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Hypnosis and Birth

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Abstract: Hypnosis is an intense altered state of receptive concentration which is maximized by motivation, such as labor and delivery. Trance capacity is a relatively fixed phenomenon which can be measured by different methods, including the Hypnotic Induction Profile introduced by Herbert Spiegel that permits the measurements in 5–10 minutes.

Various more elaborate and more consuming procedures for painless childbirth are available, such as Dick-Read, Lamaze and psychoprophylaxis methods, and obstetric analgesia/anesthesia which, however, is not devoid of fetal and maternal side effects.

Zusammenfassung: *Hypnose und Geburt.* Hypnose ist ein intensiver Zustand rezeptiver Konzentration, der besonderen affektiven Zuständen, wie sie während der Wehen und der Entbindung gegeben sind, der sehr leicht ausgelöst sein kann. Die Trancekapazität ist ein relativ abgegrenztes Phänomen, das mit verschiedenen Methoden gemessen werden kann, darunter dem Hypnose-Induktions-Profil von Herbert Spiegel, das messende Bestimmungen der Tranceintensität im Abstand von 5–10 Minuten erlaubt.

Verschiedene, ausgearbeitetere und aufwendigere Vorgehensweisen zur Schmerzminderung bei der Geburt stehen zur Verfügung, wie etwa die Methoden von Dick-Read, Lamaze und psychoprophylaktische Methoden. Darüberhinaus gibt es die Möglichkeit geburtshilflicher Analgesie und Anästhesie, die jedoch nicht von Nebenwirkungen für den Fötus und die Mutter frei sind.

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The anxiety, fear, and pain of labor exhibited by women in Western society constitute a cultural habit, supported by a network of cultural myths and learned by both females and males long before the onset of puberty. Sometimes obstetric analgesia is viewed by most women and their obstetricians as not only a necessity for the alleviation of the intense distress that they have learned "must" accompany labor but, more important, it has become to function as the agent that "permits" delivery to take place.

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However, there are alternative methods that can be used properly. In 1938, J. B. De Lee wrote, "For many years I tried to convince the profession that the way to meet women's demands for painless labor is not to give them more anesthetics but to use less of them and educate the women's minds."[1] One of the most effective means humans have to cope with pain is the mind which can be mobilized with hypnosis techniques that are certainly the safest methods for pain control and can be effective with many women. Yet, it remains a little-used adjunct to the obstetric technique. Misinformation and ignorance are the major deterrents to the acceptance of hypnosis. There are at least 10 misconceptions that, with clarification, can serve to open the way to greater professional acceptance of the use of hypnosis.[2–4] These misconceptions include:

1. *Myth:* Hypnosis is sleep.
   Fact: Hypnosis is not only not sleep, but is the opposite of sleep. It is a form of an intense, receptive, and integrated concentration. For example, none of the EEG findings of sleep are present in hypnosis. Instead, those tracings typical of alert concentration are found in the hypnotic state.
2. *Myth:* Hypnosis is projected onto the patient.
   Fact: The hypnotist projects nothing whatever. Instead he taps the natural trance capacity inherent in the patient. Trance capacity is a relatively fixed phenomenon in each adult. The range from light to deep trance states is usually constant throughout the adult years.
3. *Myth:* Only mentally "weak" or "sick" people are hypnotizable.
   Fact: Exactly wrong. It is the mentally healthy population that are usually hypnotizable. For example, schizophrenics, those with severe character disorders, the mentally retarded, and people with neurologic deficits that interfere with concentration all have difficulty in concentrating enough to shift into a trance state.
4. *Myth:* Hypnosis is dangerous.
   Fact: Hypnosis itself is not dangerous, but the trance state can be used mischievously. The hypnotic state itself is a neutral state of attentive concentration. If the therapist introduces a therapeutically wrong proposal or if he unethically exploits the patient, then of course harm may result.
5. *Myth:* Hypnosis is only a psychologic phenomenon.
   Fact: The neuropsychologic understanding of concentration, focal attention, motivation, and amnesia is still poorly understood. However, the hypnotizability is essentially a neurophysiologic capacity that has psychologic manifestations.

Hypnosis can be defined as an altered state of intense, responsive, and attentive concentration. It is characterized by a perceptual shift of awareness, in an atmosphere of trust and security. It occurs in response to a signal that activates a capacity for intense, focal concentration. Utilization of this capacity permits a "distancing" of focal awareness from its hitherto primary object. All of the individual's focal attention shifts to an intense concentration upon a new objective or goal. Thus, peripheral awareness becomes nonexistent.

