Online Training

Certification in Prenatal Counseling &
Birth Hypnosis in the Peterson Method

with Gayle Peterson, LCSW, PhD, Director of Training

author, Birthing Normally,
An Easier Childbirth and Making Healthy Families
And developer of the Peterson Method of Body-Centered Hypnosis for Childbirth

an online training for childbirth professionals

To register visit: www.MakingHealthyFamilies.com
or phone: (510) 594-6801

Addressing childbirth trauma, effective preparation, prematurity, vaginal birth after cesarean, prenatal bonding and postpartum adjustment

PRENATAL COUNSELING TRAINING WORKBOOK TABLE OF CONTENTS

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Certification Training in the Peterson Model of Prenatal Counseling and Birth Hypnosis *with Gayle Peterson, LCSW, PhD*

Module 1-Childbirth Hypnosis & Visualization in the Peterson Method

Welcome to the course in Childbirth Hypnosis & Visualization in the Peterson Method. This reader, accompanied by live training videos, will illustrate the use of the Peterson method for helping women adapt to the labor process.

Whereas some forms of hypnotherapy involve dissociation from bodily experience, (such as hypnobirthing, Mongan technique) body-centered hypnosis deepens a woman's bodily sensation, taking her into a focused experience of her physiological processes. Body-centered hypnotic suggestions are communicated, through a variety of images and sensations, to the visual, auditory, and somasthetic cortices of the brain. Later, the physical processes of the developing pregnancy and labor activate these hypnotic messages. If anxieties have been addressed successfully in hypnosis, then maternal anxiety lessens and labor is more likely to progress smoothly.

This course will allow you to begin your work in applying body-centered hypnotic technique to your practice with pregnant women. If you are interested in deepening your training, you may want to consider the advanced certification training program. In the advanced training, participants learn techniques of body-centered hypnosis applied to post traumatic stress and other issues that complicate labor. For further information on the full training programs available, please click the following link:

Online Certification Training in Prenatal Counseling and Hypnosis for Childbirth.

Childbirth is an ordeal. It can be a nightmare. Or it can be an empowering experience. But it is not neutral. It is an honor to be working with pregnant women and their families during this process, which is, after all is said and done----an ordinary miracle....I hope you thoroughly enjoy your journey!..

Gayle Peterson, LCSW, PhD, Director, Prenatal Counseling and Birth Hypnosis Training Programs http://www.makinghealthyfamilies.com/

CERTIFICATION IN THE PETERSON METHOD OF

Childbirth Hypnosis &Visualization in the Peterson Method

Required texts: ***An Easier Childbirth***, ***Birthing Normally***, and ***Making Healthy Families*** (available through Amazon.com)

Certification requires all assignments to be completed satisfactorily. The complete course may be taken without certification (without assignments). It may also be taken for ceu's (without certification and without assignments) by post test and evaluation. Ceu's with certification (with assignments completed) do not require post tests.

This reference link contains all files for the videos in this module, the PDF workbook and E-manual referred to in the syllabus for Module One. Please maintain all confidentiality, and be aware that the lectures and Body-Centered Hypnosis for Childbirth video will remain unchanged, for your continued reference. However, *the links to the lending library videos will change periodically.* If they are changed during your training, you will be sent updated links to these videos, while you are enrolled in the program. Copying or forwarding this link is prohibited.

Module One

Module One may be taken for 12 ceus
Seminar # 1

The Birth Counselor Interview and Overview of the Peterson Method for a Preventive Model of Perinatal Care

During the first seminar we will identify vertical and horizontal stressors, which impact birth stress in the family life cycle. This is your foundation for creating a body-centered hypnosis for your client. You will learn to understand the experience of giving birth for the individual woman. *No two women are the same!* Gathering information in the three areas of assessment is necessary in order to address the woman's individual fears and anxieties through this transition to motherhood. Through visual presentation (VIDEO FILE lecture and cases) and hands-on practice, the following will be addressed:

A. The three areas of assessment for childbirth: motherhood, birth and childbirth history, and present experience in the individual and family life cycles of the woman.
B. Interviewing techniques: the meta model and basic interviewing skills practice
C. Reframing past childbirth experience
D. Practice learning how to gather information in the initial interview

Required Viewing:

VIDEO Lecture 1 of *Module One*
Overview of the Prenatal Counseling Model and
The Birth Counselor Interview - 31 minutes

Required Viewing: (in this order is best)

VIDEO Lecture 2 of *Module One*
Basic Techniques of Body-Centered Hypnosis for Childbirth – 42 minutes

VIDEO cases of:
Deirdre: Birth Visualization with commentary – 70 minutes
Deirdre: Postpartum Outcome-10 minutes
Liz : Birth Visualization – 51 minutes
Video: Body-Centered Hypnosis in the technique of Dr. Gayle Peterson - 54 minutes

Additional viewing is recommended, and extremely useful:

Deridre: Birth Counselor Interview without commentary – 51 minutes
Barbara D.: Birth Counselor Interview – 53 minutes

Required Reading:

An Easier Childbirth: chapters 1-4, appendix 1
Making Healthy Families: Chapters 3-4, 11

in Workbook PDF:
1 Interview for The Union Newspaper, # 2 One Size Does Not Fit All *and* #3 The Meta Model

Review: *All* Pink Sheets in Workbook, including Empathy guidelines, assessment sheet and worksheets

Practice:
1. Do the exercises in the meta-model reading with another person to familiarize yourself with these techniques for probing.

2. Do another exercise in which you spend ten minutes or more talking with a friend about a problem or situation, using the reflective listening technique to gather more information. Do this exercise a couple of times, reviewing the empathy guidelines beforehand.

3. Familiarize yourself with the Birth Counselor Questionnaire, but realize that you should be flexible, not necessarily asking all of the questions as they are stated in the questionnaire, but rather, being sure to gather enough information to address the three area of assessment.

4. While viewing one of the birth counseling VIDEO FILEs listed above, identify of at least 4 counseling used. You may email your summary to me at gp@askdrgayle.com if you would like feedback on this exercise.

Assignment #1: Interview a pregnant woman, using the questions listed, or any others you feel are pertinent to obtain information about the assessment areas. *Use the meta model!* Record the interview, if possible. Write an assessment from the birth counselor interview, which describes the woman's birth and childbirth history, expectations for motherhood, including her own childhood experience of being mothered, and her present life experience. In other words: Use the assessment sheet. Identify any vertical stressors that might impact this birth. Relate these assessment areas to her present fears, concerns and expectations for her upcoming childbirth. Identify specific issues you want to address in the birth visualization for this particular woman. In other words: Create a birth inventory list of specific concerns for this woman related to the upcoming childbirth.

You may also ask the woman to fill out the birth inventory in *An Easier Childbirth* for additional information. You may also refer to the worksheets in the reader to organize your thoughts. Pay attention to the place in the life cycle that she is currently experiencing (horizontal stressors) and any vertical stressors that might pertain to this period in her life. It is advised that you find a pregnant woman to work with during the training. If this is not possible, interviewing someone who has been pregnant and is willing to role-play her past experience may be acceptable.

e-mail your 1st assignment to: gp@askdrgayle.com . You may also attach a recording of the Birth Counselor Interview, if possible.

Note: When sending homework, do not use the full name of the person you have interviewed. Use the first name only or a pseudoname.

Seminar # 2

Basic Visualization and Body-Centered Hypnosis for Childbirth

During this seminar you will learn the basic techniques and outline for birth visualization. VIDEO cases, practice and discussion of body-centered hypnosis for childbirth will be the focus. The following topics will be addressed:

A) Identifying factors to be addressed, from the birth counselor interview
B) Identifying visualization and hypnosis technique
C) Practice of visualization and body-centered hypnosis

D) Review of the initial assessment interview

Required Viewing: (in this order is best)

VIDEO Lecture 2 of *Module One*
Basic Techniques of Body-Centered Hypnosis for Childbirth – 42 minutes

VIDEO cases of:
Deridre: Birth Visualization with commentary – 76 minutes
Liz : Birth Visualization – 51 minutes
Video: Body-Centered Hypnosis in the technique of Dr. Gayle Peterson - 54 minutes

Additional viewing is recommended, and extremely useful:
Deirdre: Birth Visualization without commentary (recommended viewing) – 59 minutes
Barbara D.: Birth Visualization – 61 minutes

Required Reading:

An Easier Childbirth: Chapter 8

Birthing Normally: Chapter 4
Body-Centered Hypnosis for Childbirth
Chapter 1 in PDF manual

in Workbook PDF:

#5 Paging Dr. Fear, #6 Healing Traumatic Birth *and* #4 Pregnancy as Healing: Visualization and Indirect Hypnosis

Review: *All* Pink Sheets in Workbook PDF, including uses of body-centered hypnosis, techniques of body-centered hypnosis and worksheets.

Practice:
1. Do the exercise of telling a story to a friend (about 10-15 minutes) describing something pleasant, exciting or wonderful. It could be about somewhere you visited or an experience that was positive that happened to you. Be aware of using all three submodalities (visual words, auditory words and kinesthetic words) as much as possible. Then afterward, ask the person what sensations they remember or enjoyed from your story.

2. Record the session above, or do another session so that you can record it. Listen to the recording and identify how many times you used the visual, auditory, and kinesthetic sensory channels and what words elicited these senses. If you cannot record it, then ask a witness to listen to you telling the story to your friend and ask them to write down the different visual, auditory and kinesthetic words you used. Be sure to use all 3 sensory

channels at some point in your description! You may e-mail at gp@askdrgayle.com if you want feedback on this exercise.

3. Pick a VIDEO, (other than Deirdre) on body-centered hypnosis from the ones above. Write a summary of the techniques, and what specific issues you could hear being addressed in the session. What issues were raised in her birth counselor interview? How did you hear them addressed in the birth hypnosis? You may e-mail at gp@askdrgayle.com if you want feedback on this exercise.

4.While viewing one of the birth visualizations VIDEO FILEs above, identify hypnotic techniques used. You may e-mail at gp@askdrgayle.com if you want feedback on this exercise.

Assignment # 2: Interview a second woman, or you may use same person as assignment #1. (You may also use a friend or family member, as a first trial, if you wish) Identify and establish agreement on points that need healing in a body-centered hypnosis session. Record the hypnosis session, which should be approximately 40-60 minutes. Listen to yourself afterwards, and take notes on the suggestions you utilized during the session. Write a summary of the points identified in the initial interview and how you addressed them in the body-centered hypnosis session. Include techniques of hypnosis used in the session.

e-mail your assignment to gp@askdrgayle.com and attach a recording of the Birth Visualization to e-mail, if possible. *Note:* When sending homework, do not use the full name of the person you have interviewed. Use the first name only or a pseudoname.

Certification Training in the Peterson Model of Prenatal Counseling and Birth Hypnosis *with Gayle Peterson, LCSW, PhD*

Modules 2 & 3- Childbirth Hypnosis & Postpartum Counseling in the Peterson Method: Advanced Techniques

Pregnancy and childbirth presents women with an opportunity for profound insight and self-understanding. Gayle Peterson is a pioneer in the field of Perinatal Psychology and has worked with pregnant woman since 1973, to plumb the depth of this transformative period in a woman's life. Dr. Peterson's brief term Perinatal Counseling Model addresses the specific anxieties a woman experiences at the threshold to motherhood. Psychological counseling using this method enables a practitioner to effectively transfer the powerful experience of pregnancy and childbirth to her client's core sense of self. The training will also cover advanced applications of hypnosis to premature labor, breech positioning, healing traumatic birth and childbirth experience and vaginal birth after cesarean (VBAC).

Participants will learn to identify birth related issues in a woman's personal history and apply principles of hypnosis and counseling to improve both psychological and medical birth outcomes. Primary focus will be on the woman's needs and development in relationship to her developing identity as woman and mother. Family history, past childbirth, present family support, the woman's own birth experience and realistic preparation for giving birth will be covered. Supporting a woman's development through the psychological and physical transition to motherhood will be the goal of this orientation.

The four-part model includes:

- ***Prenatal Assessment Interview-module 1***
- ***Body-Centered Hypnosis-modules 1,2 & 3***
- ***Identification of Individual Coping Styles-module 2***
- ***Postpartum Interview-module 3***

I hope you thoroughly enjoy the rest of the program!

Gayle Peterson, LCSW, PhD,
Director, Prenatal Counseling and Birth Hypnosis Training Programs
http://www.makinghealthyfamilies.com

CERTIFICATION IN THE PETERSON METHOD OF

Advanced Techniques in Hypnosis for Childbirth and Postpartum Counseling in the Peterson Method

Required texts: ***An Easier Childbirth***, ***Birthing Normally***, and ***Making Healthy Families*** (available through Amazon.com)

This reference link contains all files for the videos in this module, the PDF workbook and E-manual referred to in the syllabus for Modules Two and Three. Please maintain all confidentiality, and be aware that the lectures will remain unchanged, for your continued reference. However, *the links to the lending library videos will change periodically.* If they are changed during your training, you will be sent updated links to these videos, while you are enrolled in the program. Copying or forwarding this link is prohibited.

Module Two

Seminar # 1

Adequate Preparation for Childbirth: Addressing Pain and Issues of Control

This seminar will focus on body-centered techniques for helping woman cope with labor. Realistic preparation for the woman and her partner will be addressed. The following topics will be included:

A. Identifying an individual woman's coping style(s) and augmenting this for labor.
B. Understanding and teaching the concept of "healthy pain" in childbirth
C. Understanding normal delivery: addressing 3 factors for normal birth
D. Practice session for identifying coping styles
E. Use of an audiotape of a woman's labor to stimulate discussion between her and her partner
F. Early labor projects and identifying coping styles in the context of the couple relationship

Required Viewing: (in this order is best)

VIDEO Lecture 1 of *Module Two*
Addressing Pain and Issues of Control – 19 minutes

VIDEO cases of: (in this order is best)

Sharon: Simulated Contraction Session with commentary – 25 minutes
Sharon: Pain tape with commentary – 41 minutes
Liz and Jerome: Birth Counselor Interview Segment with husband addressing pain and labor
with commentary – 11 minutes

Highly Recommended:
Deirdre: Simulated Contraction Session – 64 minutes
Liz : Simulated Contraction Session – 41 minutes

Required Reading:

An Easier Childbirth: Chapter 5 and 6
***Birthing Normally*:** Chapter 5, 6 and 7
In PDF Workbook:
#7 Maps of the Mind
Review: *All* Pink Sheets in PDF Workbook

Assignment: #3
Do the simulated contraction exercise with a pregnant woman, or friend if necessary first, as seen in the VIDEO cases and described on p. 106 of *An Easier Childbirth.*

Write a brief summary of your observations about her coping styles and what seemed to help her most. E-mail to the assignment to: gp@askdrgayle.com

Keep in mind that addressing early labor projects, labor as a healthy pain and that labor is normally a healthy stress, but not distress for the baby is a critical part of the 3rd counseling session on coping with pain. (Refer to VIDEO cases with commentary and chapters 5 and 6 in An Easier Childbirth)

Seminar # 2

Dealing with Control and Fear: Advanced Topics of Body centered Hypnosis

This session moves into special concerns and the use of body-centered hypnosis to release fear and tension. The following advanced topics will be addressed:
A. Using Body-Centered Hypnosis to address birth trauma
(a woman's own birth experience)
B. Using body-centered hypnosis in the case of premature labor
C. Using Body-Centered Hypnosis for turning breech presentation

Required Viewing: (in this order is best)

VIDEO Lecture 2 of *Module Two*

Advanced Topics of Body-Centered Hypnosis – 24 minutes

VIDEO cases of: (in this order is best)
Nancy: Working through her own birth with commentary – 54 minutes
Laura: Visualization for maintaining to term with commentary – 39 minutes
Reena: Birth Visualization for breech with commentary – 65 minutes

Highly Recommended:
Sharon: Visualization for clearing past cesareans (VBAC) – 38 minutes
Carol: Body-Centered Hypnosis for Premature labor - 36 minutes

Required Reading:
In PDF Workbook:
#8 Prenatal Bonding, Prenatal Communication, and the Prevention of Prematurity *and*
#9 Hypnosis and the conversion of breech position to vertex
Review: *All* Pink Sheets in PDF Workbook

Module Three

Seminar # 1

The Use of Body-Centered Hypnosis to address Special issues of Neonatal Loss

This seminar will focus on the special concern of stillbirth.

Addressing loss:
A. the case of Nora
B. the case of Barbara F.

Required Viewing:
VIDEO Lecture 1 of *Module Three*
Addressing Loss – 24 minutes

VIDEO cases of:
Nora: visualization for healing past stillbirth with commentary – 53 minutes
Barbara: visualization of third childbirth, following previous stillbirth and cesarean – 50 minutes

Required Reading:

In PDF Workbook: # 10 Chains of Grief: The Impact of Perinatal Loss on Subsequent Pregnancy
An Easier Childbirth: appendix 2: Transforming Fear
Review: *All* Pink Sheets including points for prematurity, breech, post-traumatic stress and loss

Assignment # 4: Choose a client, or friend if you wish for the first time that has a past traumatic childbirth, neonatal loss, premature labor or birth that needs reframing. Record the hypnosis, listen to it, and write a summary of how you addressed the past birth or childbirth.
e-mail it to: gp@askdrgayle.com

OR:

Review the VIDEO of Laura for prematurity and identify hypnotic techniques not included in the commentary. Pay specific attention to *all metaphors* and identify the embedded commands, truisms, linkages and any other techniques contained or implied within the metaphor itself. Give a brief description of how you believe the techniques worked towards the goal of maintaining the pregnancy. e-mail it to: gp@askdrgayle.com

Seminar # 2

The Postpartum Interview and the Family System

This seminar will address the family system as it changes following the birth of a baby. Common pitfalls and assessing postpartum depression will be discussed, as well as understanding the characteristics of healthy family structure and communication. The woman's experience of her childbirth however will be the main focus of the postpartum interview. The following topics will be addressed:

A. Making sense of the birth-positive reframing
B. Assess postpartum adjustment, blues, serious depression or psychosis
C. Highlight self-esteem and integrate learning for postpartum adjustment and future childbirth
D. Practice in identifying characteristics of healthy family structure
E. Practice in postpartum interviewing

Required Viewing:

VIDEO Lecture 2 of *Module Three*
Postpartum Interview – 16 minutes

VIDEO cases of: (in this order is best)

Barbara: Postpartum Interview with commentary – 68 minutes
Deirdre: Postpartum Interview – 55 minutes
Liz and Jerome: Postpartum Interview – 37 minutes

Required Reading:

An Easier Childbirth: Chapters 9 and 10
Making Healthy Families: Chapters 1, 2 , 5 *and* 7
Pay special attention to: pp.109-112: Identifying your discussion busters
Postpartum Depression Course PDF

In PDF Workbook:

#11 When Baby Makes 3, *Fit Pregnancy Magazine* (Dr. Gayle Peterson's Pregnancy Roundtable)

Review: *All* Pink Sheets, including postpartum sheet

Assignment # 5:

Do a postpartum interview with a pregnant woman. Record it, if possible. Write an assessment of the points addressed in the postpartum with attention to assisting in integrating the experience of giving birth. Also assess her adjustment to motherhood and whether she needs referral for possible postpartum depression.
e-mail your assessment to me at: gp@askdrgayle.com

E-Z STUDY GUIDE/Module One

(approx. 4 ½ hours of viewing, 50 pages reading)

This is an experientially based training program. The video cases are your most effective teachers. *Do not become overwhelmed by the amount of material before you.* Instead, you may either follow the syllabus, exactly as it is written. Or you can use this streamlined study guide to grasp the core curriculum, and then go back to the syllabus for additional resources, as needed to complete assignments and deepen your understanding. This training is front-loaded. Module two and three present less material, so it becomes easier as you go!

I. View Model One/Lecture /Seminar One (31 minutes) take notes, read the syllabus outline.

II. View Module One-Lending Library/Birth Counselor Interview /Deirdre with commentary (58 minutes)

III. Read Appendix 1 (pp. 155-158) in *An Easier Childbirth*

IV. If you are *not* a trained counselor, read #3 "The Meta Model" and do the Practice on p.2 of syllabus. If trained in counseling technique, you may skip, or skim, as appropriate.

V. View Module One/Lecture /Seminar Two (42 minutes)

VI. View Module One/Lending Library/Birth Visualization/Deirdre with commentary (76 minutes) Deirdre-postpartum outcome (10 minutes)

VII. View Body Centered Hypnosis in the technique of Gayle Peterson, DVD (54 minutes)

VIII. Read DVD Training Manual (pp.1-41)

IX. Review pink pages in pdf reader, and do the Practice exercise on p. 4 of the syllabus.

X. Go back to syllabus, assignment #1. Can you do this assignment? If not, view additional video cases in Birth Counseling (Liz and/or Barbara D.) for further absorption of the material. Read additional readings for greater background understanding. (*An Easier Childbirth, Making Healthy Families*).

XI. Go to syllabus, assignment #2. Can you do this assignment? If not, view additional videos (Liz or Barbara) and read additional reading assignments in syllabus.

E-Z STUDY GUIDE/Module Two

(Approx. 4 hours viewing, 70 pages reading)

Now you have grasped the basics of the birth counseling-birth visualization flow. Mastery of pain will ensure that the birth counseling and visualization is effective when labor begins, and dealing with complex issues of prematurity and past childbirth complications (post traumatic stress) will enable you to create more effective visualizations when these situations arise.

I. View Module Two/Lecture/ Seminar One- (19 minutes)

II. View Module Two/Lending Library/Addressing Pain/ Sharon-simulated contraction (25 minutes) and Sharon-Pain Tape (41 minutes)

III. Read #7 in pdf reader, *Maps of the Mind* and chapter 7 in *An Easier Childbirth, and Birthing Normally (pp.83-89)*

IV. Read assignment # 3 in syllabus. If you cannot do this assignment, view additional video cases of simulated contraction and pain work (Liz and Jerome, Deirdre, Liz) and additional reading

V. View Module Two/Lecture/Seminar Two (24 minutes)

VI. View Module Two/Lending Library/ Advanced Topics/Nancy-working through her own birth (54 minutes)

VII. View Module Two/Lending Library/Advanced Topics/Laura-visualization for maintaining to term- (39 minutes)

VIII. View Module Two/Lending Library/Sharon-visualization for past cesareans, VBAC (38 minutes)

IX. Read chapter 8 in *An Easier Childbirth* and in pdf reader #4 *Pregnancy as Healing* –Applied Visualization

E-Z STUDY GUIDE/Module Three

(3 ½ hours viewing, 45 pages reading)

Dealing with deep issues of loss in childbirth will enable you to create more effective visualizations when these situations arise. Particularly when a woman faces labor after a previous pregnancy loss. Postpartum counseling will ensure that previous work you have done with your client remains effective and available to her in her personal growth as a woman and as a mother throughout her life.

I. View Module Three/Lecture/ Seminar One (24 minutes)

II. View Module Three/Lending Library/Addressing Loss-Nora (53 minutes)

III. View Module Three/Lending Library/Addressing Loss-Barbara (50 minutes)

IV. Read, in pdf reader #10 *Chains of Grief* and appendix 2 in *An Easier Childbirth* (159-163)

V. Do assignment #4. If you cannot do this assignment, View additional cases from module one or two and additional readings from module one or two, for further understanding.

VI. View Module Three/Lecture/Seminar Two (16 minutes)

VII. View Module Three/Lending Library/Barbara D.-postpartum interview-(68 minutes)

VIII. Read pdf *Postpartum Depression Course* and chapter 10 in *An Easier Childbirth* and chapter 3 in *Making Healthy Families*

IX. Do assignment #5. If you cannot do this assignment view additional video cases of Postpartum Interview (Deirdre, Liz and Jerome) and additional reading in syllabus for further understanding.

Review pink pages in pdf reader!

Locus of Control

Self_____/_____Others

Increase in trust in the labor process
Increase in ability to adapt/cope
Decrease in fear/ anxiety
Decrease in physiological stress
Increase in normal outcome

Decrease in trust in the labor process
Decrease in ability to adapt/cope
Increase in fear/ anxiety
Increase in physiological stress
Increase in dysfunctional labor

Childbirth Preparation that facilitates a woman's reflection on her readiness for motherhood and for coping with labor improves psychological and physiological outcome

The Peterson method emphasizes the value of a woman's personal growth through this period of the life cycle and supports her active participation in the psychological task of *giving birth* and *becoming a mother*

THREE MAJOR AREAS OF ASSESSMENT

1) Motherhood: What is the woman's experience of becoming a mother? Including family history of:

   a) relationship to mother
   b) relationship to father
   c) relationship to parents' marital roles
   d) relationship with siblings
   e) her own role in the family

2) Birth and Childbirth History:

   a) her own prental and birth experience
   b) mother's childbirth experience, sister's, grandmother's, friend's.
   c) Her own past childbirth or related experiences of abortion, miscarriages, stillbirth, traumatic birth
   d) experience as a mother including loss of previous child, feelings of competence (or not)
   e) relationship to her own body, including concepts of femininity, socialization, acculturation, sexual experience.

