologic problems, and choice by the patient.
3. A number of patients have been hypnotized into a satisfactory trance while in labor and even while on the delivery table without any previous preparation.

Most of our hypnosis patients require no medication. However, we feel free to use whatever additional therapy is indicated or desired by the patient. We have no compunctions about using demerol parenterally, barbiturates orally, or novocaine by hypo or as a block. We frequently suggest demerol or barbiturates to the patient in prolonged labor. We sincerely believe that determination of analgesia should be made by the patient and controlled by the obstetrician within the bounds of good obstetric care. We further believe that the patient should be permitted free choice whenever possible.

Obstetric hypnosis may be indicated or contraindicated, effective or ineffective, in different patients and in the same patient on different occasions. Some of the controlling factors we have encountered are as follows:

1. Parity. Primiparae are the best subjects. Some multiparae have the habit pattern of labor pains so deeply ingrained that only age regression together with prolonged psychotherapy will prevail.
2. Infant problems. Prematurity is a contraindication to inhalation anesthesia and systemic sedation. Hypnosis alone and/or local or block anesthesia are indicated. Malposition and increased size leading to dystocia are indications for oral and/or parenteral medication in support of hypnotherapy.
3. Maternal anatomic factors, if leading to dystocia, are an indication for supportive medication. These factors may prevent caudal or saddle block, thus being an additional indication for hypnotherapy.
4. Need for surgical interference, such as episiotomy, forceps applications, Dürhssen's incisions, or section usually add to the indications for hypnosis. We have found cesarean section under hypnosis to be a thrilling experience for the patient as well as for us.
5. Labor. Over all duration, when the patient arrives in the hospital, when she requests or requires assistance, whether she is ready to deliver at the doctor's convenience, while he is out on a call, or during office hours, are all controlling factors for the obstetrician in solo practice.
6. Maternal organic difficulties. A deaf-mute cannot be handled in the same way as the average patient.
7. Last meal. The time when it was ingested may be a contraindication to inhalation anesthesia.
8. Intelligence of the patient. This should be adequate, as it usually is, but the patient must not be too critical.
9. Socio-economic status. The time involved in training is not warranted in some patients for the doctor in private practice. Some patients of low socio-economic status, however, have presented us with the most gratifying results with "on the spot" hypnosis.
10. Extraneous psychologic factors. A neighbor's dubious warning, the husband's fear, the patient in the adjacent bed complaining, inadvertent remarks by a passing doctor or nurse have on occasion interfered sorely with hypnosis in women who were previously excellent hypnotic subjects.

11. Previous failure in another's hands has added to the difficulty in some trance inductions.

12. The doctor's reputation may precede him and lead the patient into a deep trance with little or no suggestion. One Sunday afternoon we were asked to see a patient six days postpartum who had been bleeding so steadily that five units of blood by transfusion had failed to raise her blood count to a satisfactory level. Her physician asked me to see and treat her, surgically if necessary, in his absence and without the opportunity of introducing me to her. I first met this lady in the operating room, asked her to count aloud backward from 100, and proceeded to do a thorough pelvic examination, severed the sutures of a wide episiotomy repair, removed a large thrombus, and ligated a number of bleeding points with deeply placed transfixed sutures. After 40 minutes of operating time, I noticed she was in deep hypnosis, tested her, and found this to be so. Subsequently, I asked her what she did and why. She stated that she had counted down to zero, began over with 100, and went into hypnosis. This was her first experience with the trance. She stated that she did this because she had heard my 9-year-old daughter, who plays with her neighbor's child, state on many occasions that "Daddy always uses hypnosis on his patients."

13. The patient's psychologic outlook at the time of labor may vary markedly from what it has been at any other time.

14. One of our present projects consists of more accurate prediction of a patient's hypnotic response when subjected to the period of stress, labor, or section. In a very small number we have wrongly prejudged both the very good and the very poor subject.

15. The doctor's training, experience, and particularly his mental attitude are most important to the adequacy of results obtained. Of this we are certain.

A quarter century ago, in medical school, we were taught that obstetrical care involves consideration of "the three P's:" power, passage, passenger. We have since learned to adapt our medical care to our patient's mind as well as her pelvis. We are convinced that incentive, like love, can conquer all. We believe that obstetric analgesia and anesthesia must be adequate for the mother, minimal for the unborn infant. We believe that it must be suitable to the mother and fit into her psychological framework of desirability. Finally, we believe that administration of satisfactory sedation must lie within the capability of the obstetrician, particularly in the absence of an adequately trained resident anesthesiology staff.

We believe that the decreased anesthetic hazard to mother and newborn as well as the greater rapport established between patient and physician well merits the additional time required for the use of hypnosis in obstetrics.

#### Author's Note

<sup>1</sup>72 East Broadway, Muskegon Heights, Michigan. This paper was presented at the First Annual Meeting of The American Society of Clinical Hypnosis, October 1958.