An hypnotically induced trance state is the directed utilization of the individual's capacity for focal concentration. It taps this inherent capacity, enhances its

utilization and structures this utilization for the achievement of a specific goal. It occurs in response either to a signal from another, or to an internalized signal to which the individual has been trained to respond.

The subjects awake and aware throughout the duration of the trance. They often experience a "distancing" that they later describe as a feeling of being outside of themselves, peripherally "watching" what is happening to them. Situational stress such as anxiety and pain of labor and delivery seems to enhance the amenability of an individual to enter into a trance state. Motivation is extremely important.

In the past, a serious deterrent to the use of hypnosis was the claim that it took too much time to determine with whom it could be used. Criteria have been established and a set of procedures formulated by which an individual's trance capacity can now be established within 5 to 10 minutes. After that, self-induction can be taught. The induction time can vary from a few seconds to less than a minute.

The ability to look upward on signal while closing the eyelids the "eye-roll sign" has been found to correlate highly with hypnotic trance capacity. In about 75 percent of 2000 consecutive cases, a 5-second examination of the eye-roll sign accurately predicted hypnotic trance capacity. The remaining 25 percent are largely those with disturbances of concentration [2–5].

The remarkable correlation between eye-roll and hypnotizability among the psychiatrically healthy population, i.e., those able to maintain intense receptive concentration, suggests that trance capacity is either genetically determined or learned so early in life at something like an imprint level that the circuitry is essentially physiologic, or structural, rather than a trivial psychologic whim [4–6].

Trance capacity can be graded with sharper focus and with more certainty by use of the Hypnotic Induction Profile. This is a 5- to 10-minute procedure in which trance is induced with the eye-roll arm levitation methods under monitored conditions.[2,3,6]

The psychoprophylaxis, Dick-Read, and Lamaze methods also constitute ceremonies evoking the hypnotizable potential in each given patient. Although none of these methods involve the use of the term hypnosis, each of them utilizes the same capacity for concentrated focal shift operant in the hypnotically induced trance state. Indeed, the aesthetic preferences of the patient are the determining factors in deciding the type and degree of overt ritual to be utilized. In the case of its use in obstetrics, the psychological preference of the patient should be taken into consideration.

Hypnosis can be utilized as an adjunct to obstetrics to a degree that will improve the ease, safety, and overall quality of the natural function of childbirth. The disciplined use of hypnosis requires well-circumscribed conditions and specified goals. The patient coping with anxiety, fear, and pain of childbirth presents a uniquely qualified subject in that she is specially goal- oriented and tends to be experiencing some degree of situational stress. August [7] reported on 1000 consecutive cases of which 85 percent were delivered with hypnosis. Of this 85 percent, about half received, in addition, some chemoanalgesia, usually meperidine, but only 5 percent received any chemoanesthesia. Further, he reports that of 27 cesarean sections in this series, 17 were performed with hypoanesthesia alone. Of these, 12 requested and received general anesthesia after the baby was delivered;

5 received no chemoanesthesia at any time. Since this report, August informed me that his consecutive series was almost 2000 cases with approximately the same results.

We found that fetuses and newborn infants delivered under hypnosis are in better conditions and do not develop hypoxia and acidosis than counterpart delivered vaginally under general analgesia [8].

References

1. De Lee, J.B. (1939). Editorial comment: In: De Lee, J.B. and Greenhill, J.P. (eds.) *The 1938 Year book of Obstetrics and Gynecology.* Chicago, p. 142
2. Spiegel, H. (1972). An eye-roll test for hypnotizability. *Am. J. Clin. Hypnosis* **15**, 25
3. Spiegel, H. (1974). *Manual for the Hypnotic Induction Profile.* Soni-Medica, New York
4. Spiegel, H. (1975). Hypnosis: an adjunct to psychotherapy. In: Freeman, A.M., Kaplan, H.I., and Sadock, B.J. (eds.) *A comprehensive textbook of psychiatry*, Vol. 2. Williams & Wilkins, Baltimore, p. 1843
5. Spiegel, H., Fleiss, J.L., Bridgerm, A.A., and Aronson, M. (1974). Hypnotizability and mental health. In: Arieti, S. and Chrzanowski, G. (eds.) *New Dimensions in Psychiatry: A World View.* Wiley-Interscience, New York, p. 341
6. Spiegel, H. and Spiegel, D. (1978). *Trance and treatment. Clinical uses of hypnosis.* Basic Books, New York
7. August, R.V. (1961). *Hypnosis in Obstetrics.* McGraw Hill, New York
8. Cosmi, E.V. (1967). L'ipnosi in ostetricia. In: Centaro, A. and Ragazzini, R. (eds.) *Intl. Symposium on Problems of Fetal Distress, Sienna, Italy 1966.* Piccin Publ., p. 883