3) Present Experience

   a) place in life cycle
   b) career/job responsibilities
   c) relationship with spouse, family system
   d) social support system

Family Life Cycle
Stages of Development
(not including divorce, remarriage and stepfamily)

unattached adult	coupling	pregnancy childbirth	raising children	raising teenagers	launching children	grandparenting

Horizontal and Vertical Stressors for Determining Risk Assessment

Horizontal: naturally occurring stresses of specific stages of development

Vertical: stresses that occurred in the past, which can be stimulated during pregnancy/childbirth stage

\+ When Horizontal and Vertical stressors cross = greater potential for dysfunction

Dierdre's vertical stressors (1, 2 and 3)

unattached adult	coupling	pregnancy childbirth	raising children	raising teenagers	launching children	grandparenting
		1 2 3				

1- mother's first bay's death during birth
2- mother's second baby's death soon after birth
3- mother's cesarean births

Dierdre's Birth Counselor Inventory

1. Vaginal Birth after Cesarean
2. Her own Mother's History of Loss
3. Concern over Sibling Adjustment
4. Anxiety about Coping with Pain in Labor
5. Her Own Birth by Cesarean
6. Becoming 40

Disloyal Feelings Related to Relationship with Mother

Birth Counselor Interview

Purpose: To gather information, clarify, reframe

1. How pregnant are you?

2. Was this a planned pregnancy?

3. Have you ever been pregnant before?

4. What was your past childbirth experience(s) like for you? Postpartum? Motherhood?

5. What do you know about your own birth? What is your impression of your mother's childbirth experience? sister's?

6. How will having a baby fit into your current lifestyle? Will it change your longterm plans? Relationship with partner?

7. How many children were in your family? Which one were you? Any particular role you played in the family?

8. How would you describe your childhood? Your relationship to and experience of your mother? Father? Siblings?

9. How did you experience your parents' marriage? Any significant stress or loss in your childhood? If so, how do you feel about it now? How did it influence your ideas about family, parenthood, marriage?

10. Do you have any particular concerns about your baby? Childbirth? Parenting? Career?

11. How do you think you will cope with pain in labor?

12. How are you feeling about your body and its changes so far?

13. How will you and your partner share responsibility for your child in the first year?

14. What are your impressions and expectations of a newborn?

15. Do you feel satisfied with your current plans for childbirth?

16. How do you envision the birth of this baby? What is important to you? Who will be present at the birth?

There is no right order in which to gather this information. Make rapport with the woman and let the interview unfold naturally. By the end of the interview, you should be able to clarify goals with your client and objectives for reaching these goals. Occasionally, you may need an extra session to complete this process, particularly in cases of previous pregnancy loss.

PRENATAL COUNSELING FLOW SHEET

I. Birth Counselor Interview

- Assessment of 3 areas
- Construct birth inventory list

II. Body Centered Hypnosis for Childbirth

- Individualized to address upcoming birth around specific issues identified in birth counselor interview

III. Pain Work (with partner present, if possible)

- Identifying coping styles
- Reframing "healthy" pain
- Addressing Early Labor Projects

IV. Postpartum Adjustment

- Processing integrating birth experience
- Family adjustment, bonding, etc.

Additional body centered hypnosis sessions for prevention of prematurity, healing birth or childbirth trauma and additional family counseling sessions may be added as appropriate.

Reflective listening
A Midwifery Technique for Counseling

Accurate Empathy Guidelines

1. Attend carefully, physically and psychologically, to the messages transmitted by the client.

2. Listen especially for repeated and core emotional themes.

3. Respond fairly frequently, but briefly to core messages, but be flexible and tentative enough so that the client has room to clarify their exact feelings and experience. (ie; affirm, deny, explain or shift emphasis).

4. Be gentle, but don't let the client run away from important topics and feelings.

5. Respond to both content and feeling, unless there is some reason to focus on one or the other for emphasis.

6. Move gradually towards the exploration of critical thoughts, beliefs and feelings.

7. After you have responded, attend carefully to cues that either confirm that the client is with you, or deny the accuracy of your response. Does the client move forward in a focused way?

8. Note signs of client distress or resistance and try to judge whether these arise because you have lacked accuracy or have been too challenging.

PRENATAL FLOW WORKSHEET FOR IDENTIFYING OBJECTIVES, GOALS, AND TREATMENT PLAN

Name:_____

Due Date:_____

Using the information gathered in the Birth Counselor Interview, make a list of the woman's concerns and/or fears related to giving birth, being a mother, fitting the baby into her life, her relationship with her partner, or any other issues that came up for her around this transition in family life. Include your impressions of her as well.

_____
_____
_____
_____
_____
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_____
_____
_____

MAKING A BIRTH INVENTORY LIST:
From this list, distill her goals, related to pregnancy, birth, and postpartum family adjustment that you will address in your work with her. State these goals in process as well as concrete terms, including her own parameters for her goal (for example VBAC is the stated goal, but include her deisre to have a healthy baby and a more emotionally supportive and positive experience - cesarean or vaginal).

_____

OBJECTIVES:
Which of the following ways will you address these goals?

body centered hypnosis for prenatal bonding? for childbirth? for working through a past childbirth? for her own birth? simulated contraction work? pain tape? with and/or without the partner? counseling and homework to reframe and/or clarify her relationship with her prenatal practitioners? coaching her to develop her relationships with prenatal care providers? counseling and homework related to choosing a practitioner, support people for her birth, or place of birth?

DEVELOPING A TREATMENT PLAN:

Consider the issues that need to be addressed and how you will work with her to address them. Present your ideas to the woman for her consideration, additional input, etc. Write you plan out with approximate dates of planned sessions:

Stay open to changes or adjustments in the treatment plan, as the process unfolds. Adjust your treatment plan according to her needs.

BODY-CENTERED HYPNOSIS WORKSHEET

Overall purpose of this hypnosis:_____
_____

Birth related issues to be addressed (from inventory list)
_____
_____
_____
_____
_____
_____

Relaxation induction: What suggestions might you begin to give in this phase that would seed the development of the goal later on in the hypnosis?
_____
_____
_____
_____
_____
_____

Ideas about metaphors, synesthesia, or other hypnotic techniques you might use to address these issues in the birth (or other visualization) sequence?

POSSIBILE USES OF BODY CENTERED HYPNOSIS

1. PREVENTION OF PREMATURITY.

2. RESOLUTION OF EMOTIONAL ISSUES RELATED TO PAST ABORTION, MISCARRIAGE, PRENATAL, BIRTH AND CHILDBIRTH TRAUMA, STILLBIRTH OR OTHER ISSUES OF LOSE.

3. PHYSICAL SYMPTOMS- BLOOD PRESSURE, SMALL FOR DATES, ETC.

4. VAGINAL BIRTH AFTER PREVIOUS CESAREAN.

5. BREECH PRESENTATION.

6. FAMILY ISSUES RELATED TO MOTHERHOOD.

7. TWIN OR MULTIPLE BIRTHS.

8. FACILITATING POSITIVE FEELINGS AND HEALING FOR A PLANNED SURGERY (SUCH AS CESAREAN).

9. OTHER FEARS, CONCERNS.

It is important to remember that body-centered hypnosis in this context emphasizes physical and emotional learning and adaptations in the context of a safe relationship. New learnings yield an improved outcome, as new resources are available to the woman. Because body-centered hypnosis is symbolic and experiential, you do not need to know the psychological roots of a situation in order for the learning to take place. In other words, appropriately paced suggestions for the cervix to soften and open at the right time can be absorbed and adapted to on a <u>subliminal</u> level. In this way, the experience of the body leads the process of understanding which may consciously take years to fully comprehend -- like the understanding that the earth is spherical took years to understand, even as the earth itself continued its rotation.

TECHNIQUES OF INDIRECT HYPNOSIS

1. TRUISMS --- statements of fact or belief, followed by a suggestion.

2. EMBEDDED COMMAND --- a command embedded within an ongoing sentence, to sound like a suggestion. Commnads can be embedded (softened) using pauses, changes in the texture of the voice, or with the name of a person.

3. COUPLING/LINKAGE --- a suggestion that follows or is linked to a previous activity, implying that it will happen.

4. THERAPEUTIC DOUBLEBIND --- a suggestion that something will happen following making a choice between two or more possibilities that lead to the same outcome.

5. INCORPORATION/ANCHORING --- a suggestion facilitated by using an already occurring phenomenon (can also be person, place or thing) to trigger the suggestion. In the present it is incorporation. In the future it is anchoring.

6. REFRAMING --- a suggestion given in the context of a different frame of reference, changing the original meaning.

7. FUTURE PACING --- suggestions in the context of something already having been experienced or achieved, which represents a future possibility.

8. METAPHOR --- suggestions embedded in another context which is easy to identify with, but has been likened to the task being addressed. Sensation is evoked, and embedded command, truisms and linkages are plentifully used in the context of the metaphor.

9. SYNESTHESIA --- a suggestion given thorough the sound texture or quality of vocal tone used. It mixes the sensory channels, so that a sensation is evoked. Something sounds like, what it feels like.

Representational Systems

Ways we experience and integrate the world through our senses
Sub-modalities are the words we use within a representational system
Relates to the visual, auditory and kinesthetic cortices of the brain
Intra-dimensional shift changes the representational experience

Visual:

Clear----------

Intra-dimensional shift

Examples of Sub-modalities of Visual System:
Clear
Bright
Foggy
Hazy
Lightning

Auditory:
Quiet----------

Intra-dimensional shift

Examples of Sub-modalities of Auditory System:
Quiet
Noisy
Clapping
Laughter
Loud
Thunder

Kinesthetic: includes sense of smell, touch and feeling

4 Factors in addressing Pain in Labor

Teaching the concept of "Healthy Pain"

Identifying Early Labor Projects: Early Labor vs. Active Labor

Normal labor as healthy for the baby

Helping partner tolerate normal, healthy pain in labor

ADDRESSING POST-TRAUMATIC STRESS SYNDROME RE: BIRTH TRAUMA

1. Start in the present/SEED feeling what it is like to birth normally, so can imagine this possibility with baby.

2. Use yourself/presence to go back to past/comfort heal.

3. Use archetypal mother images.

4. Use other healing relationships to support past.

5. Embrace/comfort younger self.

6. Balance release/regression with support/building internal structure.

7. Eventual separation from past birth and future childbirth should emerge.

8. Follow up with separate birth visualization for baby scheduled for future visit.

POSSIBLE RED FLAGS:

- Inability to stay awake when using audiotape of birth visualization.
- Comments, as getting ready for the birth visualization - i.e. referring to suffocation, getting stuck, etc.

PREMATURITY

1. CONTAINMENT

   Be aware that your relationship is a major vehicle for containment. If previous prematurity occured, plan at least monthly contact if client comes in early in her pregnancy.

2. CONTACT

   Utilize the relationship as a vehicle by maintaining steady regular contact, if at all possible, even if by phone.

3. SUSTAINMENT

   Include images/metaphors of fullness, containment, sustaining to term; develop timeline to due date.

4. Encourage "taking time"; self-care activities and hypnotic projects that reinforce body-centered hypnosis suggestions.

5. Identify any vertical stressors of previous pregnancies and address these issues in body-centered hypnosis.

6. Do not do full out birth visualization until last 2-3 weeks in pregnancy.

POSSIBLE RED FLAGS:

- Premature birth
- Previous prematurity (childbirths)
- Feelings of deep inadequacy to care for baby
- Inability to care for self

BREECH

1. Do breech visualization as early as 32 weeks, as there is more room for baby to turn and move and more time to work through issues.

2. Identify plans for possible vaginal breech or cesarean. Lay these plans to rest.

3. Explain possibilities/theories for baby's turning.

4. Then:
   Focus on possibility of baby turning in a body-centered hypnosis.

   - Include gestalt of interior landscape of cervix, uterus, baby; address any issues that seem relevant, i.e. not being ready for the labor.

   - Emphasize following where "baby takes you" vs. control over the process.

   - Use any symbols/images she presents to you in the hypnosis.

5. Reinforce with breech tilt exercise.

6. Suggest use of audiotape at least once and as often as desired for relaxation preparation for labor (vaginal or Cesarean outcome).

7. Do breech visualization as early as 32 weeks, as there is more room for baby to turn and more time to work through issues.

POSSIBLE RED FLAGS:

- Feelings of not being "ready" for motherhood.
- Feelings that vaginal birth is traumatic/or other fears re: childbirth.
- Fears that having a baby will destroy couple's relationship.

“breech tilt” exercise

Lie with the hips propped up 12-18 inches higher than the head, two to three times per day, for between 10-20 minutes at a time. This helps to disengage the baby from the pelvis, and when the baby's head comes up against the inside of the fundus, it is inclined to tuck its head in and do a somersault into the vertex position. It is sometimes recommended to try this with an empty stomach. Small studies have reported success rates of between 89% - 96%.

USE TRUISM, EMBEDDED COMMAND, REFRAME, AND DOUBLE BIND AS DESCRIBED IN SEMINAR 2, MODULE 2 WITH BREECH TILT

GUIDELINES FOR DEALING WITH PREVIOUS LOSS ISSUES IN SUBSEQUENT PREGNANCIES

1. Incorporate anxiety vs. attempting to minimize or lessen it in the birth visualization.

2. Don't avoid using last child's name; make a place for previous bond and seed possibilities of moving on, making room for next child.

3. Recognize/acknowledge fear related to previous loss and desire related to future experience. Hold the space for both.

4. Be aware that the time of loss, when it occured in prevous preganacy, will be charged in subsequent pregnancy. Contact with you is important during this period.

5. Acknowledge attachment to last child - address disloyalty issues related to next child. Be aware that survivors guilt may be projected onto second child, making bonding difficult.

6. Be aware that facing the possibility/reality of a healthy normal child can take alot of courage. Validate that it takes courage to attach/bond again.

7. Look for ways of leaving the loss behind. But pace appropriately to the woman and her specific situation and needs.

8. Support commitment, but do not insist on prenatal bonding, during birth visualization: settle for facing/meeting the baby, but not necessarily greeting it!

9. Emphasize resiliency of life in the context of a non-blame approach and reframe loss experiences to make way for future possibilibities of live birth.

10. Be aware she may feel guilt over failure to protect her child - undermining her confidence as a mother. Seek to accept her, and offer appropriate ways to reframe any sense of failure.

PURPOSES OF POSTPARTUM INTERVIEW

1. Integrate, reframe, reinforce birth experience as positive element in her life.

2. Support motherhood and emerging identity as mother.

3. Assessment of adjustment re: bonding
   breastfeeding
   couples; support system
   - refer as appropriate

4. Assess levels of postpartum depression, if present

   - blues
   - postpartum syndrome
   - psychosis (onset 1-3 months postpartum usually resolves by one year)

   POSSIBLE RED FLAGS for #4 :

   - fears/wants to hurt baby; fantasy or impulse
   - can't take care of baby
   - father sounding desparate and afraid
   - strong or overwhelming feelings of entrappment for mother/father
   - difficult to tell you, due to deep SHAME

   Interventions for #4 :

   - referral; psychological medications
   - ongoing supervision/role-modeling for Mom vs. separation from baby
   - Communicate possible danger to husband
   - Report, if necessary to Child Protective Services

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FUNCTION: NURTURE GROWTH/DEVELOPMENT OF ITS MEMBERS

Seeks relating
to solve conflict
Seeks intimacy

OPTIMAL:
1. Satisfies both need for nurturance and autonomy/independence. Interdependent.
2. Clear gender/sex/social boundaries.
3. Equality between spouses.
4. Non-perfectionism/appropriate delegation of responses.
5. Warmth/Joy/Humor.
6. EFFECTIVE communication/Negotiation without pain: Resolve conflict Problem Solving
7. Transcendent values connection to larger whole.

Trust is **HIGH**

ADEQUATE: same: but
1. more expense to one family member.
2. less warmth
3. Individuation takes form of DISTANCING. less sharing.

Seeks control over relating to solve conflict
Fears Intimacy

MIDRANGE: CP — CONFLICT: UNRESOLVED/painful.
Authoritarian
♂ :Dominant
♀ :Submissive
Positive feelings expressed/Negative repressed.
Scapegoat
so: Negotiation compromised.

CF — Negative feelings expressed/Positive repressed.
Control thru intimidation
Parental power struggle/hostility.

LOW Trust

-Anxiety disorders
-Depressive disorders

MIXED — May alternate with different children/situations, moods.

LO-MIDRANGE — Increased efforts at control with intermittent taking charge --- melting to chaos.

borderline
Anorexia — CP — NO-LITTLE follow through.
OCD

Borderline pers. disorder — CF — Increased expressions of anger/ Verbal, abuse
Children learn to MANIPULATE/USE others as objects.
Decrease empathy. To meet needs. Decrease conscience.

Dev.Tasks Incomplete

SEVERELY: DYSFUNCTION

Attachment disorders

enmeshed — CP — Impermeable outer family boundary.
Schizophrenia — DISTRUST OUTSIDERS/LOVE IS DICTATED
crimes of disloyalty — NO INDIVIDUALS = MASS EGO ID.
to not think/feel the same.

Increase reactive parents are children.
So: boundaries confused.
Generational/Sexual.

Disengaged — CF — NO COHESION empathy
Antisocial — ANGER/HOSTILITY MASK Dependency needs completely.
Sociopathic

POSTPARTUM INTERVIEW OUTLINE

I. Elicit birth story
II. Support strengths/challenge self denigration
III. Teach birth as opportunity for learning
IV. Bridge strength/learning to future endeavors, development or childbirth
V. Support maternal-infant bond

STAGES OF WORKING THROUGH LOSS

I. Disintegration/contraction of spirit
II. Expansion/Letting go
III. Reorganization of identity
IV. Reintegration of self

RED FLAGS indicating need for treatment:

1. difficulty getting pregnant following loss
2. difficulty sustaining pregnancy following loss
3. preterm labor in subsequent pregnancy
4. difficulty feeling motivated for attachment prenatally
5. Feelings of intense guilty/disloyalty or even resentment of present pregnancy/baby
6. overall attitude of self-neglect

If no treatment: first generational stress is passed onto second generation and children can feel unwanted, survivor's guilt, or over-burdened with anticipation/fear of loss of their own children

OUTLINE FOR HEALING VISUALIZATION FOLLOWING LOSS

I. Relaxation induction
II. Traveling to the womb: use metaphor to heal
III. Compassionate witnessing of grieving
IV. Holding space for past grief and future possibility
V. Making it back to the womb for new baby/new bonding possibilities
VI. Moving on as possible after saying good-bye

OUTLINE FOR BREECH VISUALIZATION

I. Relaxation Induction
II. Progressing to metaphor: for turning to vertex
III. Womb Visualization: baby head down as possibility
IV. Birth Visualization
V. Closure/Maintaining to term

OUTLINE FOR POST TRAUMATIC STRESS OF A WOMAN'S OWN BIRTH VISUALIZATION

VI. Relaxation Induction
VII. Progressing to time tunnel metaphor with your presence going back to the past
VIII. Acknowledge pain and help her release it, taking her forward to different sensations of what it could be like in a normal healthy labor
IX. Re-do her birth through visualization of what healthy birth could feel like
X. Bring back to present through time tunnel metaphor (may include reference to visualization of a positive birth experience for her baby)
XI. Separation/Healing of her birth and this upcoming childbirth

OUTLINE FOR PREMATURITY VISUALIZATION

XII. Relaxation Induction
XIII. Progressing to metaphor: for containment, maintaining, sustaining to term
XIV. Womb Visualization: envisioning fullness, coming to term
XV. Closure/Maintaining to term

What was found? How a woman feels about her experience matters and has far reaching effects on her development as a woman, her confidence in mothering and her ability to bond with her child.

Through this research, further education and years of clinical experience, I developed a Preventative Prenatal Counseling Program to augment the traditional medical care a woman receives from her doctor or midwife.

My book, "An Easier Childbirth" is an outgrowth of this work and offers women a workbook to explore the significant emotional growth of this period and helps to ready them for childbirth. A personalized visualization script offers women the opportunity to create a body-centered hypnosis tape, which is one of the cornerstones of my Prenatal Counseling Model.

What do you get out of the work you do?

My work with couples, individuals and families brings me an ever-deepening awe of the experience of being human over the course of the lifecycle. I remain passionately and continuously engaged in not only what contributes to healthy childbirth, but also what contributes to making healthy families. After all, childbirth is only the beginning. It does pay to have a good start as this beginning forms the foundation for the future family relationships. Still, much is known about what makes for dysfunction in childbirth and in family relationships. What my focus and passion has been for the past 30 years is what contributes to healthy family relationships.

What are some keys to keeping families healthy?

Family processes that promote connection over disconnection are key to healthy relationships. These vary widely, but for example...

family rituals and gatherings that keep family members coming back for more over the years; raising and relating to your teenagers in ways that allow them to begin to pull away and separate, yet remain connected; problem-solving conflict that allows for anger to be expressed in a relationship and resentments aired, without withdrawing love; communicating more (much more!) positive appreciations (1-5 ratio) to negative or neutral interactions; learning how to recognize your partner's "bid for connection" and responding instead of ignoring it; learning to express anger without attacking - recognizing your own "discussion-busters," that is, what shuts down a discussion rather than gestates it.....and, of course being willing to look at your own family-of-origin and especially your parents' relationship with an eye toward incorporating the good but leaving behind what does not work.

Gayle Peterson, LCSW, PhD, can be reached at (530) 346-2534 or www.makinghealthyfamilies.com. Dr. Gayle is offering a certification training program next spring for childbirth professionals in Prenatal Counseling and Body-Centered Hypnosis for Childbirth.

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Suzie Daggett is the publisher of the INSIGHT Directory of Healing Arts Practitioners; 530-265-9255, http://www.insightdirectory.com.

One Size Does Not Fit All

Hypnobirthing is a method, like LaMaze, that is based on Grantley Dick Read's premise that fear of labor pain, alone, causes tension in childbirth. The circular and simplistic belief is that pain is caused by tension, based on fear of childbirth, which can be totally eradicated by banishing the belief that labor involves pain of any kind. The use of hypnosis in this context is to dissociate from the belief that labor is painful. The term, "Hypnobirthing" is misleading as it refers only to the use of hypnosis in the context of this belief. Hypnosis for this purpose has been studied and proven unsuccessful for most women. Hypnosis can, however, greatly assist women in their adaptation and coping with labor, when adapted to their specific needs. Women should not be slotted into "one size fits all" methods.

Dick Read's approach was not a scientific one and represents an overly simplistic application of neurophysiology. In the first place, tension is not only related to the fear of pain in childbirth, but to many other factors which may impinge upon women at the time of her transition into motherhood. Childbirth is only a bridge to a great and underestimated transition in a woman's life and identity. Tension around many factors, not labor alone, may cause difficulties, depending on how a woman processes this transition.

Specifically, the tension-relaxation response is mediated by the hippocampus in the brain, which affects the production of labor hormones. A woman's tension-relaxation response relates to the difference between her expectations and reality, not to the presence or absence of pain. A woman can experience pain and still experience physiological release between contractions. Body-centered hypnosis aimed at addressing a woman's unique concerns about her labor and transition to motherhood, statistically decreases the need for medication, even in those few cases in which interventions, such as pitocin, are necessary.

I use body-centered hypnosis to decrease tension about labor and birth and to resolve fears about the upcoming psychological transition to motherhood. This hypnosis is unique to each woman and is not a mass produced method. I support the individual woman in her process. It is not my goal that childbirth should be a certain way, natural or not, painful or not. Instead, my hope is to support the woman where she is in the context of her family history and culture. The result of this kind of support can be empowerment.

An authentic approach to childbirth must forego ideas about how women *should* birth, and embrace, instead, a woman's own desires. No method should dictate a woman's experience or pressure her to believe based on another's perspective. Instead it should be flexible enough to meet her individual needs and support her growth.

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Healing Journeys: Birth experience more than just having a baby

By Suzie Daggett
» More from Suzie Daggett
12:01 a.m. PT Nov 24, 2006


Gayle Peterson

Gayle Peterson, Ph.D., LCSW is a parenting and family resource expert with a research eye toward making healthy families. She was on NBC Today's show in July and has authored several books, articles and tapes. Her interest in families started with her own, and continues to this day. If you are a new parent, grandparent, or stepparent, a visit to her award winning Web site can enlighten you with ways to keep your families' relationships - child to parent or parent to parent, healthy!

The birth of your first child started you on the path of becoming an expert in childbirth, parenting and creating healthy family relationships - what were the circumstances?

When I became pregnant with my first child in1972, I instinctually decided to give birth at home. However, I had heard of no one who was giving birth at home. Fortunately, I discovered the Santa Cruz Birth Center, run by a lay midwife, Kate Bowland. The prenatal care I received from The Center embraced my past, present and future in becoming a mother. Prenatal care consisted of not only learning and participating in my own medical care, but a deep and caring exploration over the months of the psychological nature of my relationship with my own mother and the feelings I had about becoming a mother and giving birth. These midwives understood that the psychological task of pregnancy is giving birth to the identity of mother. Becoming a mother is a life transition that our culture greatly underestimates. Few other life changes are as irreversible and few life events provoke as much ambivalence. I know of no other life event that simultaneously stimulates two powerfully divergent fantasies: the promise of ultimate fulfillment and the threat of selfless sacrifice. The impending birth of my first child brought me face-to-face with myself on an entirely new journey, fraught with excitement and fear.

You have created the Peterson Method to help women prepare for childbirth and becoming a mother - please explain.

I became deeply involved in research on the safety of homebirth and the psychological nature of childbirth. My infant daughter and I visited women in their homes in the weeks before and following their childbirth.

These research interviews expanded and highlighted the nature of pregnancy and the importance of including a woman's psychological process in giving birth and becoming a mother.

The research showed that women giving birth experienced a smoother labor and postpartum when they were able to process the psychological nature of their individual experience of pregnancy and childbirth.

What was found? *How a woman feels about her experience matters and has far reaching effects on her development as a woman, her confidence in mothering and her ability to bond with her child.*

Through this research, further education and years of clinical experience working with women giving birth, I developed a **Preventative Prenatal Counseling Program** to augment the traditional medical care a woman receives from her doctor or midwife. Using this model woman benefit from the approach I was fortunate to receive during my pregnancy. My book, ***An Easier Childbirth*** is an outgrowth of this work and offers women a workbook to explore the significant emotional growth of this period and helps to ready them for childbirth, whether it be a natural, home, hospital or medicated delivery. A personalized visualization script offers women the opportunity to create a body-centered hypnosis tape, which is one of the cornerstones of my **Prenatal Counseling Model**.

3. What do you get out of the work you do?

My work with couples, individuals and families brings me an ever-deepening awe of the experience of being human over the course of the life cycle. Over the next 3 decades since becoming a mother, I have remained passionately and continuously engaged in not only what contributes to healthy childbirth, but also what contributes to ***making healthy families.*** After all, childbirth is only the beginning. It does pay to have a good start as this beginning forms the foundation for the future family relationships. Still, much is known about what makes for ***dys***function in childbirth and in family relationships. What my focus and passion has been for the past 30 years is ***what contributes to healthy family relationships.*** **(**Or just healthy human relationships!) The process of how people connect and disconnect continues to fascinate me. Identifying these processes *in vitro* as they emerge interactively in counseling/therapy satisfies not only my analytic mind but my creativity as well. I find I need both a challenging intellectual and creative emotional outlet to engage my mind, heart and body in the process. As a past serious student of Dance, I find this kind of work an important integration of body and mind, particularly the body-centered hypnosis work with pregnant women..

4. What are some keys to keeping families healthy?

Family processes that promote connection over disconnection are key to healthy relationships. These vary widely, but for example…family rituals and gatherings that keep family members coming back for more over the years, raising and relating to your teenagers in ways that allow them to begin to pull away and separate, yet remain connected, problem-solving conflict that allows for anger to be expressed in a relationship and resentments aired, without withdrawing love, communicating more (much more!) positive appreciations (1-5 ratio) to negative or neutral interactions, learning how to recognize your partner's "bid for connection" and responding instead of ignoring it, learning to express anger without attacking, **recognizing your own "discussion-busters",** that is what shuts down a discussion rather than gestates it …..and of course being willing to look at your own family-of-origin and especially your parents' relationship with an eye towards incorporating the good but leaving behind what does not work. (Learn more about developing healthy strategies for change using the free online family seminars at www.makinghealthyfamilies.com)

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An authentic approach to childbirth must forego ideas about how women *should* birth, and embrace, instead, a woman's own desires. No method should dictate a woman's experience or pressure her to believe based on another's perspective. Instead it should be flexible enough to meet her individual needs and support her growth.

Lastly, we should keep in mind that any method is only as good as its failures. Exploring the failures of "hypnobirthing" will yield valuable insight into what is missing for women, rather than interpret their failures as not living up to the model requiring one right way to "succeed" at childbirth.

Gayle Peterson, PhD
Gayle Peterson's doctoral research and dissertation was on "Body Centered Hypnosis for Childbirth". She is the author of "An Easier Childbirth", Birthing Normally" and her latest book, "Making Healthy Families". She is in private practice in Oakland and Nevada City, California and can be found on her site: www.makinghealthyfamilies.com

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#3

THE META-MODEL

The meta-model was developed by John Grinder and Richard Bandler to identify classes of natural language patterns as a means to help increase the flow of information between human beings. The basic premise is that words (surface structure) are meaningful only in that they anchor in an individual some sensory representation (deep structure). During the codification of sensory experience into words (as an individual speaks) and the process of decoding (as a second individual listens and transforms the auditory stimulus into his/her own sensory representation) important information can be lost or distorted. Deletions and distortions of experience may also occur within an individual as he/she codes sensory experiences.

The meta-model provides an identification of linguistic patterns which could become problematic in the course of communication and a series of responses through which two individuals may use to insure more complete communication. Attention to non-verbal gestures and behavior and to context will also greatly enhance the unambiguous transference of information.

I. Gathering Information

A. Deletions

1. Simple Deletion: when some object, person or event (noun phrases or noun arguments) have been left out of the surface structure.
   eg. I'm really uncomfortable.
   response: Uncomfortable about what specifically?
2. Lack of Referential Index: when an object or person (noun) that is being refered to is unspecific.
   eg. a) They never believe me. Response: Who specifically never believes you?
   b) That doesn't matter. Response: What specifically doesn't matter
3. Comparatives Deletion: when a referent is deleted during a comparison (ie., good-better-best; more-less; most-least).
   eg. Its better not to force the issue.
   response: Better for who? compared to what?

B. Unspecified Verbs: verbs which are not entirely explicit where sometimes the action needs to be made more specific.
   eg. He really frustrates me.
   response: Frustrates you how specifically?

C. Nominalizations: when an ongoing process is represented as a static entity in a way which may distort its meaning.
   eg. I can't stand her insensitivity.
   response: Her sensing what about whom; and how specifically?

II. Limitations to an Individual's Model

A. Presuppositions: when something is implicitly assumed in the other person's communication which may, if taken for granted, cause limitations to a persons choices about the experience.
   eg. If you knew how much I suffered, you wouldn't act this way.
   There are three presuppositions in this statement: 1) I suffer 2) you act this way and 3) you don't know.
   response: 1) How specifically are you suffering? 2) How specifically am I acting? 3) How do you know that I don't know?

NOTE: There are a large number of different types of presuppositions that can be identified. For a listing see The Structure of Magic by Richard Bandler & John Grinder.

B. Modal Operators of Possibility and Necessity: statements identifying rules about or limits to an individual's behavior. (ie., possibility = can/can't, it's possible/impossible, will/won't, may/may not; necessity = should/shouldn't, must/must not, have to, etc.)
eg. 1) possibility: I can't relax. response: What stops you?
2) necessity: I shouldn't let anyone know how I feel about that.
response: What would happen if you did?

C. Complex Equivalence: when two experiences or events come to stand for each other but may not necessarily be synonymous.
eg. She's always yelling at me ...She hates me.
Response: Does yer yelling at you always mean that she hates you? Have you ever yelled at anyone that you didn't hate?

III. Semantic Ill-Formedness

A. Cause-Effect: when an individual makes a causal linkage between their their experience or response to some outside stimulus that is not necessarily directly connected, or where the connection is not clear.
eg. This lecture makes me bored.
Response: How specifically does it make you bored?

B. Mind-Reading: when an individual claims to know what another individual is thinking without having received any specific communications.from the second individual.
eg. Henry never considers my feelings.
Response: How do you know that Henry never considers your feelings?

C. Lost Performative: Statements and judgements that an individual considers to be true about the world which may be generalizations based on the individual's own experience. (Lost performatives are characterized by words like: good, bad, crazy, sick, right, wrong, true, false, etc.)
eg. Its bad to be inconsistent about what you think.
Response: Bad for whom? How do you know that it is bad to be inconsistent?

D. Universal Quantifiers: Words which generalize a few experiences to a whole class of experience; (characterized by words like: all, every, always, never, etc.)
eg. She never listens to me.
Response: She never listens to you? How do you know that she never listens listens to you?

	EXAMPLES	NAME OF VIOLATION	CHALLENGE	MATERIAL RECOVERED
Gathering Information	He's grateful I'm scared I'm angry	Deletion	What, Who	Deleted Material
	They, we, everyone, some people.	Lack of referential index	What, Who	Specify Referential Index
	Upsets, hurts, gives, loves, does.	Unspecified Verbs	How, specifically	Specified Verb Complex Equivalence
	Frustration, depression, happiness, confusion.	Nominalization	How, specifically	Specified Verb Complex Equivalents
Limits to the Speakers model	All, everyone, everything, always.	Universal Quantifier	Exaggeration "Has there ever been..."	Counter-example Subjectively perceived consequences
	Can't, should, must, ought, necessary, couldn't.	Modal Operators (Possibility and necessitly)	What stops you "What would happen if..."	Meta- outcome Projected effect
Semantic Ill-Formedness	The devil made me do it. She makes me mad.	Cause/Effect	how, specifically x cause y	Subjectively Identified Cause
	I know what you're thinking. I know you don't like me.	Mind Reading	how, specifically "how do you know.."	Complex Equivalent
	All girls should behave properly.	Lost Performative	According to whom	Deleted Performer

Ex. in 2's or 3's

GATHERING INFORMATION

1)

DELETION

1) I don't understand.
response: You don't understand what?

2) I don't like my doctor.
response: What don't you like about him?

3) I'm afraid.
response: Whom or what are you afraid of?

4) He's the best.
response: He s the best what?

5) He's the best doctor.
response: He's the best doctor amongst whom?

6) I had a wonderful birth.
response: What was wonderful about your birth?

7) I had a terrible forceps delivery with my first child.
response: What was terrible about it for you?

8) I had a hard time with the pain in labor.
response: How was it hard for you?

2)

LACK OF REFERENTIAL INDEX

1) No one seems to care about the baby.
response: Who, specifically doesn't care about the baby?

2) They are insensitive.
response: Who, specifically is insensitive?

3) It was hard.
response: What specifically was hard for you?

3)

UNSPECIFIED VERBS

1) He hurt me.
response: How, specifically did he hurt you?

2) They ignored me.
response: How specifically did they ignore you?

3) The children force me to punish them.
response: How, specifically do they force you to punish them?

4) I tried to remain calm during contractions.
response: How specifically did you try to remain calm?

4)

NOMINALIZATIONS

1) I don't get any appreciation.
response: How would you like to be appreciated?

2)Pay attention.
response: What would you like me to attend to?

3) I regret my decision.
response: Does anything stop you from re-deciding?

4)I want help from him.
response: How,specifically do you want to be helped by him?

5)I want support from my husband during labor.
response: How do you want your husband to support you?

6)I want understanding from the people attending my birth.
response: What do you want people to understand about you?

Limiters-ways we limit our intake of information in the world
Represent our beliefs...

1) UNIVERSAL QUANTIFIERS

1)I never do anything right.
response: You absolutely nver do anything right?
or Have you ever done anything right?

2)You're always lying to me.
response:I'm always lying to you?

3)It's impossible to get what I want.
response: Have you ever gotten what you want?

4)My husband never listens to what I say.
response: He never listens to anything you say?

2) MODAL OPERATORS OF NECCESSITY

1)I can't do it.
response:What stops you?

2)I have to have my husband with me in labor.
response:What would happen if he wasn't there?

3)I have to take care of my mother's feelings.
response: What would happen if you didn't take care of your mother's feelings?

4)I can't tell him the truth.
response: What will happen if you do?
or What stops you from telling him the truth?

5)I can't change doctors now.
response: What stops you?

6)I must have my daughter present at the birth.
response:What would happen if she wasn't there?

Semantically ill-formed statements

1) CAUSE AND EFFECT / represents rules, beliefs, or suppressed feeling.

1)Your tone of voice bothers me.
How does my tone of voice bother you?

2)He makes me angry.
How is it possible for him to anger you?

3)I'm sad because you're late.
How does my being late make you feel sad?

4)His ideas annoy me.
How does his ideas annoy you?or
How does his ideas make you feel annoyed?

5)My doctor's manner made me feel horrible during my last pregnancy.
How did his manner make you feel horrible?

6)My wife's anger made me feel inadequate.
How did your wife's anger make you feel inadequate?

2) MIND READING / may represent false conclusions

1) Everybody thought I was taking too much time.
How,specifically do you know they thought this?

2)I know what is best for her.
How,specifically do you know what is best for her?

3)He knows what I will need in labor.
How specifically does he know what you will need?

4)My mother will know what to do in the case of an emergency.
What makes you think that she will know what to do in an emergency?

3) LOST PERFORMATIVE / Represents beliefs, rules

1)It's wrong for a baby to cry.
It's wrong for whose baby to cry?

2)This is the right way to cope with labor.
This is the right way for whom to cope with labor?

3)That's a sick thing to do.
Sick for whom?

4)Homebirth is the best kind of delivery.
The best kind of delivery for who?

5)Underwater birth is easier.
Easier for whom?

directions:
Fill in the blank with a true response for yourself. Tkry to make it a meaningful statement about something in your life right now, or in the past. State the sentence to your partner. Your partner is to ask you questions to derive deeper experience based on the meta model just described.

1. I don't like_____.

2.I get really angry when_____.

3.People don't understand me when_____.

4.I wish I were better at_____.

5.I wish my (girlfriend, boyfriend,husband,wife) would_____.

6.I really appreciate my mother's way of _____.

7.It is confusing to me when_____.

8. If someone really loved me they would _____.

9.I'm really scared of _____.

10. I'm very excited about _____.

never again held or stroked by her mother. Lily was so amazed at the clarity and detail of her image that she sketched it out and took it to her mother, who was mystified, since Lily was showing her exact and detailed sketches of a house that they had lived in only until Lily was two years old.

SECTION 3
Equivalence in Sub-Modalities: Synesthesia

We usually consider that each of our various sensory systems holds reign over unique domains of experience. It is more correct, however, to say that each of our senses is capable of discriminating particular domains of *environmental stimuli.* Each of the senses of vision, audition, kinesthesis, and olfaction monitor different types of environmental stimuli, but *organize that information into similar classes of experience.* These organizational classes are what we are calling the sub-modalities. The representational systems, then, are unique in terms of the environmental stimuli they monitor, but in most cases are equivalent in the perceptual distinctions they are capable of making. For example, all four of the representational systems (vision, audition, kinesthesis, and olfaction) are capable of providing information in the sub-modal classes of "location" and "intensity." If we can specify in what ways the sub-modalities of the representaional systems are equivalent and where they "cross-over," we will be in a position to generate strategies for change at the sub-modal level (which, as we have seen, is the level at which change actually occurs anyway.)

Following is a chart of the sub-modality equivalences which have come out of the research reported in the appendix.

VISION	AUDITION	KINESTHESIS	OLFACTION[7]
color	pitch	temperature	fragrance
brightness	loudness	pressure	concentration
saturation	timbre	texture	essence
shape	patterning	form	—
location	location	location	location

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Chapter Six

Multi-Modality Visualization and Techniques of Indirect Hypnosis

This chapter focuses on the use of multi-sensory experience (transmitted through memory) to aid in developing and facilitating resources for labor, birth and parenting. The term "visualization" has been used in the past to describe a process which engages internal visual imagery for learning, or for resolving painful emotional experience. However, "visualization" does not adequately describe the process that we have been using with great success in the perinatal period.

Much of the literature describing visualization has popularized the term, but has not further defined it beyond the visual. "Visualization" is misleading for our purposes, as it implies an emphasis on the visual sensory modality, ignoring the significance of the somesthetic and auditory cortices of the brain, which include the other four sensory channels — hearing, smelling, tasting, touching. It is symptomatic of our visually dominant culture to describe all such internal experience, or fantasy, as "visualization." If the internally generated experience is represented in *only* the visual cortex (imagery), we fall short of the impact of

emotional learning and the experiential quality of what multi-sensory internal experience can offer.

Secondary Cortices of the Brain; the Limbic System and Memory

The limbic system, considered a part of the "old" brain, is intricately connected and related to biological interpretation of emotional experience. It is this area of the brain that regulates hormonal flow through the hypothalamus which activates or inhibits hormone release from the pituitary. Pregnancy and birth processes depend upon the maternal flow of hormonal release from the pituitary to ensure both maintenance of the pregnancy and labor contractions to bring forth the life within. The limbic system is also connected through the hippocampus to the secondary visual, auditory, and somesthetic cortices which are utilized in long term memory storage.

For our purposes, the point of significance of the brain's regulation of emotion through the limbic system is the experiential data stored in secondary cortices of the brain. Memory is created in a highly charged emotional experience, due to a registering of significance through the limbic system of the brain. Because the experience of a personal event is unexpected, out of the ordinary (as in an emotionally defined traumatic experience) it is transferred electrochemically (acetylcholine is the neuro-transmitter) through the hippocampus which acts as a bridge between the limbic system and long term memory storage.[88]

If events are not perceived as carrying value or significance to the individual, the data is kept approximately seven hours in short term memory, never to be encoded in long term memory storage.

An example will serve to illustrate the significance of emotional intent in the creation of memory. Think of all the dinners you have prepared for yourself or your family. Because the dinners may amount to hundreds, without particular individual significance, you will remember only those that carried some emotional significance to you, either pleasant *or* unpleasant. If, for example, during one evening of making dinner, a grease fire was started, that dinner would be remembered, while others blend together with little, it any, differentiation. Likewise, a particularly satisfying, successful dinner might also be recorded in long term memory due to its emotional significance.

As events are re-lived, or remembered, the secondary cortices of the brain are utilized for re-experiencing the event. Without the involvement of the secondary cortices, memory cannot be re-lived by the individual. These encoded memories of significance form the screen through which the present is experienced. The individual begins to create expectations for the future based upon perception of past experiences.

By involving the secondary cortices in formulation of "new experience" in the visualization session, memory is formed. Memory of significant emotional events can be encoded in the multi-modality visualization through symbolic experience involving the participation of the limbic system with electrochemical transmittance to the secondary cortices. "New experience" is that which is experienced anew, and can be either "real" experience, generated from the outside, or "internal" experience, generated from such a process as multi-modality visualization.

The term "multi-sensory visualization" more accurately describes the work that we do with pregnant women in a holistic context. It involves the creation of memory which can be accessed during labor. Multi-sensory means the creation of memory involving experience in all (or most) sensory channels through the secondary (memory) cortices. Multi-sensory visualization should serve to engage all three secondary cortices of the brain (visual, auditory and somesthetic). The somesthetic cortex may be activated through one or more of the sensory channels it encompasses — taste, smell, touch, hearing, or vision. The greater the involvement of all sensory channels, the fuller and deeper the experience. However minimally, all secondary cortices of the brain must be included to justify use of the term, "multi-sensory."

Multi-sensory visualization for birth serves to offer a normal birthing experience which becomes embedded in memory. A multi-sensory visualization offers choice of response on an emotional level, for the woman giving birth again, who has had a difficult or traumatic birth.

Emotional Learning

Behavioral psychologists theorize that learning takes place within an emotional context. A behavior may later be repeated so many times that it becomes generalized. The first time we learned to cross the street, for example, we are taught to carefully look both ways, and are impressed with the potential danger and importance of the task at hand. As we learn to cross the street

alone, without the presence of an adult, we replay, or access the emotional state of caution and care that we learned in order to complete the task of crossing the street safely. However, in time, we repeat the action of crossing a street so many times, and so many different streets, that our initial learning becomes *generalized* and the emotional impact falls away. When actions or learnings are repeated numerous times, learning theorists have observed that the repeated behavior becomes independent of the initial state in which it was learned.

The experience of labor and birth is not sufficiently repeated for the average woman of today, to become generalized. Therefore, the emotional state associated with past births may continue to be accessed during future labors. Women who adopt out babies and have unresolved guilt or grief associated with this past experience may find themselves having flashbacks to that prior birth during labor and delivery of their next child. Similar flashback type experiences can occur with other emotional states calling for attention during the next labor to heal or resolve past pain. When the associated feelings of a past birth involving stillbirth, miscarriage, abortion, or adoption are not expressed, guilt or grief emerges with increased likelihood during the next labor in order for the psyche to pursue its natural, healthy course of resolution. Such emotionally charged states can surface during pregnancy. Holistic intervention can serve to travel through and soften the charge of the previous experience. The following case example from *Birthing Normally* illustrates this possibility.

> Barbara was a twenty-eight year old woman planning a home delivery for her second pregnancy. Ten years earlier she had given birth to a baby which was adopted out. During the initial interview (a routine birth counselor interview included in the holistic prenatal program) Barbara was unable to recall any of that past birth experience. She seemed afraid of remembering the past, and spoke about this pregnancy and birth as her first. This was her husband's first baby. At seven months of pregnancy, Barbara was told that she might benefit from relaxation training to help her during birth. Her midwife suggested that the actual physical occurrence of labor and delivery could stimulate the currently unavailable memory of Barbara's past birth experience and that she might benefit from uncovering that memory before labor, and learning what that birth had been like for her.

> Barbara came for therapy sessions four times in the next six weeks. Because of the imminence of the birth, this timing (seven months gestation) was a perfect stimulus for motivating Barbara to participate in a healing relationship. As women enter late pregnancy, the potential energy of the building pressure of movement toward birth can catalyze emotional resources for which insufficient energy had previously existed. A sense of immediacy becomes increasingly dominant as the date of delivery nears. In this way timing can play an important role in facilitating needed psychological growth.
>
> During her first session, Barbara participated in reliving her birth of ten years before. In a relaxed state she was able to visualize and remember the labor, her feelings of shame and inadequacy, and her guilt about her son. As she relived the experience, she was able to create change in her visualization, to give herself the right to hold and touch her baby and to say good-bye to her son. She had not been able to hold, look, or talk to her son when his birth had occurred. Visualizing her son, she was able to feel the loss she had so long avoided. Her grief poured forth. As she became aware of her gift of life to him, she was able to move toward an acceptance of her actions and resolution of her guilt.
>
> In our second session, Barbara created a visualization of meeting her now ten year old son, knowing him, and finding herself unafraid of the truth of her motherhood. Barbara had previously been tense and afraid of the possibility of ever being sought out by her son. After her second session she was unafraid of this possibility. She felt she might welcome it, should it occur. She had now accepted her past. As she reclaimed that past, she experienced the beauty and strength of her first birth which could act as a resource for the coming labor and delivery.
>
> During her third session, Barbara's focus was on her present pregnancy and a visualization of the birth experience as it could be for her this time. The completion of a labor with the birth of the present baby which she would keep and mother was a fulfilling and exciting visualization experience for Barbara. She was

free of psychological guilt. Distrust of her body's association to her first childbirth was no longer a burden for her.

Barbara came for a fourth time with her husband, who had been experiencing performance anxiety about his role as "labor coach." A deeper understanding of his own coming identity as a father lessened his anxiety about the birth, and further cemented their commitment to one another and the family they were creating.

Barbara's first childbirth no longer remained hidden from her, but could be remembered in the present as a source of strength and confidence of having created life and given birth once before. Having accepted her loss and grieved for the necessary separation from her first child, Barbara could express her guilt and resolve her emotional pain before her next labor. She was free to validate herself as a woman giving birth for the second time. She had given birth once before, ten years ago. Her body could now guide her present child into her arms, as it had almost done years before. The present baby could now be accepted as a new individual who was hers to mother.

Through four counseling sessions during the last trimester of pregnancy, Barbara was able to transform past shame and failure into a present resource for birth and mothering. Anxiety about a possible meeting with her first child no longer plagued her as she became free to be the person she wished to be. She gave birth naturally to an eight and one-half pound baby boy at home, after four hours of active labor.

A multi-sensory birth visualization during her last session served to create an experience encoded in memory offering greater emotional choice to Barbara. With the added memory of the visualization experience, her first experience of birth was *no longer* her only emotional association to labor. After expression of grief and acceptance of her past, Barbara was able to allow herself to participate in a multi-sensory experience of labor and birth for her coming child. We can never (nor should we desire to) "wipe out" past experience as an accessible emotional state for a future labor. We can *offer choice* on an emotional level for another emotional state associated to labor and birth — that of a normal and healthy delivery in which she will keep her child. Multi-sensory

visualization for birth is the expansion of choice on an emotional level.

A normal multi-sensory visualization of birth includes techniques of indirect hypnosis and what has been popularized as "neuro-linguistic programming" (NLP).[89-91] However, the intent and philosophy for application is different than that of NLP. This difference is that birth cannot be programmed, as people are not computers. Human nature defies such reductionism in all forms, including the fields of psychology and medicine. The potential for human creativity far exceeds the concept of "programming," and does not explain the problem solving capacity of the human being, nor the phenomenon of pregnancy, the creation of life in physical form.

When we as holistic practitioners utilize multi-sensory visualization for increasing potential for problem resolution and normal delivery, we cannot lose sight of the fact that the power of birth is within the pregnant woman. All we can do is offer her choices of emotional states on which to depend during labor and birth.

Strong emotional associations to an experience of normal delivery provide an emotional context for the woman who has never given birth before. A powerful experience can result from a multi-sensory visualization for birth, beginning as a relaxation. A brief outline of this kind of experience useful for childbirth classes, is described in *Birthing Normally*.[55] As a woman enters labor, the birth visualization is designed to trigger emotional resources for dealing with the process, particularly in unmedicated situations. Developing resources for coping with pain in labor are also addressed in holistic childbirth classes.

Women who have not previously experienced childbirth quest for an emotional context to prepare for the unknown of birth. Since learning is dependent upon an emotional state, a woman preparing for her first labor will indeed find an emotional context in which to embed her learnings. A normal multi-sensory birth visualization can provide an inner image of birth offering an emotional or experiential context for preparation that is both realistic and reassuring. In addition, her birth visualization catalyzes personal resources for labor in the pregnant woman. Suggestions for adjustment and adaptation stimulate resources for dealing with the upcoming labor.

Emotional "flashbacks" can occur when we are re-presented with a situation already experienced as traumatic in the past. Birth is no exception. When faced with a subsequent birth, women commonly "flash back" to previous labor experiences. A

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labor immediately preceding the current one is usually prominent. If the previous labor was experienced as a positive, uplifting experience, "flashbacks" occur as commonly as when labor was experienced as deeply depressing and fearful. The woman experiencing flashbacks to a previously positive and exciting memory may not notice or label such flashbacks as they do not call up anxiety. Her reliance upon past experience to prepare and make sense of her current labor will be significant, and represents the same phenomenon as flashbacks identified as frightening or negative. We simply flash back to any associated past experience and will usually associate to that emotionally charged association which is the strongest. Flashbacks serve an emotional context reflecting a woman's resources for dealing with labor. A multi-sensory visualization for birth may also serve this purpose. During labor, many women report flashing back to the images and sensations used during a multi-sensory birth visualization. Several women have experienced repeating metaphors from the multi-sensory visualization which helped them in labor. These include "I knew the wave (contraction in an ocean metaphor) would always come to shore."

The multi-sensory experience of visualization can offer an effective means of linking an emotional state with learning and preparing for birth. This emotional context offers a sound foundation of confidence and security in the labor process for the woman expecting her first child. It also offers a viable alternative for experiencing increased confidence and security as an emotional state for the woman who has past traumatic or fearful labors. When emotions from past trauma have not been resolved, it is usually necessary to resolve the emotional rejection that so often ensues, before turning the attention to a birth visualization. Accepting the past "self" that gave birth renders a woman free to forgive herself. Connecting, reliving and healing past loss, whether it be the loss of a child or of self-esteem, yields a woman more access to her resources for coping with the upcoming labor. The experience of acceptance or healing reclaims parts of herself needed for her next labor (as with Barbara). The emotional work of forgiving forms an experience which becomes a strongly available choice for access or linkage during birth. We could even think of forgiving as transforming the past traumatic experience.

For many women, the experience of birth has been associated and inextricably linked with traumatic experience. Because emotion serves as the "glue" of human perception, traumatic memories can be triggered when the physiological state of labor is re-entered. If an experience of forgiveness has already occurred during visualization, the emotional association to forgiveness or acceptance will also be experienced in association with the physiological state of labor. Memory operates in this manner of emotional association, since creation of memory is dependent on an emotional context.

The following case from Claudia Panuthos' *Transformation Through Birth*[92] reflects the emotional work of integrating past parts of ourselves in life experience.

> Amy lost her daughter, Tara, two hours after birth. Amy had carried to full term and seemed to have a normal pregnancy. Tara was delivered vaginally after a seven hour labor. The delivery was very pleasing to Amy, since her son had been born by cesarean section.
>
> Tara had multiple birth defects, including a malformed, lower-intestinal septum. Joe, Amy's husband, immediately said he wanted to hold Tara, and encouraged Amy to do the same.
>
> In an act of absolute courage, Amy and Joe named their daughter, held her, and said good-bye to her. They did so against the advice of medical personnel, and they felt they had to fight to claim their child.
>
> After several months of grieving, they came to us because they felt a deep lack of peace and a painful hole in their lives. They both wanted children, yet felt they could not become pregnant again until they resolved their loss.
>
> We recalled the events of the pregnancy and birth and settled these so that both Amy and Joe could move on to full grieving of Tara. Then, we introduced the healing process derived from the Senoi ritual.
>
> We asked them each, in separate sessions, to see Tara as they remembered her, focusing her into view as best they could, and to let us know when they saw her. We then asked them to ask Tara from their hearts — not minds — if she wanted anything further. Amy said Tara wanted her, Amy, to forgive herself. Joe said Tara wanted nothing.
>
> We asked Amy if she would be willing to forgive herself. Amy replied that she would. We then asked each of them to ask Tara to take them to the source of

her power. Tara took each of them to the summer home where she had been conceived.

We then invited Amy and Joe, separately, to ask Tara for a gift — a gift that would represent her appreciation to them as loving parents and a sign of their eternal love. Each of them received a heart. Amy's came in the form of a gold locket. Joe's came in the form of a red valentine.

We then invited each of them to go out into the world and find these gifts, to bring them home, and to keep them as reminders of Tara and the eternal love between them.

We then asked each of them to let Tara know that they would be okay — so that if she, Tara, needed to move on anywhere, she would be free to do so. We reminded Amy and Joe that they would never forget or stop loving Tara, and added that if anyone ever encouraged them to do so, to reject this advice immediately. However, losing a child and suffering were very different, and we asked them to consider never suffering unnecessarily again — to welcome their sorrow and tears but never to suffer from self-criticism, or attempts at justifying, or anything else.

Last year Amy and Joe gave birth to a beautiful son, Matthew. They brought Tara's gifts to Matthew's birth and felt they acquired much self-confidence from her symbolic presence. They grieved and healed and allowed the birds of sorrow to pass without nesting in their hair.

We can never "get rid of" our past, as we can never deny our own past experience, feelings and actions. All that we have been must be accepted and integrated if we are to have fullest access to our resources for coping and problem-solving in the present. When clients speak of "getting rid of" an aspect of themselves, our job is to help them accept, or welcome that part of themselves and their past. Our task is to facilitate an integration which can recover important and necessary resources. As with Barbara, her past became a resource for her coming delivery, instead of a shame to be forgotten. For how could she ever forget?

Integrating that which we desire to reject in ourselves or our past deepens our resources for coping or problem-solving. We render ourselves more accessible to our capacity to accept and love ourselves as well as others. It is only natural that such an emotional state leaves us more resilient and able to solve and resolve challenges as they come up. A child is more secure, resourceful and capable of dealing with life when she has been raised with at least minimal consistency of love and caring. Research on autistic adults and children have long documented the absolute necessity of love for normal human development. Love and acceptance are not luxuries, but essential elements for life. Babies raised in institutions with little handling, have been observed to die for lack of loving care communicated by touch.[97]

To be self-generative adults, we must not only be able to love others, but also ourselves. The pregnant woman is no exception. As she grows a child within her, she must be given every opportunity to generate her own self-acceptance for any part of herself that has remained unacceptable, particularly in regard to past childbirth or mother-daughter relationships. Women who have lost their own mothers at an early age often experience rejection of themselves as mothers-to-be. Resolving grief, anger, and love from the past can free a woman to relearn a living concept of motherhood in her life.

Learning takes place in an emotional context. Emotional associations to past events can be relearned in an alternate context. Multi-sensory visualization is the creation of memory on a neurophysiological level which engages the limbic system. The use of multi-sensory visualization may provide an alternate emotional context for association at birth, and may also serve as a primary emotional background for the woman preparing for her first baby. Birth visualization in multi-sensory context simply provides for choice of emotional response to labor. Unlike other childbirth methods of preparation, a multi-sensory visualization must address emotional learning.

Didactic vs. Emotional Learning: The Search For an Emotional Context

Holistic prenatal care is oriented towards the emotional and experiential aspects of preparation that prove so meaningful in labor and delivery outcome. Didactic teaching is the usual western method. However, an emphasis on more "education" to the childbirth process, when done in only a didactic fashion,

ignores the emotional integration that is elemental to learning. Our society is so lacking in community and the experience of group sharing on a daily level, and so women are left with whatever emotional impressions about birth that they have picked up. Women have been left alone to fill in the emotional "glue" necessary to understand and prepare for childbirth in the prenatal setting. For some, this emotional context may be very conducive to normal birthing and fear may be minimal. For others, past experience or associations (mothers, sisters, friends) are called upon to fill in the emotional background, and fear may be the emotional candidate used for learning. In a holistic approach, we must respect a woman's need and search for an emotional context in which to embed her preparation for the unknown. Whenever we prepare for something of significance for which we have never before prepared, (as with a first baby), we search for an emotional understanding of what to expect. The emotional aspect of preparation is inevitable. It is not a choice. Therefore, we cannot offer a woman preparation in which we expect her to have "no expectations" for birth. Traveling through emotional preparation is recognized and encouraged in a holistic model and a multi-sensory visualization provides an opportunity for experiential learning of the birth process. It does not take the place, but occurs in addition to the didactic teaching that may take place with the aid of a birth atlas.[93] Multi-sensory birth visualization is the inner, experiential path of birth, while didactic presentation for the external eye is provided in the usual manner with diagrams and definitions of first, second, and third phases (stages) of labor.

In a basic, multi-sensory birth visualization we attempt to provide the potential for "flashbacks" of experience which may be utilized during labor. Suggestions for a woman's intimate and individual adaptation and adjustment to the process is also communicated during the multi-sensory visualization.

Flashbacks are experientially linked to the individual's past experience, and can come out of memory experience which was "real" or created within the context of the multi-sensory visualization or even the relationship between practitioner and client (especially true in psychotherapy relationships). The brain does not differentiate between "real" memory (that which happened in the "real" world) and memory that is generated internally (through multi-sensory visualization, dreams, etc.) in the manner in which it is encoded neurophysiologically in the brain. The person is aware, knows whether an occurrence is a "real" event or one experienced internally, but the emotional significance can be

equal, and both can be remembered. Like multi-sensory visualization, past "real" events no longer exist — are no longer happening, except in the experience of memory as the mind re-lives that emotionally encoded experience. Such is also the case with visualization.

The greater the practitioner's ability to engage all the sensory channels in the visualization the more experientially deep the process may become. As the visualization is experiential, it becomes a valid memory which can be utilized as a resource when that memory experience is activated during labor. Like any other flashback of a positive, normal experience, multi-sensory visualization memory can provide an emotional context in which to adapt to labor and birth.* It can provide a framework for faith and belief in the body process.

Birth is a doorway for the integration of body and mind. A woman's body encompasses her baby during pregnancy, and much work is being done to nourish and grow a child, but without the attention of the conscious mind. Everything happens automatically until birth when the process becomes "conscious-cized," and a woman must relate to her baby as consciously separate from her body. Once the baby is born, conscious thought determines when to pick the baby up, to feed, change, and dress the baby to protect it from cold. Birth constitutes the transition from intuitive mothering to conscious, deliberate mothering. Birth visualization aids in the development of trust and faith during this transition.

The advantage of using multi-sensory visualization for physical processes is that it becomes possible to identify emotional factors related to physicality. Emotional correlates to physical problems may be rendered more available for resolution when such resolution is needed. The use of multi-sensory visualization to explore the emotional associations to body experience can be invaluable for resolution of the presenting problem. Applied to pregnancy and birth, an exploratory visualization may be utilized as a tool for resolving complications of pregnancy. Multi-sensory visualization is a technique in the holistic model for prenatal care, which allows for an understanding of the emotional aspects which are a part of the woman's experience. A holistic model for prenatal care must include the emotional, as well as physical aspects of the woman, as important and meaningful. When using this method to explore the emotional correlates to the physical

* The reader is referred to Holistic Prenatal Care workshops offered by the authors for further experiential learning.

experience, the woman and her practitioner involve themselves in free discovery of internal experience. The following example can briefly represent the spirit of the exploratory nature of visualization for one particular woman experiencing a breech presentation.

> Martha came for relaxation and visualization after her midwife discovered that the baby had just turned to the breech presentation. During the visualization, Martha was asked to become her baby: to describe the baby's experience and perspective in the first person, such as "I'm now sitting upside down." She presented the real fear of the baby inside her, which was also the fear of the psychological baby of her own ego. She feared losing her husband through birth. Martha discovered that she felt she predominantly mothered her husband in their relationship together. She found that his son-like dependence upon her lent stability to their relationship. She had hoped for a shift of energy as the pregnancy developed so she would be receiving more of the "mothering" attention from him. She had expected to shift her mothering energy as the pregnancy became term, to redirect this "mothering" energy to her baby. She also discovered that this had not occurred. She had expected their roles to change, and that having a baby would cause her husband to switch into the "mothering" role for her, in this way affecting what she felt had been a needed change in the relationship for a long time. She felt her husband was withdrawing from nurturing her and simultaneously demanding more and more mothering attention from her. She expressed verbally that she wanted "a turn," "a change in the direction" of that energy.

Linguistically, people often speak in literal terms which have direct symbolic as well as literal meanings. Freud had discovered this long ago when he developed his method of "free association" in a reclining position. Carl Jung took Freud's discovery one step further in utilizing symbols as expressions of living, or "real" experience in his therapy with patients. Jung used "active" association, or dreaming, to change emotional experience and redirect the patient's energy towards self-acceptance. However, he also recognized the symbolic, verbal representation of his patients as very concrete and real experience. "Freudian slips" of the tongue have long been recognized as having meaning on a "sub"

conscious or intra-psychic level. Milton Erickson found that he could diagnose physical problems, and often did so, by listening to the linguistical choices his patients used to describe experiences of an emotional nature.[5-4] Erickson believed this phenomenon to be based on the fact that the patient has unconscious, or "body" knowledge that he/she is unaware of on a conscious level. We have found this to be true in pregnant women who intuitively "know" the sex of the baby, based upon the belief that their body "knows" such details. Although below her common awareness, inside herself and with her body's knowledge, she is either "making" a boy, or a girl. As a woman accepts the fact that her body "knows" the sex, it has been our experience that she may in fact get in touch with such body knowledge which is then spontaneously verbalized during the visualization process.

The Unconscious Construction of Language

The reader may now be asking the question, "But why should such information come out linguistically, on a verbal level?" The answer is that our *selection* of words is not consciously determined. We begin a sentence without knowing yet how it will be completed. Verbal expression may be started consciously, meaning the left hemisphere of the brain is involved, The choice of words to *describe* an experience emotionally are taken from the thought processes of the right hemisphere of the brain, formerly called the "unconscious" or "sub-conscious." As a culture we have emphasized the importance of left hemispheric thinking, (i.e. analytic logic, and reducing a whole to analyzable parts). As right hemisphere phenomena are recognized they have been labeled as "sub-conscious" or coming from the "sub-conscious." Yet no "sub-conscious" exists as an organ. There does exist a right hemisphere of the human brain which thinks in wholes, rather than parts, and synthesizes the feeling content of verbal expression.

"Freudian slips" were simply the right hemisphere's search for the correct linguistical representation for the feeling content of the patient's communication. Erickson identified language choice as involving knowledge beyond that of which the patient was aware. Erickson considered body knowledge part of the patient's knowledge as a human organism, below their conscious experience, but nonetheless available.

To complete sentences, talk, or express concepts, ideas, and experience through language, a person must "intuitively" or "unconsciously" select words that describe, and tonality and

phrases (pauses, variation in pitch, loudness) that express or represent, the internal experience. The right hemisphere of the brain is involved in choosing the tonality, phrasing, emphasis, and descriptive words of the communication. We do this automatically, using the right hemisphere to search our vocabulary for words and phrases which communicate feeling, while simultaneously utilizing the left hemisphere to identify the intent to begin and complete sentences about the phenomena being described. As children, we had to learn how to speak in complete sentences. The left hemisphere is involved in grammatical construction of sentences, which later becomes automatic as we utilize language. When children first talk, they speak in concepts represented by one word or one phrase, just as adults learning a new language will tend towards incorrect grammar, or incomplete sentences while the right hemisphere offers phrases (hand movements and non-verbal expression as well) or a significant single word in an attempt to describe something. As the left hemisphere learns new vocabulary and grammatical construction, the right hemisphere has more word choice from which to effectively communicate the emotional expression. Linguistically, it is the right hemisphere which chooses the words used, even as the left hemisphere completes the construction in grammar and sentence form. Oftentimes in multi-sensory visualization, a woman may be speaking in phrases, or incomplete sentences, as she speaks from a deep relaxation, using more the feeling (right hemisphere) part of the brain to communicate. This is often the case in dreams as well.

Jung recognized the value of "symbols" as communicating emotional significance in dreaming. The right hemisphere is the half of the brain involved in emotional feeling and association. It is also connected into the autonomic nervous system which helps to regulate the unconscious body workings, such as the beating of the heart, respiration, digestion, and other workings of the smooth muscles of the body. The involuntary, or autonomic nervous system is connected into the lower uterine segment as well.

We can begin to understand that there is much that we are not conscious of at any particular time. When engrossed in reading a book, we may be unaware (not conscious) of someone entering the room, or the hands on the dial of our watch. What can be accessed through the right hemisphere of the brain has long been labeled as "subconscious" or "subliminal." Perhaps it is time in the twentieth century to demystify ourselves from this shadowy and sometimes disturbed "subconscious" as we begin to recognize our culture's natural bias to left hemisphere thinking. Betty

Edwards writes beautifully of the bias our educational system has taken in its emphasis on analytic left hemisphere skills applied to areas of math and reading while ignoring the skills of the right hemisphere in spatial relationship of wholes and expression of emotional content.[96] As children, most of us have not developed right hemisphere skills and thinking. So, as adults, we find ourselves aware of "intuition" and "hunches" but having no idea where they originate! The thinking processes of the right hemisphere go unrecognized, and have been given a mysterious location called the "subconscious." There is more freedom (and less fear) in exploring that which is felt and expressed by the right hemisphere. It is no longer mysterious that we may "feel" in our bodies what may be occurring on the inside ("making" a boy or girl, etc.) and express that knowledge through the words chosen by the right hemisphere to communicate.

Betty Edwards was able to teach non-artists to draw, using exercises to develop the skills of the right hemisphere. Her exercises necessitated the participation of the right hemisphere on an experiential level, resulting in an amazing (to us, culturally) increase in her students' abilities to draw. What we have called "talent" is becoming recognized as skill which has fallen by the wayside as our educational system teaches mostly from a didactic, left hemisphere orientation.

As holistic practitioners, we too have come largely from a didactic educational background with little integration of left and right hemisphere thinking and skills. Our ability to perceive and think using input from the right hemisphere has often been ignored. Naturally, we use our right hemisphere on a daily basis — to talk, to feel, to write, to persuade, and even to communicate caring and love. But most practitioners of medicine do not know how to use right hemisphere thinking on a *conscious* level. Thus, we often refer to "hunches," and may rely on our intuition as well as professional training. We are limited without the development and utilization of the right hemisphere in our understanding and ability to identify the source of our "hunches." What contributes to "hunches" that are correct and to those not born out in physical reality as we know it?

In addition to being culturally non-dominant in right hemisphere thinking and application, we are a predominantly visual and kinesthetically oriented society. Logic of the twentieth century has followed that which can be *seen* on an external basis. Problem solving and resolution has been limited to some extent to the visual cortex of the brain. Role modeling has proved an

effective means of teaching in our society because of this heavy orientation to the visual modality for processing experience. The development of the auditory cortex has lagged. Utilizing what is *heard* as well as what can be seen is of vital importance in the clinical setting.

We cannot "see" a woman's experience, except with our inner eye, or secondary visual cortex, which must represent that which is *heard*. The accuracy of our *hearing* will determine our ability to accurately represent her experience to ourselves. To describe her experience of a multi-sensory visualization of her baby within her womb, a woman must use both right and left hemispheres to put that experience into the auditory realm of language. As we develop our capacity to hear, we can identify where our "hunches" come from, and begin to understand the relationship of linguistics to human experience and physical manifestation.

It is therefore not at all mysterious that Martha uses the phrases "a turn" or "change in direction" when describing her feelings about her relationship with her husband, discovering how she felt about the couples' dynamics in relation to her coming baby. Without having yet discussed her breech presentation, an acute listener (and experienced practitioner) would have been able to identify the *potential* for the baby having changed positions, much as Erickson listened to language and could identify probable diagnoses.

Many practitioners who tend toward an affiliation with a holistic philosophy can identify times when "hunches" experienced clinically were born out in actuality. Many midwives attribute "psychic" descriptions to such experience. However "psychic" such experiences may be, they are also logical and can be heard in linguistical representation of experience. Our task as holistic practitioners is to *make available* description of an experiential and emotional quality, such as is possible in a variety of ways, including multi-sensory visualization, for exploration of a physical problem. We cannot look for cause and effect, as that would presume that we know more than we do. As practitioners we must learn *not* to interpret a woman's experience, but simply to *explore* and *discover* the experiential nature of her pregnancy with her. This unassuming and open attitude is necessary, in exploratory visualization. A holistic practitioner does not presume knowledge, or proclaim the "cause" of a physical symptom, but simply explores and discovers at the same time as the client. Any pre-judgement will color and limit the practitioner's ability to be useful.

Skills of hearing and right hemisphere thinking must be developed, if the practitioner is to clearly trace and identify where such "hunches" and "intuition" have originated. As practitioners, we must be able to trace our "hunches" or conclusions to the client's linguistics to be accurate and not mistake our own internal experience as the client's. The more experienced a practitioner becomes, the more easily he/she can trace feelings to their correct source. In this way, we continually develop our capacity to think with the right hemisphere, as well as the left, to make clinical use of our feelings and apply them accurately.

As Martha talked about her need for a "change in direction" of the energy between her and her husband, she began to imagine an energetic reversal with her becoming the recipient of the nurturing energy she needed from him. Doing this, she became aware that it was *she* herself, lying on the couch in the room, who was giving herself that energy. She followed suggestions to contact an inner part of herself that could begin to give her the nurturing she needed to have the energy to mother her baby. She felt herself experiencing the nurturing she had been missing. She discovered that she had been waiting for this change in energy to come from outside herself, rather than searching for it within herself. The awareness Martha came to is sometimes all that is needed for the baby to turn head down. Body adjustment can occur as the mind becomes aware of conflict being expressed. Body tension comes from the work of hiding conflict from consciousness. If Martha is scared and is not supposed to know she's scared, and can hide these fears, her everyday life seems undisturbed. In peak experiences such as birth when the veil of such secrets lifts, body functions may break down as neuroregulatory systems struggle to handle and sort previously hidden emotions. Emotions provide the link between consciousness and body. Crying is a good emotional release, and helped Martha realize she could begin directing her energy inwards to her baby, and begin her long delayed nesting. Her body had known this need longer than was comfortable. As Martha began to redirect her mothering energy inward, she also increased (in her initial belief system) her risk of losing her husband. She became aware that either she could risk the loss of her husband (according to the unconscious family rules she was abiding by) or lose her experience of mothering. Her visualization provided a form of psychophysiological centering. Martha's husband was planning to be present at the birth. He was ambivalent in his desire for her to become a mother as her due date approached. When Martha stopped mothering him, and began paying attention to herself, he in turn began

to give her more of the nurturing and support she needed from him. Changing or re-balancing the family system needed to happen, but required facilitation from the therapist in the multisensory visualization experience to overcome the family inertia toward that change. The family system had insufficient resources to change its own patterns. An intermediary system of therapist and family was required to create change. Then the family could separate from therapist and continue its own unique path of growth.

The baby did turn back to vertex and Martha had a normal vaginal birth.

A similar situation occurred with another woman whose baby had turned to the breech position. Her family was having many financial and emotional problems. Other people were sleeping uninvited (by her) in their house. Catherine had become the recipient of much stress and tension. Two other children were eliciting behavior problems in association with the tension of the household. At the beginning of pregnancy Catherine had bled and had threatened miscarriage. Her midwife intuited that the family situation was not helping Catherine and referred her for therapy in her eighth month of pregnancy. Therapy continued until the day before labor began. Many feelings were expressed along with important life changes. Much relief was in the air in the last therapy session, when feelings of love and acceptance could finally come through between the marital partners. Later that evening the baby turned to vertex and was born the next day with a normal one hour and forty-five minute labor.

Women give birth in a style unique to how they live. How a woman handles crises and challenges arising during or before pregnancy gives clues as to how she and her body will handle birth. No birth can ever be predicted, but tendencies and trends can be identified. Multi-sensory visualization can provide opportunity for expression and exploration, as can other forms of family or individual counseling.

One woman referred by her midwife often worried intensely about events just before their occurrence. She realized, "You know, things always turn out real fine for me and I'm always surprised." Such a statement reflects an underlying biobehavioral tendency positive for birth in revealing that the objects of Charlotte's anxiety usually transform to gratifying events. Her experience of her anxiety, even in the form of worry, cannot be underestimated in its impact on problem resolution. Worry gives expression to anxiety which can end in rearranging perceptions of

the world and even plans for events, such as birth. Birth can be a positive and normal experience for her despite high levels of surface anxiety. Charlotte's work of worrying could be explored and perhaps identified as "fruitful" rather than merely compulsive or without benefit. Pregnancy and birth did not differ from other aspects of Charlotte's life in the sense that Charlotte is a person and will give birth in her own style. Women can make tremendous changes during labor. Visualization may facilitate changes and reorganization of perceptions before labor, thereby increasing the likelihood of normal birth. Early intervention is most preferable; however, some emotions are not easily surfaced before seven months pregnancy when birth is experienced as imminent to the woman. Some emotions do not surface until labor.

Utilizing Both Hemispheres of the Brain

Research on the functions and activities of the two hemispheres of the brain have revealed the right (in most people, although sometimes reversed) hemisphere to be attentive to wholes or gestalts, in terms of comprehension.[98-99] The right hemisphere participates in selection of tonality, and phrasing used in construction of verbal sentences, while the left hemisphere gives the content, or thought. The right hemisphere utilizes spatial relationship engaging in activities such as drawing and understanding the contextual framework involved in communication. The left hemisphere specializes in "taking things apart", or "breaking things down" (to components to analyze), while the right hemisphere is utilized to "put things back together", or to synthesize.

In today's society, we have become "left" hemisphere oriented, only because we have specialized in analytic thought and applied such thought to most fields of endeavor, even to the arts, in order to "perfect" technique. The right hemisphere, however, has been given recognition for "creativity" and the tide is turning as we now exist in a new age, a kind of renaissance of *holism*.

Holism comes from the old English, *hael*, to heal, or to *put together again*. In language, to convey meaning, or context to our messages, we must choose words, tonality, emphasis and phrasing to communicate. We engage our right hemisphere of the brain to choose the emphasis and words from a feeling context for the whole of what we are trying to say. Of course, we do not even need to think about it. Language construction becomes as unconscious or automatic as walking. Yet at one time we did not walk and had to learn, and we did not talk, except in phrases and

incomplete sentences. Before the left hemisphere comprehends grammatical construction and acquires an enlarged vocabulary, a young child is dependent upon the right hemisphere to communicate messages, using only phrases and tonality for emphasis. Very quickly the young child acquires language skills and vocabulary and becomes able to express tonality, phrasing, and emphasis (right hemisphere) while utilizing complete sentence structure and being able to choose from a more complete vocabulary (left hemisphere) to express him/herself.

Language is one of the most intimate expressions a person can use to represent personal experience to another human being. How a person synthesizes language to represent experience reflects the feelings and beliefs about that experience. The words chosen, the tonality and phrasing generated, in addition to non-verbal expressions (right hemisphere selection) all come together from a person's internal experience. The verbal expression is a very intimate representation of what is being felt (right hemisphere) and thought (left hemisphere) on the inside. It is one of the closest, most immediate and accessible symbols of the client's internal experience. Words actually *grow* out of internal thought and sensation for all of us, much like a painting grows from the artist's hand, or music from a musician.

We are all artists of our native tongue. As practitioners we can increase our sensitivity and auditory skills to better comprehend the beliefs and feelings of the pregnant woman as she describes her experience through language. Feelings, attitudes and beliefs are all part of the gestalt of human experience communicated through language.

Language: A Medium for Experience

We all use both hemispheres of our brains, particularly when we are enjoying ourselves. When we enjoy and indulge in music, we utilize the right hemisphere to participate in tonality change, or melody. Following the melody line along, we participate in the sensation of rhythm and rhythmic alterations (left hemisphere) providing a totalization of experience that can be very enjoyable. With both hemispheres immersed in experience, there is no "observer" or "ego." There is only experience.

Un-self-conscious experience results from integrating both hemispheres in the participation of the process whether it be music, art, or multi-modality visualization.

The practitioner utilizes language as the medium for creating experience in a multi-modality visualization process. In order to fully appreciate the multi-modality birth visualization included in the transcript of the next chapter, it is necessary to hear it, and be able to study in depth the nuances of tonality, phrasing, and linkages to suggestions that occur. An in depth study of this nature can begin at a workshop or seminar. However, the techniques for indirect hypnosis (suggestion) utilizing both hemispheres of the brain can prove effective in understanding the transcript of the birth visualization to follow. The following techniques of indirect hypnosis will be identified as they appear in the transcript.

Embedded Commands

Embedded commands are suggestions which take the form of phrases, or separate messages for the right hemisphere of the brain. These messages stand out because of pauses between words, changes in intonation (including volume, pitch, speed, and textural quality of the voice) or an ungrammatical use of language which creates confusion (to the left hemisphere) causing the message to stand out separately to the right hemisphere. Using a person's name can also serve to punctuate the sentence so that a part of it (a phrase) is emphasized as a separate message that is easily comprehended by the right hemisphere.

> Example: You don't have to . . . Mary, cry, . . . if you don't want to.

"Mary, cry," can be separated by (1) pauses in language, (2) change in volume or textural quality of voice or (3) use of the personal name, Mary, to break up the sentence. "Mary, cry," can stand out as a suggestion to the right hemisphere in one or all three ways.

Truism

A truism is a statement that the client accepts or believes to be true, followed by a suggestion, which is often secured by yet another truism that follows that suggestion. Because the left hemisphere is "satisfied" by truth or fact, it does not seek to question, analyze, or negate, leaving the right hemisphere free (without any self-talk) to accept the suggestion given.

Example: "With your next breath you can become aware of the fact that you are breathing oxygen right into your baby now, so that you might even imagine what it might look like on the inside of your womb, because you too were on the inside of a womb at one time, a different womb, but still you have been on the inside so that you can give yourself the right to imagine what it might look like on the inside of the womb right now, the placenta carrying oxygen through the cord right into your baby."

The suggestion to "give yourself the right to imagine what it might look like on the inside of the womb" is preceded by three truisms — that oxygen is coming into her body and into her baby, that she was once inside her mother, and that her womb is not the same womb as her mother's, but is a womb. The suggestion is followed by truisms of physiological validity, including the existence of a placenta, an umbilical cord, and the passage of oxygen into the baby. The left hemisphere is occupied with asserting (participating in) the validity of the truisms both before and after the suggestion, and so is less likely to interfere with the suggestion to the right hemisphere to create an experience (imagine) as an image of the inside of the womb. Women will usually be able to focus themselves internally, sometimes much to their amazement afterwards, when recalling the visualization experience.

Linkages or Couplings

Linkages are conditional statements which associate an action, behavior, or event with a suggestion. Linkages are usually best used in conjunction with a truism for distraction purposes, in satisfying the left hemisphere of the brain.

Example: "As you stand up and walk, the baby's head can come right down with the force of gravity and movement, and the cervix can continue to open."

"As you stand up and walk" is linked to the cervix opening, and secured with the truism that gravity will cause the baby to come down. The left hemisphere is likely to be occupied in one of two ways: (1) by tonal inflection of conditional statements (if this . . . then that) which have been and continue to be rewarded as true throughout life to some degree. Since childhood, we have learned that if (as) we turn a door handle in just the right manner, we can pull the door open. If we follow directions on a map, we are likely to find ourselves at our desired destination.

In addition, the linkage is secured by (2) occupying the left hemisphere with a "truism" about gravity, which is not likely to promote negation. The suggestion that the cervix can continue opening is more likely to be accepted, and entertained by the right hemisphere if the left hemisphere is engaged and so not in a position to reject the suggestion, or censor it.

Interspersal Technique

Interspersal is a technique of making certain words within a sentence or a paragraph, usually with volume, tonality, or textural changes in voice, stand out as a separate communication. Like other techniques of suggestion, it can be used in conjunction with other suggestive techniques. Interspersal is often layered between truisms and embedded suggestions.

Example: "You might think that you can't even *relax* into the discomfort of labor because you're not *into the pain* at all and I can understand that *of* and about you and *your labor.*"

The suggestion to "relax into the pain of your labor" is given within a larger sentence that occupies the left hemisphere of the brain. Rather than insist to a woman that she can deal with the pain of labor, she may be more able to accept the pain, as her left hemisphere is validated (and occupied) with the also very real validity of her fear. The message to "relax into the pain of your labor" is a separate communication through use of tonality, volume, or textural quality of the voice. Other forms of emphasis are also possible (non-verbal, body, facial expression) but are not mentioned here, as we are restricting our focus to increasing the use of voice and language for creating experience. This is especially reassuring for clients who close their eyes as they visualize, to represent internal experience.

Therapeutic Double-Bind

A therapeutic double-bind occupies the left hemisphere, involving it in deciding between several choices, each leading to participation in the given suggestion.

> Example: "You may find it more comfortable and easier to go deeper into the relaxation lying down on the floor, or sitting . . . whatever position is comfortable for you to go deeper into a relaxation, is fine."

The suggestion "to go deeper into a relaxation" gains the participation of the left hemisphere, as it becomes involved in choosing a position to relax into. Any chosen position presumes cooperation with the suggestion to relax. If the left hemisphere becomes occupied with choice of position, is is unlikely that it will be able to "talk" the right hemisphere out of the suggestion to relax, with such beliefs as, "but I'm not good at relaxing," or "I'm just too nervous a person to relax now in this setting," etc. As the left hemisphere is occupied, beliefs which might limit the experiencing of a relaxation are suspended, and the person is most likely to discover their own ability to relax, given the participation of both hemispheres in the process.

Metaphor

As with any of the previously mentioned techniques, metaphor utilizes embedded commands, truisms, linkages and double-binds in a variety of interconnected layerings of communication.

The beauty of the metaphor has long been recognized for healing purposes. Water imagery for healing and reducing pain has been with us from times past. One of the reasons for the effectiveness of the metaphor in suggestion relates to the metaphorical imagery acting as a kind of double-exposure to the actual process being described. Therefore, suggestions of all technical variety can be given about the metaphorical images that are true (the water falls cooling the rock) which occupy the left hemisphere and gain its participation, while the right hemisphere is free to accept the suggestions regarding the actual physical occurrence (soothing a burn by "cooling" it).

> Example: "You might even feel the contraction coming, surging like a wave building on the ocean, and it's building, and building, and building, and your baby's diving and diving and diving right down on the cervix, and you're breathing and breathing right through it, but then the wave comes to shore and you always know it will, the waves of the ocean always come to shore, and you rest and your baby rests, always sinking down, like the sand does, as the wave goes in, sinking, sinking down into the very bottom of the ocean, between each and every contraction, so safe and secure, because the waves always come to shore, always . . . ."

The suggestion for feelings of security and safety as the contraction builds, are believable in the context of the metaphorical ocean. Truisms about the ocean, "waves always come to shore," "sand sinks down to the bottom" occupy the left hemisphere in the context of the ocean, and leave the right hemisphere free to accept suggestions for feelings of security and confidence in the birthing process, as well as suggestions for sinking into a deep relaxation in between contractions.

Reframing

Reframing is a technique used to completely change the beliefs about a particular event or process, by describing it from a point of view which presumes different beliefs about that same process or interpretation. The result is often an "Aha" experience, as reframing suspends a person from their belief system, and temporarily engages them in a completely different experience of the world. Reframing can also be used to redefine a person's interpretation of an experience, in order to transform the experience from something "negative" into something that can be used as a resource for the future. In the case of Barbara described earlier, reframing took place as Barbara began to view her past experience of childbirth as a resource for future childbearing, rather than a shameful event to be hidden.

> Example: A woman comes in for her prenatal exam. She is one week from her due date. She puts her hands on her womb and wonders aloud about how hard it will be for her baby to leave the nice, warm walls of the womb and the security of this beautiful place.

The practitioner replies by "reminding" the mother that babies do grow out of the womb, even the security of the womb itself would be threatened for it to go on beyond exactly the right time for that baby (approximately 9 months) and besides, of course it gets a little crowded in there after awhile, and a baby wants, very much senses the biological need to come out of the womb, into its outer home, into her arms, the arms of the family to grow in.

The practitioner and woman might go on to talk of the woman's pregnancy coming to an end and her natural feelings about not being pregnant, but the reframing of birth, coming out of the womb as healthy (desired) for the baby, has already been addressed. Reframing served to introduce a belief (based on truisms and other forms of suggestion) that the baby did not necessarily find the womb as forever secure but that in fact, beyond a certain point, it became more secure to be on the outside. The security or "home" for the baby was reframed as becoming more desirable on the outside, in her arms, than on the inside of her body. Arms become the "home" for the baby, rather than the womb. In this way, a mother can be encouraged to abandon the view of her baby as "reluctant" during birth. The baby is therefore no longer "homeless" to be on the outside, for the definition of home has changed in anticipation for birth.

Synesthesia

Synesthesia refers to the mixing or synthesizing of two or more sensory modalities, resulting in an experiential quality to the phenomenon being described. Artists of all mediums have mixed sensory experience to create artistic expression. The artist's audience is able to participate in the experience of mixing visuals with somesthetic sensations. Some visual forms may even impart an auditory quality to the observer.

Poets are long time artists in the use of synesthesia, overlapping auditory phrases with visual imagery to create a somesthetic sensation or quality. Artists impart experience, as we all attempt to do in our daily communication with others, by mixing the visual, auditory, and somesthetic equivalencies. David Gordon, in his book *Therapeutic Metaphors*[100] delineates the following table of equivalencies in the various sensory modalities.

The word "synesthesia" comes from the latin, *syne,* meaning to mix and *sthesia,* meaning feeling or sensation. Synesthesia is the opposite of anesthesia, which means to take away, or separate

VISION	AUDITION	KINESTHESIS (SOMESTHESIS)	OLFACTION
color	**pitch**	**temperature**	**fragrance**
brightness	**loudness**	**pressure**	**concentration**
saturation	**timbre**	**texture**	**essence**
shape	**patterning**	**form**	---
location	**location**	**location**	**location**

out, feeling or sensation. While anesthesia deadens sensory experience, synesthesia heightens the experiential quality of the message being communicated by deepening the sensory involvement. Many readers may remember a form of synesthesia taught in high school English classes, onomatopeia, simply meaning that a word sounds like what it feels like, thereby crossing both the somesthetic and the auditory cortices of the brain. Words such as "slippery" or "slick" may impart the quality of sensation through an emphasis of the sounds of these two words as they are pronounced. Another example of synesthesia comes from Lewis Carroll's poem *Jabberwocky*.[101]

> 'Twas brillig, and the slithy toves
> Did gyre and gimble in the wabe:
> All mimsy were the borogroves,
> And the mome raths outgrabe.

The word "slithy," for instance, calls to mind many similar words evoking the sense of slithery or slimy or sliding. This is a form of synesthetic onomatopeia.

Synesthesia is utilized by all of us on a daily basis and is an element of our deepest experiences of joy and sorrow. The practitioner can utilize and expand on the naturally occurring synesthesia found in language to enhance the communication of the suggestions given in a visualization experience. Synesthesia allows the client to deepen his/her faith in the suggestions imparted. It also allows for changes in beliefs through altering or reframing the sensations of particular events and processes. Use of synesthesia will be noted when possible in the visualization transcript in the following chapter. All textural qualities of voice

and intonation represent the application of synesthesia. Some words are misspelled intentionally in the transcript to give the reader an indication of change in volume or vocal texture. Only the obvious variations will be visually marked in this manner (such as OOOpen). Nuances of synesthesia will be individual to the practitioner, and can only fully be appreciated on an audiotape.†

The Power of Suggestion

To understand the clinical usage of suggestion or indirect hypnosis, it is important to remember that no amount of suggestion or hypnosis will ever make a person do anything that they do not already want to do. Suggestion can be very effective in helping a woman give birth who fears motherhood or feels for some reason that she hasn't the resources to birth her baby. However, she does want to birth, even though she may have difficulty believing in herself.

Suggestion, or indirect hypnosis, whether used in context of multi-modality visualization or verbal interchange, can only serve that part of the person wanting or desiring a particular outcome. Without access to personal motivation, hypnosis is useless. Hypnosis simply serves to tie up the cerebral beliefs, fears, or criticisms of the left hemisphere, enabling the right hemisphere of the brain to experience that which the left hemisphere has inhibited but would like to experience. For example, a woman may feel that she is too "nervous" to relax effectively for natural childbirth. She does, however, wish that she could relax. She just does not believe in her ability to do so. It is her belief in herself that is lacking, not her motivation. Desires and wants reflect motivation, while beliefs may restrict or enhance a person's ability to attain that desire.

If the holistic practitioner is to engage the woman in a relaxation process that occupies her left hemisphere, thus suspending her ability to repeat her beliefs to herself (and censor participation in the suggestions to relax) then she may easily find herself attaining that state of relaxation desired. Hypnosis is the art of

† Audio cassettes (inquire about video cassettes) are available through Mindbody Press to demonstrate the authors at work utilizing these techniques for various problems. Popular tapes include vaginal birth after cesarean visualization, birth visualization, infertility visualization, and breech visualization.

suspending belief systems, so that a person may engage in that which they desire.

The holistic practitioner should understand that the power of suggestion always lies within the individual to accept such suggestion. Acceptance is possible only where there is motivation or desire for that suggestion to be realized.

We can never make a woman birth normally. We can, however, support her in believing in herself and facilitate her access to her own resources for birthing or mothering through the use of suggestion. The holistic practitioner remains ever aware that the power of actualization lies within the individual, and not with the practitioner. We can only be facilitators to the process.

Indirect hypnosis is always being used, without conscious awareness, by everyone who uses language to communicate. We often intuitively utilize truisms and tonal emphasis of the voice to help a woman through labor. We can increase our effectiveness as practitioners through a deeper study of the techniques of visualization and of indirect hypnosis, and through a constant attention to our intent and personal goals in helping to facilitate the normal birth process.

Chapter Seven

Applied Visualization

The following birth visualization and its discussion can further our understanding of the conscious utilization of language to create an experience to facilitate movement of the childbirth process towards normal outcome. The comments offered about this visualization can serve to bring together for the reader the concepts of the elements of suggestion, right and left hemisphere communication and use of the secondary cortices of the brain to create memory. The reader may be aware of many of the intuitive suggestions given in his or her own practice, without ever knowing the elements of what was being done. Language comes more or less naturally to all of us, with varying ease of expression. Linguistics serves as a prime source of human communication and internal experience. Multi-modality visualization provides a kind of poetry that we are all capable of mastering to varying degrees. Marks in the text will highlight information pertinent to the construction of the experience for the woman.

Birth Visualization

Celine is expecting her first baby and is eight months pregnant at the time of this visualization. She speaks about the births of friends and relatives who have had difficulty with their babies getting "stuck" in labor, or not starting labor and needing induction. She has come for relaxation preparation for labor and wants to prepare for something she has never done before.

This visualization represents a birth visualization of the type that can be used in classes. Suggestions given specifically for Celine will be identified. While techniques will be discussed, tonality and phrasing cannot be fully appreciated without the aid of an audio tape and further training in a seminar taught by the authors. Celine's birth will be discussed following the discussion of the birth visualization.

The following table for the identification of indirect hypnosis will be used in the transcript:

T = truism
E = embedded command
L = linkage
R = reframing
M = metaphor
D = double-bind

Pauses are designated by dots (. . .). Capitalization and phonetic spelling indicates emphasis in volume or other textural quality of voice tonality as noted.

Hypnotic techniques identified by no means represent a conclusive identification of technique, but serve as samples of what appears throughout the text on multiple levels. The reader can identify further technique for self-learning.

Celine's Birth Visualization

So just now, I'd like you to give yourself the right to just listen to your breathing, now, for a moment, so that you can just take that a little bit deeper by breathing right down . . . your body deeper and deeper down into the diaphram . . . and any sounds that you hear, **[R]** *you can just let them take you deeper* **[E]** *. . . into the relaxation . . . gradually, taking your own time . . . so that with your next breath . . . you can just begin to imagine breathing any tension out from your shoulders . . . right down through your arms to your elbows . . . and even deeper down to your arms,*

your wrists, and hands . . . and even right out your finger tips . . . . You just don't need any tension there right now **[T]** *. . . you can just begin . . . to relax, to let go* **[E]** *. . . so your arms don't have to do anything right now,* **[T]** *they can just be . . . supported . . . by the floor . . . so that with your next breath,* **[L]** *you're free . . . to go right down into your hips now, just beginning to breathe out any tension from the hips* **[E]** *. . . And you can just become aware of the fact that the hips, have actually moved outwards,* **[T]** *actually moved outwards in space, actually created a cradling space for the baby . . . created that cradle, from which you can actually . . . take the baby out of* **[E]** *. . . as it's nearly grown now* **[T]** *. . . And as you go into labor, there's a hormone that relaxes the cartilage, a hormone called relaxin,* **[T]** *. . . relaxes the cartilage, and even the bones, the bones connect so that it can OPEN.* **[E]** *. . . So that with your next breath you can go even deeper down into your thighs, and you might even give yourself the right to just BECOME AWARE* **[E]** *. . . to just become aware of, what the thighs might look like on the inside, the nerve network, the blood vessels,* **[T]** *and each nerve connects . . . at exactly the right place and at exactly the right time in the thigh without you even needing to think about it* **[T]** *. . . and the hormones that flow from the pituitary right down through the blood . . . are also another thing that you don't even need to think about.* **[T]** *It's much like the pituitary gland of the baby that releases the hormone, that releases the oxytocin from your pituitary gland to start labor* **[T]** *. . . and each nerve connects to exactly the right part of you, without you even needing to think about it.* **[T]**

Comments

The relaxation process is begun, utilizing many truisms to gain the participation (and trust) of the left hemisphere, so that Celine is free to experience the suggestions to relax (embedded commands) and participate in them through linkages to her breathing. The relaxation induction is a most important part of the visualization as the entire birth visualization will draw on the suggestions that will be experienced in the relaxation induction.

I have just begun to address Celine's fear of labor not starting on time, by connecting the event of labor to her experience of nerve connections in the body, thereby building an experience of faith in the body which continues to be linked to labor as the visualization experience evolves.

It can happen incredibly fast . . . an impulse from your brain, can reach your toe in less that three hundredths of a second **[T]**. *It's an*

incredibly fast process [T] *. . . So that with your next breath, you can just begin . . . to continue breathing right down your knees, so that any sensation, or certain sensations that you might feel in your knees right now can just begin to build . . . and . . . Build . . . And . . . BUILD, until finally it's just breaking free, right down your legs, just washing right down through your ankles and feet, right out your toes, just like a dam breaking, and just washing down, into its natural places where it wants to go** *. . . in the mountains and streams, coming very, very peaceful . . . as the water's not dammed up anymore, it flows . . . right down . . . making it's way down to the source where the water might come from, down into the ocean . . . even . . . so that just now, your legs, too, can just begin . . . to relax . . . can just begin . . . to let go* [E] *. . . They don't need to walk anywhere* [T], *or hold up your body or anything . . . . They can just begin . . . to let go* [E] *. . . supported by the pillows* [T] *. . . so you can then feel free . . . to focus on your throat now . . . and the throat is a very important part of the body . . . and has a connection to the vagina in childbirth . . . so that you can just give yourself the right . . . now . . . to become aware of the fact that you're taking in the air that you need for yourself, for every cell in your body,* [T] *your baby, for labor, for birth,* [L] *and as you breathe out . . . just letting the throat open, a little more, and a little more, with each breath down . . . so it's almost as if the throat very gently responds by . . . yielding* [E] *. . . a little more . . . a little more to the air coming into the throat . . . . You might even imagine what that might actually look like on the inside . . . the actual cells of the throat . . . loosening . . . a little more, and a little more with each breath down . . . and out . . . down . . . and out . . . so that as you're breathing* [L], *each cell is getting all the oxygen it needs* [T], *which makes it . . . incredibly resilient and stretchy . . . you might have noticed that in the skin, that when your skin has the oxygen it needs, even from vitamin E, which increase oxygen absorption* [T], *that your skin is much more flexible, resilient . . . stretchy*† *. . . so that you can take yourself even deeper down now, into your chest . . . . following yourself deeper and deeper down into your body, without even needing to think about it . . . the air travels to places, to all places, in your body that need that oxygen,* [T] *even in this moment . . . all movements just releasing* [R] *. . . letting go, yielding . . . a little more, and a little more, with each breath* [L] *down . . . and out . . . down . . . and out . . . as you can just become aware that as you breathe in, you're . . . actually creating more space in*

* This refers to the waters breaking. The waters are reframed as bringing labor on, rather than not bringing it on as her friends have experienced.

† This refers to suggestions for flexibility and stretchability in the vagina. The throat serves as metaphor for the vagina, as the linkage between the two has already been made.

your body [T] *as you breathe in, your chest, your stomach rises, and falls* [T], *. . . rises and falls again . . . so that as you breathe in* [L], *you actually create more space on the inside of your body* [T], *more space for your heart, your lungs, for every internal organ in the body to find its natural, healthy position on the inside, always adjusting to find the healthiest place in the body at any given moment in time* [T] *. . . so as you go deeper down into the stomach, you're very aware of the stomach having done that throughout pregnancy . . . of having moved up and out of the way of the baby as it grows. . . . of having adjusted . . . to a higher space in the body for the baby to be made before it's pushed out . . . and before it dives out . . . the stomach is an incredibly flexible organ on the inside* [T] *. . . incredibly flexible . . . always adjusting . . . each part of it, finding exactly the right place that it needs to be . . . without your even needing to think about it . . . it's automatic . . . the same process takes place . . . the same for you that adjusts the stomach without you even needing to think about it . . . is the same part of you that adjusts the hormones . . . in the body in the labor process* [L], *pushing, as the baby dives out . . . so that with your next breath, you can just begin to take yourself down to your stomach now, just beginning to . . . BREATHE OUT any tension from the stomach* [E], *you just don't need it there anymore . . . so that you can just begin to . . . FEEL the stomach* [E], *kind of smoother . . . and smoother . . . and SEE it* [E] *. . . much like a very calm, peaceful, lake* [M] *. . . in which you might . . . skip a stone . . . and that stone might make circles outwards and outwards and OUTWARDS . . . creating more and more calm and inner peace, a kind of calmness you could almost HEAR . . . you could almost hear that calm . . .*

Comments

Further suggestions are made now, to strengthen the suggestion that labor will start spontaneously. Trust in the body process is being experienced as Celine experiences truisms about her body, which are linked to the labor process. Continued suggestion to experience the automatic processes of the body are given to build trust and belief in the body's abilities in labor. Celine is being guided towards indulging herself in the experience of many bodily workings, which are continually linked to labor. Seeing, hearing, and feeling are specifically mentioned now, in order to gain the participation of all of the secondary cortices of the brain.

. . . just letting yourself go, just as you did there (as she sighs) go with your body, it's so easy . . . It's almost as if you can't even resist it at all . . . . When those twinges come up, they happen, they're discharged [R] (referring to slight bodily twitches) *it's an adjustment on the inside,*

very much a deep, Deep, adjustment . . . organizing and reorganizing the resources, organizing in new ways and better ways, that's what the organs do . . . . So that with with your next breath you can take yourself even deeper down, right through the pelvis, and even deeper down through to the vagina, just beginning to BREATHE OUT any tension from the vagina **[E]**, *so that . . . it's as if you were breathing in through your throat* (as she inhales) . . . *and right OUT your vagina* (as she exhales) . . . ‡ *just go in through the throat, opening . . . and right OUT through the vagina* (as she exhales again) . . . *a very, clear OPEN* passageway . . . for learning, . . . for birth . . . and you might even begin, now to imagine, what your actual vagina does look like on the inside . . . the pink, resilient cells, full of oxygen, very, very stretchable now with the relaxin coming through . . . Very stretchable . . . just OOOpening, a little more, and a little more . . . with each breath OUTT, each breath OUTT and down . . . OOPening* (soft voice now) *from the inside OUTT* (soft and breathy) . . . *so that as you breathe, the oxygen goes to the Deepest, Deepest tissues first . . . and then SPREEAADS* (soft and breathy) *from the INside out . . .* † *SSPREADS out . . . like a ripple, in that water, in the lake . . . spreading out, SMOOOTHHING out, OOpening* (very soft voice) . . . *and your body always giving you what you need* **[R]** (referring to her movements, jerks) *to adjust, on the inside . . . adapting, always adapting. Your skin does that automatically, without you even needing to think about it* (said very quickly, lightly) *If it gets too hot, the pores open, and you begin to sweat . . . so that it keeps internal adjustment . . . perfect* **[T]** (pronounced with perfection, emphasizing consonants) *or when it's cold out, the pores then tighten* **[T]**, *so that . . . internal process is maintained perfectly* (consonant emphasis again) . . . *always adjusting on the inside . . . for the natural outcome, that the body wants . . . to maintain that temperature, inside of the body . . .*

Comments

Synesthesia through voice texture and tonality now increases in variety as the relaxation induction is nearly complete. Now in a deeper state of relaxation and participation in the visualization,

‡ I match my words to her breathing to engage her participation in the suggestions. This is a form of truism, matching her own bodily experience which she would accept as true.

* An example of synesthesia, using voice tonality and tempo to deepen the suggestion. This is one of many examples of synesthesia which the reader may identify throughout the transcript.

† The reader can recognize the truism present within the metaphor in this example.

Celine is free to experience resources within her body that are presently occurring (skin adaptation, etc.). These suggestions continue to reinforce confidence in the automatic workings of the body. I can now already begin to refer to past experience within the visualization itself, such as the "lake." The relaxation process continues to build on itself in this manner.

The "natural outcome that the body wants" is again referred to here, sandwiched between truisms. This suggestion calls on the part of herself that is motivated (desires) a natural, normal delivery.

NOW (little louder) *I'd like you just to go to a point on the back of your neck, and this time . . . just breathing right DOWN* (louder and deeper tonality) *your back . . . just SSLLIPING and SSLIDING right down each vertebra, and you . . . don't even need to think about it, as you go from the FIRRST* (long and drawn out, sounds like the voice is sliding, as tone lowers, slows, on particular words) *to the SSECOND* (tone is deeper, low, even sleepy) *one, even deeper down to the THIRRD one, there's more and more SPACE between each and every vertebra* **[T]** (return to more normal speed) *more and more space created between each and every vertebra, more and more SSPACE* (soft and breathy) *on the inside . . . So that as you relax* **[L]** *in this way, Celine, . . . you release to yourself . . . an INCREDIBLE amount of RESOURCES* **[E]** (sounds incredible in tonality) . . . *an inCREDIBLE* (softer) *amount . . . for the body . . . to Find it's own natural, healthy position on the inside* **[E].** *Each vertebra is always adjusting like that, just as you are now* **[R]** (rolling over on to her side) . . . *each vertebra is always adjusting on the inside, finding the perfect positioning . . . perfect positioning. Sometimes MOVING itself can be very, very relaxing* (referring to her change in position) . . . *much like when . . . you roll over in your sleep, without even thinking about it, and the minute you do, you roll over, you move around* (said very quickly, lightly) . . . *you fall into a DEEEPER sleep.* **[R]**‡

Your body knows how to do those things without you even needing to think about it **[T]**, *just trusting, always trusting it, as it does now . . . so that your breath just continues RIIGHT Down your back, slipping and sliding right Down towards the middle of your back, even deeper Down through to the lower back, as you breathe, you might even remember . . . what it's like to slide down . . . a slide* **[M]** . . . *when you were very*

‡ Reframing, or incorporating movement, or environmental sounds in the clinical setting can provide great impetus to deepening the suggestive experience. Whenever there are sounds, etc. that the practitioner might imagine could be disturbing, it is very beneficial to include them in a reframing process.

young perhaps even . . . coming to . . . a slide for the very first time you might imagine how you (said very quickly, with speed, light and high tonality) *walked up the ladder and how it's pretty scary 'cause you'd never done that before, you'd never slid down a slide before, you might have seen or heard other people sliding down it, but you'd never done it yourself* (refers to the words she used in describing the fact that she'd never given birth before) *and when you got to the top, it was so high up* (tonality very high) *and you were so small, so high up there, and so scary, that you thought you might even fall, but you sat down* (tonality drops and deepens) *and you were gripping very tightly to the bars at the top, but you just went ahead and you LET GO* **[E]** (louder, with much breath and excitement, releasing the sound) *and right Down you slid, right Down to the bottom . . . . And it was SOO much Funn, so much fun, that you went back around again . . . to the steps, and climbed up the steps, one by one and one by one, to the the top again . . . where you kind of remembered the scary feeling, but you also remembered, MORE POWERFULLY* **[L]** *. . . the time when you let go at the top . . . the time when you let go . . . . So you sat down, and you let go, again* (in a forceful whisper, as if like a secret) *it was so much fun, and you knew it's safe, 'cause you've done it now* (grammatical changes in past and present tense to link the metaphor to the present task of labor) *and you went down again, and again, always learning how to let go . . . at just the right time . . . . So that now with your next breath, you can come all the way DOWN through to your tail bone.*

Comments

The slide metaphor creates the experience that Celine has described about birth — that she's never done it before, though she's heard of others' experiences. She is scared of first time experiences. I take her through her fear to the learning adjustment of another new experience she has mastered in her life, creating a sense of knowing and confidence in her ability to let go for birth, at just the right time, reminding her of her own ability to learn and adjust, linking it to birth in the fact that it appears in this visualization. Note the changes in the nature of the truisms as the session progresses. Initially truisms are very practical and realistically oriented, to gain the trust of the left hemisphere. As this trust grows, resulting in a deeper and deeper relaxation, the truisms can become freer in form, since the left hemisphere will continue to believe in the factual quality, if the pacing has been accurate. Pacing refers to the increased freedom possible in the construction of truisms tied directly to the responsiveness of the client. Truisms are anything that the client will consider

believable given the context. The deeper into the process the client lets herself go, the more freedom the practitioner has to formulate suggestions that will be helpful to her. Trust, in any context constitutes a form of truism, as for whatever reasons, the client trusts (believes), she is more capable of experiencing and using suggestions given in simple conversation.

I'd like you to just . . . become aware now . . . of a muscle . . . that wraps around your pelvis, the back of your uterus, which is called the psoas muscle **[T]**. *It's an inCREDIBLY STRONG muscle . . . because it's the DEEEPEST, DEEEPEST muscle in the body* **[T]** *. . . and it's like a fan, it fans out along your lower back and across from your left side to your right, so that, it maintains a balance. It's an incredibly important muscle in that it creates balance in the body because it does span you from left to right, in the very center . . . of your body* (changes in grammatical articles from neutral "the" to possessive "your" are intentional) *and it's very subtly activated by breathing* **[L]**, *you can just SENSE IT now* **[E]**, *very subtly activated, and more so . . . by making love* **[L]**, *and by pushing a baby out* **[L]**, *and because it's the DEEpest, DEEpest muscle in your body* **[T]**, *it spans the whole lower back* **[T]**, *wraps* (said so that it sounds like its wrapping) *itself around the uterus in the back . . . it's an incredible . . . STRENGTH in the center of your body* **[E]** *. . . an incredibly strong muscle in that way* **[T]** *. . . so that, just now with your next breath, you can just take yourself back to that point on the your neck* **[E]**, *. . . just beginning to let the relaxation . . . SPREEADD* **[E]** *. . . all by itself . . . just up your scalp, so that any remaining tension can just begin to fall away from you on the lines of your hair, right Down to the floor . . . right down your forehead, so that your eyebrows . . . can just begin to drift . . . further* **[E]** *. . . further apart, right Down through your nose and cheeks, jaws and ears . . . right Down through to your throat again . . . so that Now as you're breathing* **[L]** *. . . you can just become aware* **[E]** *. . . of the fact that your baby is getting oxygen without you even needing to think about it* **[T]**. *It's taking in the oxygen, and even feeling the movements now as you move, as you rock* **[T]** *. . . senses that on the inside, fully equipped with sensory mechanisms* (small chuckle) *just like we are now* **[T]**. *You can give yourself the right to imagine* **[E]**, *what it might look like on the inside because you were once on the inside, too so you have been there in a way* **[T]**, *. . . to just feel what it might feel like on the inside of the uterus, now . . . And even to hear the sounds that are happening, Right Now, on the inside, the beating of your heart . . . the baby can HEAR that* **[T, E]** *. . . The sound of the blood coming very, very effectively through the placenta, and into the baby . . . the baby can . . . hear that sound* **[T, E]** *. . . the rumbling of your stomach, the baby can . . . hear that sound* **[T, E]**. *So that just now* (very softly,

slowly spoken) *I'd like you to go ahead, and if you want to . . . describe to me what it looks like on the inside right now* **[E]** *. . . only if you want to . . .*

Exploratory Visualization

Using truisms about the process (sounds on the inside; having been on the inside of a womb herself) and embedded commands to see, hear and feel the internal environment of the womb, Celine is guided towards exploring the nature of the experience inside of her own womb. "Exploratory" visualization is the part of the visualization in which the practitioner may receive verbal feedback from the client to further ascertain the direction to pursue. Sometimes the exploratory part constitutes most of the session, although this is not the case with Celine.

Celine: *It looks . . . shiny, glistening . . . red . . . kind of bumps and bulges . . . cushiony.*

Gayle: *Mmmhhh . . . and does it have a kind of smoothness over the bumps . . . ?*

Celine: *Shiny, smooth . . .*

Gayle: *Shiny, smooth . . . even slick, huh . . . on the inside . . .*

Celine: *Glistens.*

Comments

Celine begins to represent her experience visually (shiny, glistening, red) and switches into a somesthetic representation (bumps, bulges). Her somesthetic (sensation) representation mirrors her fears of the baby getting "stuck" on the bones of the pelvis, expressed earlier in the initial interview. Her fears are revealed in her internal representation of the womb. The "bumps" and "bulges" are cushioned, but are parts of the womb which represent her concern for the baby getting stuck.

I begin an *interdimensional shift* — meaning that I want to create a reframing of the bones (bumps and bulges) as something that will *facilitate* rather than hinder labor. I proceed to describe the "bumps" and "bulges" as "smooth," the opposite end of the rough-smooth scale of her somesthetic description. "Bumps" and "bulges" have been defined by Celine as making it "rough." (She described the labors of her friends in this manner, saying their babies became "stuck" on the pelvic bones. By switching to the

opposite end of the somesthetic dimension (rough-smooth) within the same sensory modality (somesthetic), an interdimensional shift occurs ensuring that the internal experience of the bumps and bulges is facilitative of the labor process.

Celine accepts the suggestion, taking in the description of the smoothness in her repetition of it. The process of reframing is completed in Celine's acceptance of the "slick" quality of smoothness on the inside of the womb. She nods and embellishes the suggestion visually (glistens).

Gayle: *Mmhhmmm . . . and can you see your baby right now, it's got little foot prints, little hand prints, all its own,* **[T]** *already made, and little hair that grows all over its body now that will very soon fall off* **[T]** *. . . as it gets ready . . . to dive out . . . and as you look at that baby* **[L]**, *just give yourself the right to now . . . hear any message that it might want to communicate to you* **[E]**, *right now, about . . . anything in particular . . .* (Long pause, Celine's face flushes, eyes water at the corners) *and just Feeel your love . . . as your most Powerful, Powerful, resource . . . always, always . . . there . . . Anything it needs to communicate with you, needs not even be said, out loud, but will happen, on the inside the part of you that will be asking, can get the answer without you even needing to think about it, it all happens on the inside just like labor* **[T]** *. . . the hormones flow . . . and the process begins . . . as it comes out, as it comes out, to the outside . . . Any reorganization, any adaptation can take place, as you hear the baby* **[L]** *now speak to you . . . to that part of you that would want to know . . . or need to know . . . how . . . to do it . . . so that throughout the visualization* **[L]**, *now as you go forward in time you can continue, the fine tuning, the adaptation of the inside . . . reorganization, the fine, fine tuning . . . can occur, without you even needing to think about it, it just happens . . . on the inside . . .*

Comments

During our initial interview I had asked Celine what she thought she needed for labor. She replied that she needed to trust in her love for her baby and to feel a sense of inner peace. I can embed these resources that Celine has identified as needing into the visualization. "Peace" has already appeared several times, beginning with the stomach and the lake metaphor. I incorporate her flush as the sense of the love connection between her and the baby. Because of the deepness of her trance state I can continue giving suggestions for adaptation and adjustment to labor, as if coming from the baby, creating an experience she has already defined a need for — trust in her love for this child.

A trance state represents the combined experience of relaxation and a concentrated internal focus. Celine is both deeply relaxed and intensely focused on her internal experience. This is a similar state to labor which requires an increasingly focused and internalized concentration. Celine is now guided towards the cervix and into the labor and birth part of the visualization.

Birth Visualization

. . . So that just now I'd like you to go ahead and take yourself forward in time now, as if through a time tunnel . . . just going a little forward in time when your baby will be just a liittle bit bigger than what you've been seeing [T] *. . . just a little . . . just right . . . and as the baby gets very, very ready to dive out* [L] *. . . it's pituitary gland releases a hormone . . . a part of it KNOWS when its ready, and then you respond, by CLICKING* (synesthesia) *. . . into the response of releasing oxytocin from your pituitary gland . . . and as that happens* [L] *the head also becomes . . .* (tone shifts to very deep and heavy, tonality falls low) *very, very, HHeavey . . . comes right DOWN on the cervix . . . so that even right now as I speak* [L] *, the hormones are already softening the cervix on the inside in the last month of pregnancy* [T] (shift in time from future to present is intentional) *already adjusting on the inside, so it's like a soft pillow, the inside tissue of the vagina . . . that surrounds the opening, very soft tissue, on the inside . . . as the baby's head comes DOWN the cervix begins to oopen, so that you might be going through early contractions very soon in the next few weeks.* [T] *You might have a twinge here and a twinge there, as the head comes down a little more and a little more as the baby gets very ready . . . to dive full force out . . . because it wants to see you! And besides you know, it gets very crowded in there after awhile, it does not want to stay in there after awhile, when it's ready to come out, it WANTS to be out, very much wants that, and that's something that mothers can know, can feel very good about knowing that their babies in labor very much want to come out of that space and into their arms* [R]. *It's just a natural, INSTINCTIVE process . . . natural LIFE process . . . just doesn't wanna stay in there anymore then . . . and then there'll come times when the contractions are coming and GOING and coming and GOING but always the head is the heaviest part of the baby's body now* [T] *, so the baby's head, comes right down on the cervix, comes right Down, that's the way nature has it, comes right Down on the cervix, 'cause of gravity* [T] *, so that . . . as a contraction comes* [L] *it's like a wave were building on the ocean* [M] *, and it's coming and it's Building, and it's BUILDing, and it's BUILDING, and the baby's head is Diving, Diving Diving right down on the cervix, and you can feel the baby's head diving right down, and firmer and firmer and OOPening and*

OOPening, and OOOpening, and you begin to breathe and breathe and breathe right through it as the baby dives and dives and dives . . . but then the wave comes to shore . . . the wave comes to shore (voice tonality falls, slows) *and then the contraction ebbs away and you always know that each and every wave, is very, very safe, and the most effective it can possibly be . . . very safe because* [L] *the wave always comes to shore* [T] *. . . . Always, and you know that. You know it more and more as* [L] *you continue into the next contraction and the next one* (refers to both the visualization and to actual labor) *. . . and in between each and every contraction* [L] *, you can sink Down* (voice falling in tonality, slows, then picks up) *deeper and deeper down into your own resources, and just resting in between even as you do things, in early labor . . . internally you'll be resting, and very, very peaceful, and noisy* [R] (refers to noise outside) *as the case may be . . .*

Comments

Voice tonality and texture is so subtle and varied at this point it is virtually impossible to fully convey the nuances of technique in written word alone. Voice intensity rises and falls with contractions creating synesthesia — mixing the auditory with the implied somesthetic sensations for labor, yielding an experiential participation in the process. The ocean metaphor continues, used to embed truisms and other forms of suggestion that can be triggered in labor. The ocean matches her geographical environment. Metaphors are most effective when matching the physical habitat in which the woman lives. In the southwestern part of the country, desert and mountain imagery with running streams work well, while in the Midwest, the sound of traveling vehicles coming down a winding country road has been useful. Any metaphor may work for embedding suggestions but naturally occurring images of the woman's environment may be more readily accepted by the woman as it already represents an intimate part of her daily experience. Additionally, when a woman feels alienated from where she is living, metaphors matching her childhood environment can return her to the sense of communion with Nature that is so helpful for labor.

. . . but then with the next contraction, you can Feeel it coming, it's as if another wave is building, and it's swelling up in the ocean and it's building, and it's BUILDing, and the baby's coming down Firmer and Firmer on the cervix, Diving and Diving and OOpening and OOpening, and you're breathing and breathing and breathing right through . . . and

you always know, the wave will come to shore (tonality begins to fall now, after previous build in intensity) *always know it, so that, just now the contraction ebbs away, (in a whisper) and the ocean, when the wave goes in, it takes sand with it* **[T]** *and the sand goes very DEEEP DOWN into the bottom of the ocean so that the ocean is always WASHHING the sand . . . rePLENISHHING it . . . from the bottom of the ocean . . . the sand goes DEEEPER and DEEPER* (tonality lowers and softens) *DEEEPER* (tonality lowers more, softens more) *down . . . in between . . . each and every contraction the sand . . . sinks down . . . to the very bottom. There's an inCREDIBLE amount of resources . . . on the bottom of the ocean . . . kelp, seaweed has AALLL the minerals and trace elements known and not known to man . . . incredible amount of resources on the very bottom every element is there . . .* (suggestions for labor) *. . . and you rest, and your baby rests . . . . Now another contraction is coming and you can feel it swelling and you can hear it almost as the wave builds. You can hear it Building and BUILDing and BUILDING and the baby's Diving and Diving and Diving right Down on the cervix, and your breathing and breathing and breathing right through, and you're cervix is OOPening and OOPening and OOOPening and you're breathing and breathing and breathing right through, and this one is STRONGER and FASTER* (said very quickly and with emphasis) *than the one before and it's coming faster and FASTer into shore as it's still building and building and building . . . and the baby's diving and OOPening and the cervix OOPENS and OOPENS and OOOPENS, and then the wave comes to shore* (tonality lowers, softens, slows) *and you always know it will, it'll always come to shore . . . can feel so safe and secure so secure, always make it to shore . . . the waves of the ocean always make it to shore . . . and again taking the sand back down as it goes deeeper and deeeper down into the bottom* (voice fading to a whisper) *. . . the sand drifting, drifting, down . . . and then you rest . . . and your baby rests . . . in between, each and every contraction. And just the sense of knowing . . . Tom's there, just the sense, reminds you* **[L]** *. . . to sink down* (voice very soft, drops even lower in tonality on this word) *to the bottom of the ocean . . . sink down* (barely audible, but clear) *. . . just his voice* **[L]** *and his face* **[L]**, *his touch* **[L]** *. . . guides you down, into the bottom of the ocean. All the elements are here . . . trace elements needed in the earth . . . are there . . . and there's even little fish* **[M]** *down there* (little louder, even tone) *and the ones on the very bottom of the ocean even generate their own little lights, as they travel . . . little schools of fish . . . you might even see a school, yellow fish coming out of . . . a coral . . . caaave . . . coming right out . . . of a cave . . . almost as if they're being pushed out of there by their Mama fish shooing them along, shooing them along. They must go somewhere else to find something to eat now. And some of them . . . some of the little babies . . . stop and gather something*

to eat. They might even get a little stuck 'cause they're so little they might get stuck onto a rock here or there but always their mother comes and pushes them along, pushes them along and so they never are in danger of ever getting stuck or left behind 'cause their mother is always there pushing them from behind . . . and with the help of the water **[R]** *. . . they swim on, to a place where they need to go to find new food . . . a place they Need to go . . . 'til they come to, perhaps, the arms of an old crab, that they can then . . . eat from. But now another wave is coming . . .*

Comments

It is important to link suggestions to naturally occurring factors (such as Tom's presence) to secure the triggering (accessing) of suggestions to labor at the time it occurs. I link all of the suggestions from the ocean metaphor (security, replenished resources) to seeing, touching, hearing, or knowing Tom is there. Her senses are directly linked, via Tom, to stimulating the suggestions given during the actual labor process. This is sometimes referred to as post-hypnotic suggestion. Linking future occurring phenomena to present suggestions forms a linkage that can be associated to. Seeing and touching Tom forms a truism in experience when it occurs in labor, increasing the likelihood of the suggestions and feelings from the birth visualization be triggered in association as they have been mentioned in the visualization and will predictably occur naturally in the labor environment of the future. Physical settings (such as going to the hospital, birth center, etc.) can also be used in this way.

. . . you can feel it surging and surging and building from the inside, and this one is more and more powerful, more and more effective at moving the baby right DOWN and it's building and BUILDing and BUILDING and the baby's diving and diving and diving right down towards the cervix, and the cervix is OOPening and OOOPening and OOOPENing and the baby dives and dives and the wave builds and builds, coming faster and faster into shore, faster and faster into shore (emphasis on the "s" sound, and with speed) *and more and more effective, at getting there . . . and the baby's coming now . . . the baby's head is coming right through the cervix, you FEEEL it, coming right through the cervix, right through as the cervix is completely oopen and free, and the baby's diving right through it now . . . then the wave ebbs away* (tonality continually falling in volume, intensity) *the wave always comes to shore . . . ALWAYS comes to shore, always comes to shore. It feels good . . . your baby's head is*

coming right through your cervix . . . (in a whisper) *right Down . . . it's like it's coming home, it's coming into it's own home . . . your own house where you live, it's coming . . . it's coming home in that way . . . as it comes out . . . to it's outer home, in your arms, and now you rest, and your baby rests, in between each and every contraction, you rest and your baby rests, always sinking deeper, deeper down* (sing song tone, very soft) *deeper and deeper down into the bottom of the ocean . . . now another contraction is coming, it's building and building* (tonality accelerates, gaining in volume and intensity) *it's coming faster and faster than the one before, as the baby slides down, as it slides down through the slippery, slippery, shimmering . . . shimmering cells of the sides . . . and it's gaining momentum, and now the baby's DIVing and DIVING, and DIVING down for the opening, and you begin to push, and to push, and to push, and to push, and the baby's diving and diving, and diving right down towards the middle of the vagina . . . but then the wave comes to shore* (tonality fades, slows) *and you always know it will, you always know it will . . . and very soon, in the next, perhaps, several contractions, as the baby dives through the vagina . . . the wave will bring your baby out* (tone lowers) *the waters will bring your baby out, waters'll bring your baby out* (in a whisper) *. . . sinking deeper and deeper down to that place, Tom reminds you Tom reminds you of it . . . place in yourself, bottom of the ocean, psoas muscle** *. . . Now another contraction's coming* (voice tonality picking up in volume) *and this one's building faster and faster and faster, and the baby's diving, and DIVing and DIVING right down . . . you begin to push, and to push and to push right out, and the pressure's coming right down as the baby's head, DIVING DOWN for that opening and your vagina's* (very forceful, but with less volume) *beginning to open and OOPen and OOOPEN and OOOOPEN as the baby comes like a ripple, just like a ripple* (refers to waters bringing the baby out) *. . . and then the contraction fades, and you rest, and the baby rests, always sinking deeper and deeper down, always deeper and deeper down in between . . . each and every contraction . . . and with the next contraction, now you can feeel the baby coming down. Lots and lots. Lots and lots. The wave's building, and BUILDing, and BUILDING and the baby's diving and DIVing and DIVING right down, right down on the opening, so that just your vagina begins to burn a little, burn a little bit, but the contractions building, and BUILDing, and BUILDING and you begin to pant and open pant and open pant and open* (breaks into panting learned in childbirth classes for crowning) *and you begin to pant, and pant, and pant and pant and pant and pant and pant and*

* I can now go back to one word phrases which represent experience in which suggestions were embedded during the relaxation. These are reinforced and linked again to something which will be present during the actual labor.

pant . . . and right out comes the baby's head (tonality communicates excitement) *slippery and warm, between your legs, right out it comes, right between your legs, right there . . . you can hear it breathing* (soft whisper) *there's another contraction coming . . . and it's building . . . and it's building . . . and it's building . . . and you begin to pant and pant and pant and pant and pant and pant and right OUT comes the baby's shoulders, right OUT* (tonality communicates enthusiasm and relief) *slippery and warm baby, and just as you see it, you reach down to HOLD the baby in your ARMS, Celine,* (refers to holding in arms now instead of womb) *that's where it's headed, headed for your arms, Celine, and this isn't even that far away . . . very, very much yours, your right to feel that baby in your arms, now, and as you feel that* [L] *as you see it* [L] *, as you hear it* [L] *, your body will even continue, to contract down without you even needing to think about it . . . and right OUT will come your placenta, very whole and full, and you'll feel very, very good, very good, very good to have the placenta come out . . . and then your uterus continues to contract DOWN, very Firm, and hard like a rock, very firm, very fast . . . because that's the way the body's made, as you continue the process as you look at the baby, as you hear it, it stimulates the oxytocin in your body to continue . . . being . . . made . . .*

Comments

Seeing, hearing, touching, or even knowing the baby is born is linked to the placenta coming out with continued linkage for the uterus to continue contracting down to a pre-pregnant size.

Some very interesting research by Niles Newton and Margaret Mead have substantiated the fact that oxytocin is released as a mother does actually see, hear, and touch her baby. Even more interesting is the data Margaret Mead collected on tribal people who believed that it was necessary and important for the mother to see, hear, and touch her baby after birth in order for the placenta to be expelled! Perhaps indirect hypnosis is simply another kind of knowing, or intuitive body knowledge.

. . . so that now you can just enjoy, and indulge in holding your baby with Tom . . . the most important thing right now to just give yourself the total right to just enjoy that baby in your arms right now . . . and the trust . . . it has, and have . . . in your love (in a slow, deliberate whisper) *the trust in your love . . . trust in your love . . . trust your love* (changes to a statement, tonality remains soft, gentle, but firm) . . . (very long pause)† *. . . Now, very gently, you can just let that scene*

† Celine is again given the direct suggestion to trust in her love, one of the resources she reported needing for labor.

begin to fade, into the future, the near future very much where it belongs, as the baby gets very, very ready to be born, to dive down . . . you can very much, just let that fade into the future now, taking yourself back now, to your breathing, to your body on the inside, very much giving yourself the right to ENJOY this last bit of pregnancy (tonality sounds like a question) . . . *just fully enjoying this last bit of pregnancy* (voice tonality drops on the last word, sounding like an answer to a question) . . . *even though you may be very, very ready . . . to have it be over, and to have your baby in your arms, just fully enjoying, the last bit of pregnancy* (intent is to build a sense of the inevitable end of pregnancy, thus the implied suggestion of the inevitable beginning, or starting of labor) . . . (long pause) . . . *so that just now as you're breathing* **[L]** , *without yet opening your eyes, you can just BECOME AWARE of yourself in the room now* **[E]** (tonality gradually becoming louder to a normal, conversational level) *just SENSING how far your body is from the ceiling* **[E]** , *locating your body in the room, how far you are from the walls, very much the CENTER of the room right now, very much the CENTER . . . and as the center* **[L]** , *you can become . . . very ENERGIZED* (emphasized to sound full with energy) , *reorganized* (referring to the many suggestions throughout the relaxation) . . . *and whole . . . and just taking your own time, I'd like you to just think about coming to a comfortable sitting position, but only in your own time . . . giving yourself the right to imagine moving each muscle, and maintaining that relaxation* **[E]** (refers to all suggestions, experience within the relaxation/visualization) *as you come to a natural sitting position* **[L]** , *just moving each muscle that you need to get there and relaxing each muscle after you move it . . . just like a cat moves in the warm sun* **[M]**, *just taking your time . . .* (implied suggestion to sit up) . . .

Celine took a copy of the audiotape home with her to use for relaxation purposes as she desired. Her copy of the tape did not contain her own verbal statements in the exploratory part of the visualization, since hearing herself in the past would not necessarily serve her in future and changing experiences when listening to the tape at home. Copies of tapes made for client's use do not include client statements but contain only the guided experience to re-use on their own. Change naturally occurs, and varying suggestions may stand out, at different times that the client utilizes the audiotape. The client is not held back by reminders of their own experience in past sessions. It is not advisable to tape the client's response on a tape she will utilize at home as it may also contain awareness of issues or beliefs that the woman is not willing to be aware of in her regular waking state. If she is not

ready to be reminded of such associations, she will be likely to reject the visualization altogether and not make use of it.

Celine's Birth

Celine's waters broke on a Monday morning at 1:35 A.M., approximately four weeks after the visualization session. She was not, however, in labor when she called her midwife at 2:30 A.M. Contractions had not yet started (Celine's fear). She decided to take a bath, and then lay down to listen to the tape of the visualization. She fell asleep listening to the tape and awoke a few minutes after 7 A.M. with very strong contractions. Her labor picked up quickly in speed and intensity. She gave birth to a healthy seven pound, twelve ounce baby girl at 11:26 A.M., with no complications. Her total labor was less than four and one-half hours, and she had no perineal tears.

Exploratory Visualization for Phobias

Physically presenting symptoms, including those linked to phobias, can provide opportunity for exploratory visualization, a technique for ascertaining the psychoemotional aspects of physiological functioning.

Having discussed in detail the general construction of a birth visualization, we can further an understanding of the nature and use of exploratory visualization through the following case example presented in descriptive form.

Marianna complained of a phobia to having her blood drawn. Whenever she was to have blood drawn for testing, she became extremely anxious, cold and clammy, and would then faint. She felt trapped and frightened, as she was pregnant and expected to have blood drawn for testing several times during her pregnancy (related to anemia). She came for help when she was four months pregnant, having fainted one month prior and fearfully anticipating the next time blood would be drawn.

The following visualization is presented in shortened form (instead of transcribed form) and without identification of technique, to give the reader an experiential (right hemisphere) feeling for the flow of a multi-modality visualization experience and its impact upon outcome. The exploratory component is emphasized.

After a complete relaxation induction, I (G.P.) began to describe Marianna's vein on the inside of the arm at the elbow joint (antecubital vein). I asked her to imagine being just that one tiny part of her, her vein, which is, in fact, a part of her, so that she really does have the right to "imagine now, being just that one small vein part."

As she imagined herself being just her vein, I encouraged her to speak in the first person, as she, as the vein anticipating the needle coming toward her. Marianna described herself as frightened as she saw a man coming toward her with a needle. She "knew" the man was coming toward her to get information from her and she feared that he would find out "something."

I asked her what it was that he might find out and exactly who wanted this information. Marianna saw the doctor and "knew" it was her father. She had not seen her father since she was two years old and her parents were divorced. Thereafter, she was cared for by her grandmother while her mother worked.

In the years of growing to adulthood, she recalled her family discussing her father's "badness." Though Marianna had not seen her father in 21 years, she had received regular birthday gifts from him during her childhood. She remembered her feelings of anxiety receiving his gifts and the quiet family discussions inevitably ensuing, painting him as a negative and worthless human being.

As Marianna remembered her anxiety about her family's opinion of her father's worth, she described the face of the doctor becoming that of her father (as she remembered him from a picture seen during childhood). She continued to speak as the vein, stating her fear that her doctor/father would test her blood and find something wrong with it. She associated to the idea that something was wrong with her blood, as if being of her father's blood and being genetically the daughter of both her father and mother had created a fear of not belonging with her family. They might discover the secret of the "badness" of her family blood. Her badness reflected the feelings that she was made biologically from her father who had been condemned

by her mother and grandmother. The creation of an irrational fear — that she did not belong — related to the phobia.

Marianna began to recognize her need to accept the part of her coming biologically from her father and to resolve her distrust of her own basic "wholeness" and "goodness."

I proceeded to explain to her the similarities of veins in the body to the nurturing vessels and roots of a tree traveling from the tips of the branch *arms* of the tree deeper down into its trunk, and even deeper down to its root system from which the tree springs. I went on to extrapolate in fine detail how the roots *originating* in the tree come from a variety of sources in the ground (streams, minerals, etc.) involving *differing* points of origination contributing to the tree's wholeness. The point that differing points of origin (metaphorical referral to her father and mother) create the wholeness and goodness of the tree's solid existence in form was continually developed through various truisms involving various nutrients needed by the tree which were coming from different and unknown (father) reservoirs in the ground. Then I proceeded to turn the direction of attention to the entry of the needle for drawing blood.

I first described how the sap (blood) in a maple tree flowed easily into a bucket when a person tapped (drew blood) its bark for excess maple syrup. I talked about how proud the tree was of its fine use for all the nutrients entering the rootlets in making a most delicious, life-giving syrup. I further described how easily the tree would spill forth syrup when tapped correctly by an experienced syrup gatherer, and how quickly and efficiently the sap would coagulate to stop the flow at exactly the right moment . . . and how good it (the tree) could feel by knowing naturally exactly how much syrup to let flow and exactly when to seal over, without any inner disturbance to the tree itself.

As the visualization was brought to a close, I gave Marianna the suggestions that she could, at her next blood drawing, call upon the strength of a tree, and, as she felt the needle, she could remember the image of a maple tree (she had grown up in Vermont).

Marianna had her blood drawn the next week without difficulty, and continued to report no problems with blood-drawing.

Therapy continued for further resolution of identity changes during pregnancy. Eight months later, during the last phase of our work together, Marianna wrote a poem about her personal symbol of the tree. She showed no awareness of the relation of the symbol chosen to our session eight months prior, yet, her poetic description gave reference to roots and the sense of belonging to a family.

Marianna's visualization experience was a valid reality with its unique and inviolate memory storage and living symbols. Marianna used the secondary visual, auditory and somesthetic brain cortices to create a real and valid reality — that of being the vein and confronting symbolically her inner fears of personal inadequacy and incompetence.[‡] By turning her attention almost exclusively to the secondary cortices of the brain involved in indirect, *secondary* rather than *primary* sense data, Marianna was able to give concrete form to vague and anxiety producing feelings. Secondary sense data is that which is seen, heard, or felt in the mind, as opposed to what is actually before the sense organs of the eyes, ears or fingers. Sitting in a cafe, remembering last night's dream or imagining the plan of afternoon events, involves secondary sensory experience. Primary sensory experience involves the visual lay-out of the cafe, sounds of the waiters and diners, and feelings of the hardness of the chair.

The working ground for resolution of her phobia was the territory of symbolic experience, involving the secondary cortices of the brain. The reason for the effectiveness of suggestion, indirect or direct, was the *concrete nature of experience* in the secondary cortices, involving the creation of memory *identical to* memory created from primary experience (usually defined as "actual" experience).

If you were to remember an event from childhood, you would become aware of the use of secondary information brought to primary awareness through encoded memory in the secondary

[‡] The reader is referred to Douglas Hofstadter's chapter on Brains and Thoughts in his book, *Godel, Escher, Bach: an eternal golden braid*[2] for further discussion of living symbols and the nature of brain symbols during the visualization process.

cortices of the brain. If we were to tell you of Gayle's Polish grandmother or Lewis' Cherokee-hillbilly grandmother, you would think of your own grandmother, as well as conjuring images of these colorful characters from the authors' lives. Secondary, associational brain areas would be at work.

You can remember the sound of a person's voice, even though that person is not actually present. By "hearing" it in the secondary auditory cortex, you may re-experience that person's presence. You may remember the sight of a face, again by stimulation of the *secondary* visual cortex, since the person's face is not actually before you, but must be recreated from memory. The pain of a slap on the face may also be re-lived through the secondary somesthetic cortex, and you may even put your hand to your face or flinch at the memory-experience of that slap. In short, secondary data can be brought to the level of primary focus, and is experienced as if it were occurring in the present. Even childhood events can be so vividly re-experienced. Equally, symbolic experiences can carry the power of actual experience as in Marianna's example. Marianna's visualization as she experienced it is actually the creation of memory. Once the symbolic experience occurs, it can be remembered as easily as any past experience. This memory of symbolic experience is not neurophysiologically different from memory of verifiable, consensual events. Both are accessed identically and neither have a "real" (in the mundane sense of that word) existence in the present.

Symbolic experience is identical to "actual" experience by the time it reaches the stage of memory. Neither memory could be seen as presently occurring. Both are brain events. Recall of the intensity of a symbolic experience (a dream, for instance) can be as high as a prior, consensual event. Both memories can claim equal validity to influence the client. Only the whims of yet another brain area (usually considered the "reality tester" of the pre-frontal cortex) differentiate symbol from consensual actuality. Indirect hypnosis aims to relax the usual critical observation of this reality tester long enough for the symbolic experience of labor, or of personal goodness in Marianna's case, to be accepted into long-term memory storage as reality and not imagination.

Through symbolic experience, including multi-modality visualization, memory is created. As such, symbolic inner journeys provide experience from which the client can change beliefs about the world.

Examples of technique have been identified in the preceding transcript. The reader can further extrapolate techniques of

suggestion not labeled for practice. The following section contains shortened versions of visualization transcripts for specific cases in which the reader is free to read through the visualization without interruption.

Visualization for Complication Resolution and Prevention

Visualization for prevention of complication can be very effective for a variety of presenting problems, as well as recurrent complication in past obstetrical history (repeated inductions, prematurity, etc.). The following cases are presented here in shortened form to stimulate the reader towards possibilities of application in the clinical setting.

Visualization for Breech

Jessica was a twenty-seven year old mother referred for breech presentation at thirty-two weeks gestation. She had a previous history of breech presentation with her first pregnancy, fifteen months earlier, resulting in a cesarean. She had experienced ruptured membranes with no onset of contractions, also contributing to the decision for cesarean. Other women in her family had also experienced breech presentations at term. She had been told by her previous obstetrician that she had probably inherited a pelvis shape encouraging the breech position.

In our experience, it is advisable to do a visualization for breech as soon as the diagnosis is made. Our society has such fears of the breech presentation that women can be acculturated to think of themselves as abnormal or at-risk even if the baby might spontaneously turn to vertex within several weeks. If the woman is already past thirty-two weeks, time is of the essence. The sooner she can address issues pertaining to motherhood or beliefs about the baby and birth, the more time there is for adjustment to belief change. This was particularly true for Jessica, who not only had a past history of breech presentation, but also an absence of onset of labor, both leading to her cesarean. Had she started labor on her own, she would have had the option of vaginal breech delivery in the past. Jessica is planning a vaginal birth after cesarean with her second pregnancy. A breech presentation would preclude her option for a trial of labor for vaginal birth.

The following transcript represents the exploratory part of the visualization, in which the reader can become aware of the

beliefs Jessica has about the cervix which encourage a breech position. I (G.P.) work with Jessica on this imagery, until she is finally able to experience the suggestions given.

. . . so that you can actually TAKE TIME in your pregnancy every day . . . to follow that baby . . . that you need to Follow it . . . (refers to her having said that she needs to give herself more time with this baby before it's born) *. . . to follow it DOWN, DOWN, DOWN* (voice tonality dropping) *to the cervix even . . . where you need to follow it . . . now . . . as you look DOWN, at the cervix down, just like that baby way up high looking DOWN at the cervix now, down towards the cervix just tell me what the cervix might look like, feeel like, on the INside now, the INside of the cervix now as you look DOWN at it . . .*

Jessica: *. . . looks . . . warm . . . inviting, pink in color . . .*

Gayle: *and the shape . . . what shape is it?*

Jessica: *. . . round . . . almost like a . . . pool, yet it's pink . . .*

Gayle: *and soft . . . did you say?*

Jessica: *No, it's not soft. It's like something that . . . you dive into.*

Gayle: *Hmmm. It may be very helpful to know now what happens in the last months . . . of pregnancy . . . and on into . . . labor, is that the RELAXin* inCREASES, the relaxin inCREASES, and as the relaxin inCREASES into the PELVIC AREA NOW, . . . begins to soften, even at thirty weeks, even at thirty-one weeks, more so at thirty-four weeks, more so at thirty-five weeks* (voice gradually gains in volume and speed and then drops as softening begins) *. . . begins to soooffften, sooften from the INside out, from the inside out it starts from the INside out . . . softening . . . becomes very, very soft* (voice drops softly) *and that softness spreeaads, spreeads out outwards . . . through the cervix. Just now I'd like you to go ahead and feeel what that actually feels like on the inside . . . and just tell me how soft . . . how soft it can feel on the inside of the cervix as you look at that warm . . . softness . . .*

Jessica: *It feels . . . like a sponge . . .*

Gayle: *almost mushy in a way . . .*

Jessica: *No. No, it feels like a sponge that . . . set out to dry, and it's hard. It's . . . it needs to be wet, to make it soft again . . .*

Gayle: *Uh-huh . . . and you know . . . about the fluids on the inside of your body . . .* (whispery soft) *. . . and what is happening right*

* Relaxin is a hormone found in the body which increases in pregnancy, especially with subsequent pregnancies.

NOW. And this can be very, very HELPful information to know actually what's happening physiologically on the inside . . . (vocal quality assumes a sing song informational tone) *. . . as mucus is being formed and reformed and REformed and inCREASes in the last few months towards labor . . . inCREASes towards labor in FACT, the sponge would soften . . . more . . . and moore . . . and MOORE* (deep and breathy) *until it almost was mushy* (voice goes up very high in a hypothetical tone) *. . . on the INside, a kind of healthy, healthy mushiness . . . soft* (voice softens) *and spongy and wet* ("T" sound emphasized) *very, very wet . . . so wet and so slick almost . . . that, when the baby's very ready, that it is like a slide . . . is like a slide that you can't even help but go right down . . . can't even help but go right down, and with the waters breaking . . . you can imagine what that would be like on a slide, coming right DOWN . . . if you've ever been a child or seen a child go on it's stomach head first down a slide, sometimes they'll put wax paper down to make themselves go down very, very fast* (slight laugh) *very, fast, have you ever seen that?*

Jessica: *Mmm huh*

Gayle: *. . . ever seen a child do that, or wax the slide, they do that in the park down the street. That's what the waters do with the help of the mucus, the COMBINAtion of waters and mucus is inCREDibly slippery, slick even, and just as that child goes right DOWN the slide* (voice lowers, slows) *children like to do that, they like to . . . fly in a way, down the slide, head first even . . . very slick and wet. So that just now you can begin to feel, perhaps . . . a little more of what's actually happening on the inside . . . the softness, the wetness . . . what does it look like NOW in the cervix, what does it feeel like . . . as you begin to TAKE THAT INFORMATION IN, process it . . .*

Jessica: *It feels more comfortable . . . it feels like . . . like a . . . dampness, like a lawn with . . . with dew in the mornings . . .*

Gayle: *Hmm. It might even be soft like a pillow. That's why people like to lay their heads, just like you are now, laying it on a pillow, almost soft like a pillow is . . . but only it has an opening to it . . . like a doughnut,* (slight laugh) *but that pillow . . . How does that feel to you now, that cervix, does it feel . . . like a soft pillow?*

Jessica: *It feels . . . soft, like to . . . like to rest my head on it . . .*

Gayle: *And now, we can just go on a little bit with the physiological learnings, about labor, birth, starting labor . . . sometimes with women I've worked with who have had some difficulty in the past, one woman didn't understand exactly HOW labor STARTED, it's usually some piece of information they're missing . . . but as you know that, that piece of information, it stimulates an even deeper adjustment in the body, as if you*

have the right hemispheres and the left hemispheres of the brain working together, harmonizing in a way, it can be very helpful, to just KNOW what's actually happening on the inside, the wetness, the softness, inCREDible softness, that inCREASes as the baby grows, as the relaxation continues to spread . . . to become more and more dominant in your body, so that there's more mucus, more and more waters, slippery, slippery, warm and wet . . . on the inside . . . and as the baby grows (voice becomes louder, after having been very soft) *if we take ourselves forward in time now, when the baby will be very, very READY to be born, very READY to come out into your arms, to see you, feel you on the outside . . . to hear your voice on the outside, too, the baby will really, really WANT to be born. And this begins, it just begins to happen, in about the seventh month, when the baby's becoming bigger, and a little bigger, just right, and very very ready to be born, where the inside becomes less interesting, because the baby WANTS to be born, and so the outside becomes more and more* (builds in volume) *enticing . . . and just as you move, and SETTLE INTO . . . these learnings, you can even identify, in the next couple of months of what it's like when a baby just wants to be out. It no longer wants to stay inside . . . it WANTS to be born, an impulse to be born, instinctive even, biologically, physiologically, . . . the baby KNOWS on a physiological sense that it is time to come out, the healthiest place BECOMES the outside, it BECOMES that way, and when the baby's very, very ready to be born, it releases a hormone from it's pituitary gland, which causes a hormone to be released in your pituitary gland, which CLICKS labor into place, which STARTS the oxytocin flowing, just STARTS the oxytocin flowing* (softer, but with intensity) *as the waters . . . break, sometimes that happens first, sometimes it doesn't, but it's a sign of beginning, that the baby's putting that hormone out, and the HEAD can come DOWN,* (voice becomes heavier, slower) *HEAD can come DOWN so that, I'd like you to just IMAGINE what it would be like, for a moment, to totally indulge in what it would be like if you didn't need to worry about positioning, but you just had to . . . CONFRONT THE LABOR . . . and deal with labor . . . and this is something you can afford to do while you listen to the tape and at other times, you can deal with other possibilities, but right now, just as you listen to this tape, you can give yourself the total possibility to INDULGE, in what you would FEEEL like,* (now, becomes a whisper) *if the baby were head down right NOW . . . incredible relief, which affects the lower uterine segment, incredible RELIEF . . . of the baby being head down, but HOW . . . how would that happen . . . as the baby grows, it's head gets HEAVIER, and . . . HHEAVIER HHHEAVIER . . . and the hheavier and hhheavier the head gets, . . . and there's so much more room down in the soft wetness* (whispering gently) *ATTRACTS . . . DIVE right DOWN onto that pillow, right DOWN onto that cervix . . . the baby can just DIVE . . . just*

like a pear, . . . that's getting very, very ripe, but not dropping yet, a chemical kind of reaction has to take place in the tree, in the stem, the very STEM of the pear, it just gets ready, and ready (voice picks up speed) *and it just gets hheavier and hheavier and hheavier and right, THUD* (loud, then immediately returns to soft voice) *right DOWN it comes to the ground . . . when you're least expecting it, . . . you might hear a THUD, and there's the pear on the ground if you were around the pear tree. Of course, most people won't even HEAR the THUD, it'll just happen . . . and they might be aware when they eat a pear, or fruit that it happened, but they don't think about it, it's just something that's taken for granted* (matter-of-fact tone) *that yeah, the pear was ripe . . . and ready . . . to come right DOWN to the ground . . . as the baby gets bigger . . . it comes right DOWN, because the head is the very hheaviest, hheaviest part* (softly) *of the body . . .* (now voice rises in volume, as heading towards the birthing part of the visualization) *. . . I'd like you to take yourself forward in time now . . . to when, the baby will be very, very ready . . . to be born, very ready to be born . . .* (continues into birth visualization with baby assumed to be in the head down position).

Comments

As Jessica talked during the visualization, her experience of her cervix can be heard to be not only unrealistic to the internal body processes, but uninviting to dive into. Her imagery is not congruent with labor and birth. I begin to build an image that is more yielding to the birth process, and work with her on that imagery until it becomes actually changed in her own experience. This is often necessary in order to work with a client towards changing the beliefs. It is a client's beliefs which develop the imagery that she will allow herself to experience. As a practitioner is able to work with a woman to change her imagery, she helps to change her beliefs and orientation towards her birthing. Jessica's imagery reflected beliefs that may have been reinforced by her past cesarean. However she was able to re-work her imagery of the cervix as a soft and pliable part of her body, which did become congruent with the reality of a baby diving through. The practitioner can be aware of his/her own reactions to the client's imagery, as it is not difficult to identify the incongruity of "diving "into a "hard, dry" cervix. When incongruities are identified, the direction for change (softening and moistening the cervix) is also evident.

Other issues that were significant for Jessica included the belief in the baby as delicate and the security of the womb beyond the nine month gestational period. Suggestions which address these issues can be identified in the transcript.

I was able to very briefly discuss the experience of pain in birth with Jessica, and asked her to return at a future time to talk further. We also touched on her tendency to rely on her mother, who was there at her first birth, to do the work of labor for her. She chose not to come in an additional time before birth, but to use the tape to prepare due to lack of funds.

Jessica gave birth vaginally to a healthy, full term baby boy weighing nine pounds, thirteen ounces. The baby turned to vertex the week after the visualization session. Her labor was augmented by a very slight amount of oxytocin (her obstetrician described it as "placebo") when her dilation slowed down at nine centimeters. Jessica was very joyful about her birth experience. She did report that it had been longer and more painful than she had been prepared for, never having been in labor before. As of this writing she is currently pregnant with her third child and looking forward to another vaginal birth.* She came in for a visualization session early in the pregnancy for nausea and getting in touch with this baby, and plans to return to talk about the issue of pain in labor.

Visualization for Past Neonatal Death and Prematurity

Melinda was a thirty-five year old mother, pregnant with her fourth child. Her first child died *in utero* during labor from a cord accident. Her first labor started three weeks past her due date. Her second baby was born four weeks premature and her third baby was born nine weeks premature. She had also been hospitalized twice due to problems with bleeding after a miscarriage which occurred one year prior to her fourth pregnancy.

Melinda traveled a great distance to come for holistic intervention toward what she believed would be her final pregnancy and birth experience, as she did not desire any further children. She very much desired this final birth to go smoothly, normally, and naturally and wished to do all that she could to give herself and her baby this opportunity.

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* Jessica gave birth vaginally to a healthy eleven pound girl after four hours of labor, twenty-five minutes after her arrival at the hospital!

The following transcript represents part of a visualization session in which issues of obstetrical risk were addressed. The suggestions are aimed toward maintaining the pregnancy to term (she is almost seven months pregnant) and creating an emotional experience within the visualization of the safety of the inside of the womb in the last two months of pregnancy. I make use of Melinda's own experience in her mother's obstetrical history to build experience of safety and normalcy as an emotional possibility, given her own past complications of birth.

(very softly, intimately) . . . *and as I talk of you . . . then to some extent I'm also talking to . . . your baby on the inside right now of you right now . . . you're very much ONE with the baby, even though when the baby's very, very ready . . . you'll become, two, and at that point you'll be very, very ready . . . to become two, but right now* (voice picks up excitement) *you're very much ONE, it's a very special, special time in the life cycle. And no matter how many times you've done it . . . it remains very, very* (emphasized) *special, and very unique* (reframing) *very, very unique even as your mother . . . had . . . two pregnancy experiences with babies, in which, ONE was very, very different than the other. One was very different than the other . . . and as you came into your mother's womb, . . . you grew . . . and you grrew and you grrew* (increasing slightly in volume) *until you were very, very READY to be born, very HEALTHY and FULL, very whole . . . a full seven and one-half pounds . . . seven and one-half pounds . . . that's a perfectly AVERAGE weight, perfectly average weight. And a baby can feel very, very good . . . about being seven and one-half pounds . . . can feel very good, just as you must have felt, or your mother must have felt, when she was HAVING a second baby growing so large and full, even after the first baby had not made it . . . that full or large. Her first baby had been very complete and had only grown to . . . a lesser weight . . . still, she probably felt very good to know, that you were growing full and strong despite all the medical doctor's worries* (sing song quality) *and aaalll their worries, about your mother's health, and her history and on and on and on, and your father being a doctor, all those factors . . . your mother created, and helped nourish . . . you on the inside, and in a very important way, Melinda, you cooperated WITH her, a baby cooperating with the mother . . . to reach seven and one-half pounds! very, very fulll term . . . very full term experience that you have in your own blood, Melinda because you grew to seven and one-half pounds as a baby so in a sense there's a part of your body, or unconscious, whatever you want to call it, that has ALREADY experienced that very normal, normal growth pattern . . . that very normal, coming to term . . . and that can feel very, very good to know that's part of your cellular memory for yourself, part of your cellular memory . . .*

and you just, vicariously fantasize how it might have felt to your mother, to have done that, despite aalll the medical people who were worried around her . . . even including . . . her husband that she was able to do that with you. That's a fine bond to have with a mother . . . a very, fine bond that you can DRAW ON NOW even as you begin to go deeper down into the chest, now as you relax, little more, and maybe just a little more . . . so that your breathing (The relaxation process continues through the body. The following metaphor is included here for the reader's interest.)

. . . you might even remember when you were very young, swinging on a swing . . . and going up . . . and going back . . . and going up . . . and going back (picks up rhythm) . . . *but then you'd go up higher . . . 'cause you'd pump your feet higher . . . and then you'd fall back . . . and then you'd go higher . . . very high . . . as high as the swing could go . . . because the poles, if you remember the poles in some playgrounds, were very securely cemented ones that were VERY SECURELY CEMENTED . . . INto the tar, or the blacktop . . . THOSE were the ones that you could swing very, very high on . . . you might even remember SEEING somebody swinging very high . . . and FREE, and you might even remember yourself how much fun it could be, the thrill of going DOWN to gravity and right back up . . . just swinging . . . back and forth . . . back and forth . . . your body LEARNED HOW to do that, without you even needing to think about it, it came to terms, with adjustments, minor adjustments, but very significant adjustments in the legs, even as you're adjusting now* (as she moves) *in the legs, and the arms, and the whole torso of the body, to swing . . . back and forth, and up and down, back and forth, and up and down* (voice lowered to a whisper) *each body muscle, groups of muscles in the body, all had to COME TO TERM . . . with . . . that movement . . . all had to come to term with CARRYING your body, in your body up and down . . . and back and forth . . . carrying it, very, very securely in the swing . . . very securely seated in the swing . . . each muscle group, each ligament group . . . each tiny nerve in the body, you might even THINK of it, that way even . . . adjusted . . . to coming to terms with CARRYING your body . . . forward, and back, carrying your body . . . forward . . . as in time going forward . . . a time when you got off of the swing . . . and then you were very, very READY to get off the swing, but the time when you were on it was very much fun . . . the time when you sat down* (voice drops) *very safe, as you sat down, and the seat cradled you . . . cradled your buttocks even, and you were very secure if you had one of those swings that bends like maybe one of your daughters swings on sometimes . . . so that it fits you, uniquely FITS YOU, the person who is swinging . . . and then you can even continue DOWN through your lower back . . . all the way DOWN to the tailbone . . .* (relaxation continues through the body)

. . . and it's so nice to know that you've already made the elements before (visualizing on the inside of the womb now) *it's made placentas, it's made cords before, they've been DIFFERENT, and as the body learns how to make . . . these elements, it's EASIER, much EASIER for the baby to grow . . . much EASIER for the cord to come very SMOOOTHLY, very SMOOOTHLY, and very flexibly out of the placenta and INto the baby's navel . . . and you might even imagine now that little baby growing right now, getting what it needs, flowing very freely . . . FREELY and yet attached, but yet flowing very freely even though it's attached . . . on the inside now . . . as if the baby could make friends with the cord because you know cords can be very playful . . . cords can be very playful, and sometimes babies even squeeze them, squeeze them . . . and always the cord can remain, very, very flexible inCREASingly so with subsequent pregnancies, inCREASingly so, more and more relaxin is able to come through . . . quicker that's why women often comment on the fact that their hips got so wide so fast with subsequent pregnancies* (slight laugh) *and they're only a few weeks pregnant you know, but because they've been pregnant before their body KNOWS HOW THOROUGHly, as the pregnancies progress . . . their body responds quicker . . . to increasing the flexibility in the bones, in the very cartilage . . . and right through into the cord as well . . . there's a certain flexibility that's involved . . . in the cord . . . which is part of a response to . . . and in response to, the pregnancy . . . and the availability of the RELAXin . . . which inCREASes with each subsequent pregnancy a little bit . . . just exactly RIGHT at that point in time . . . and it can feel so much BETTER . . . so much BETTER to . . . a placenta, or* (little laugh) *even to a uterus or even to the hips, to have already done it once, to have already known how that can happen and how it can flow . . . because the body responds quicker . . . the amniotic bag . . . can be tough and FIRM and yet . . . very FLEXible . . . the cord can be tough and firm and yet MORE FLEXible, more FLEXible . . . and the baby can be very, very FREE . . . to move around, . . . free to move around . . . and to get to KNOW, get to KNOW the intrauterine environment, much larger now, and you're much more yielding, to the baby's kicks, than you would have been with a first pregnancy, or even a second, because you spread out faster . . . there's more room on the inside . . . you've been stretched before, more room for the baby to FIND IT'S WAY AROUND, to find it's way around* (implying to find its way safely around the cord) *. . . on the inside . . . without you even needing to think about it . . .*

Comments

Melinda gave birth naturally to a healthy seven pound, twelve ounce baby girl three days past her due date. Her labor was approximately three and one-half hours. She expressed feeling wonderful about the birth, and a sense of peace about her first stillborn child.

Visualization for Uterine Fibroids

Celia was a thirty-five year old woman with a daughter from her previous marriage, pregnant with her second child when she came for visualization. She was five months pregnant and diagnosed with uterine fibroids.

She had been referred by a friend in Minneapolis (Celia's home town) who had been urging her to see us for some time. Celia had not done so in deference to what she called her skeptical part. The crisis that led to her decision to come related to her obstetrician telling her she would have to stay in bed for the next ten weeks to reach thirty-six weeks of pregnancy and not deliver prematurely. She said she realized that the threat of a miscarriage gave her a sense of choice about becoming a mother. She now realized that she really wanted motherhood, and wanted to do all she could to lessen the chance of miscarriage or prematurity.

Celia's daughter, Pauline, was born ten years ago. Celia had been following a strict macrobiotic diet. Pauline was very small, but otherwise normal. Celia didn't have enough milk and had begun supplementing with goat's milk by four weeks postpartum, since Pauline did not gain weight. Celia believed she had the first natural birth at her hospital in St. Paul. She had a five hour labor, experiencing herself having to chase the nurses away who were coming after her with shots and potential injections.

Celia became pregnant with Pauline on the eve of the break-up of her first major relationship with a man who helped her manage a graphic design shop which she owned with her brother. They split up at four months of pregnancy. She moved out. She continued to see him every day at the shop. That pregnancy was miserable from an emotional standpoint. She was depressed, irritable, etc. From a physical standpoint, she was very healthy, without even a trace of nausea. She had been diagnosed as having a small fibroid by her doctor prior to that pregnancy and had been using natural methods to rid herself of it. She returned to the doctor to learn if it was gone, when he told her she was pregnant with Pauline.

Her current pregnancy had been emotionally "fine" but physically very stressful. Unlike during her first pregnancy, Celia experienced much nausea for the first four months. Her ulcerative colitis had also been acting up. Two weeks prior to her initial session, after a long car trip, she began to feel something "different" and her doctor noticed another fibroid above her bladder, causing her discomfort. The old fibroid was six centimeters on sonogram. She expected it was eight centimeters when she came to us for her first consultation for holistic treatment. Her new fibroid was bigger. Her obstetrician told her that he didn't want the fibroid to compete with the baby for the blood supply, because the baby would win. He feared the fibroid would die and become necrotic, starting premature labor. Celia was afraid to work on her fibroid going away, since she was afraid that would start premature labor. We told her that there were other natural ways for a fibroid to disappear than to become necrotic and die. We suggested that if visualization had the power to make it go away, it could certainly have the power to do so safely.

Celia's Visualization

Issues addressed during the visualization included the threat of premature labor and the possibility of cesarean for this birth. The larger fibroid was currently blocking the uterine opening with its mass between the cervix and the baby's head.

When Celia talked in the visualization, it became apparent that she had previously made a clear and emotionally charged decision *never* to have another child after the trauma she felt she went through adjusting to a family in her first marriage. She felt as though her first husband had "pushed" her to have the first baby, and then resented his lack of sharing in the parenting which had been far more than she had bargained for. Since her second marriage, she had become pregnant and wanted to have a child, even though she felt conflict concerning her past feelings and decision *not* to have another child.

. . . even coming to TERMS with, the eighth or ninth vertebra, coming right DOWN the back . . . and you might even remember, Celia, with Pauline (her daughter) *or maybe even yourself, going down a slide for the very first time in your life . . . a child* (voice lowers and gradually rises) *steps . . . up the ladder . . . rung by rung* (very deliberate) *and step by step . . . up . . . and a child might have sat down at the top, looked around, and been kind of frightened because how was she going to figure out how to get down the slide from so high up* (slight laugh) *it*

might have been kind of scary, and they might have let go too soon or too early or maybe somebody coaxed them down, but they came at an angle, maybe they had a spill, and maybe they picked themselves up, picked themselves up, and . . . maybe they didn't even want to go again, on the slide for a long, long time, but . . . I don't know if you've ever seen this happen to a child, but sometimes they have to be given TIME . . . given time TO ADJUST in order to . . . to try it again, and they might even try it . . . get half way up there, way up there and then come back down, but SOMEtime, SOMEtime . . . children WILL do it again, they will do it again, as they See other people doing it and they See them enjoying it, they WILL do it again . . . it's kind of the beauty of childhood and of the body in that sense, when they see that kind of freedom in somebody else, that kind of enjoyment, they will FINALLY come to the top, but usually it's when they get there themselves . . . finally they step, one by one up the ladder to the top the very top and there might be even . . . might be even kind of . . . scary at the top, but if they can SIT DOWN and can MAINTAIN and SUSTAIN themselves down the slide, . . . can sustain and can REALize, that they can . . . LET THEIR BODY GO to gravity and without pushing them, without anybody pushing them they can DO it. They can DO IT, and it's safe, and then finally they can SUSTAIN and MAINTAIN until right DOWN they come at just the right time, right down to the bottom of the slide, finally, . . . and it might have been so much fun, that then they might go around again and climb rung by rung, step by step up the ladder to the very top, until . . . again they feel free, and more confident in that sense . . . children LEARN that kind of confidence in the playground, actually . . . children LEARN that kind of confidence. I don't know if you ever remember Pauline, if she had any experiences like that, but . . . just now with your next breath you might even imagine sliding right down, to the tailbone . . . (relaxation continues and Celia explores the baby on the inside of her womb, and the visualization continues in addressing the fibroids and the ambivalency to motherhood) *. . . why don't we go ahead and continue . . . to look around . . . as babies actually CAN MOVE AROUND* (refers to an earlier conversation of fibroids moving out of the way of the baby) *. . . until perhaps they can see . . . can see them* (fibroids) *even like gentle mushrooms, gentle, small mushrooms . . . soft, flexible . . . where do you see them, in your house, since actually your womb is like a house right now to you* (she is imagining herself as the baby) *just like it's a house to the little balls* (fibroids), *too . . . and can you SEE THEM MOVE . . . Celia have you ever seen those little pearls of oil, that you can put in water for an oil bath, or a bubble bath?* (she nods) *you know how they can come together and move around and float . . . how they can kind of stick together and move?* (nods) *You might even SEE THAT happening . . . with . . . with the little balls . . . of them moving . . . out of the way*

. . . out of the way of the baby, there can be plenty of room, there can be plenty of room, . . . in a sense you know you're like a garden (gentle laugh). *You like to make things on the inside of the womb* (laughingly) *even when you have babies or not . . . and so there's no need to think that you can't make a baby* (in answer to her fears she expresses while describing the womb earlier). *You can. But it's like a garden. It doesn't mean you can't grow other things too. And in gardens, if you've ever done a lot of gardening you'll notice, that you can PLANT THINGS so that certain things MAINTAIN and SUSTAIN and CONTROL . . . other things in the garden. You can plant corn, just the right height to NURTURE other plants BENEATH it. It works in harmony that way . . . or you can, uh, grow tomatos, in more sun or less sun depending on how much, you want the tomatos . . . how prolific you want the tomatos to be. And so gardens, you know, there's that way of PLANTing gardens, and MAINTAINing them, but also in nature there comes a certain balance where trees, shrubs, in the wild . . . will work things out, in order to SUSTAIN certain balances of things in the forest. Large trees won't let too . . . too many little trees grow, but they'll let a certain amount of little trees grow. Or a small tree growing up may shoot up, and TAKE THE SPACE of other smaller shrubs. And yet the shrubs may remain, but they only maintain at that level. They don't grow beyond that, because one of them, namely the tree, just shoots up faster. And so, there's a certain balance . . . in nature. And it seems to me that for you that might . . . BE TRUE about the womb in your case, it's a very prolific womb* (slight laugh) *and, we can be happy about that, or maybe even proud about that in a sense, I don't know what that would mean to you personally, but* (very conversational tone throughout unless otherwise indicated), *you might not like that in SOME ways. And yet it is very prolific, it tends to make things, and it's the part of the body, it's the only part of the body, Celia that can . . . really do that in reality . . . really make another person, and well, you can also make other things on the inside of the womb . . . and there CAN BE ROOM, as the baby's on the INside.* (visualization continues with Celia talking about how she feels about the balls, fibroids, on the inside of her garden) . . . *Your womb can be a very special womb, a very softly cushioned womb* (reframing fibroids as cooperative with the pregnancy) *softly cushioned, just the right amount of cushion, just the right amount of cushion, on the inside . . . and can you see the placenta?* (description of placenta takes place) . . . *the placenta READIES the womb for mothering, in a way, READIES the womb, as it's the only time you make a baby, is when you're a mother, already on the inside, mothering a baby in the womb now . . . It's like the internal mother on the inside . . . . If you were to fall backwards in time . . . you'd come to a time when you'd had a baby in there before and decided not to have one in there again, just falling backwards in time . . . you might come to that time you had in the past, when you promised yourself to not ever do this again* (have a baby) *and . . . just describe that time to me, now* (Celia does so, and the visualization continues after she has described feeling trapped in motherhood, and that all that brought her through was her love for her daughter) . . . *you might even now MOVE FORWARD in time Celia, when you decided to redecide . . . to redecide that decision. When was just the first seedling of that redecision?* (She describes it as when she was falling in love with her new husband, and wanting a child with him) . . . . *And Vick is very, very different, isn't he, a very different person? Because he didn't even push you to do this, did he?* (Vick is her second husband.) *So there must have become a time when your own little seedling began to grow . . . when you decided for yourself to have a child . . . and we can move forward in time now . . . to a point when you not only were willing to, but you WANTED to . . . have a baby* (voice lowers) . . . . *And can you see that younger Celia, the one who made those vows, to not ever have a child, can you see her face, now* (Celia describes her) *and if you could REACH OUT to her now, reach out to her, and soothe her, because you know, she really needed someone then, really needed someone to help her . . . all she had was this vow to herself that she'd never do it again, but she really needed something more, didn't she* (Celia nods) *she really needed somebody* (Celia begins to cry) . . . *and just cradle her . . . cradle her . . . comfort her . . . to MAKE FRIENDS with the past . . .* (the visualization continues, and the resource of Celia's love for her daughter is brought to the forefront as a resource in her redecision to have another child and to find peace with this decision in the present)

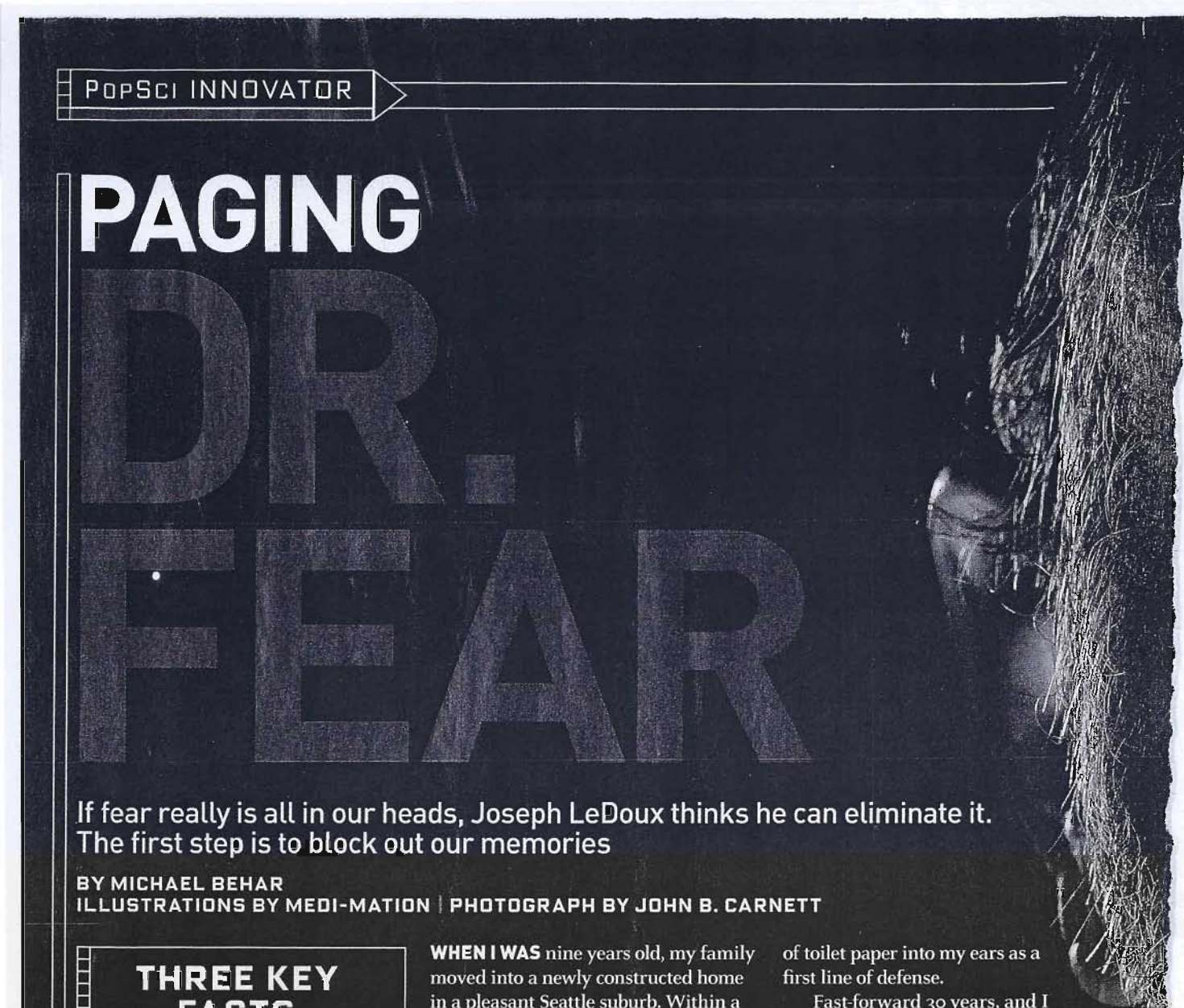
At her next session, Celia engaged in art therapy, drawing a good-bye card to her fibroids. Her doctor had informed her that he could no longer feel the fibroid he was worried about, and had taken her off bedrest. Celia was exuberant about being able to go swimming again.

Celia gave birth to a full term healthy baby boy after a normal labor of approximately four hours.

Many decisions, or promises to ourselves, are made in life in order to get through a difficult time. As with Celia, these past devout resolutions can come up to haunt us and impede our happiness in the present. The power to re-decide at any point in time is always with us, but sometimes needs to be brought to light in the present. Accepting the part of ourselves in the past that was hurt or grieving can free us to re-direct the intent and energy of our lives. This is the spirit of how we can best use multi-modality visualization.

#5

PAGING DR. FEAR



If fear really is all in our heads, Joseph LeDoux thinks he can eliminate it. The first step is to block out our memories

BY MICHAEL BEHAR
ILLUSTRATIONS BY MEDI-MATION | PHOTOGRAPH BY JOHN B. CARNETT

THREE KEY FACTS

Fear is controlled through the amygdala, a small chunk of the brain that **directly activates your fear response, bypassing the conscious mind.**

By blocking the "fear memory"—the original cause of a given fear—**Joseph LeDoux has shown that the fear itself can be eliminated.**

New trials will explore whether **drugs can alter specific memories** (and the fears they cause) in soldiers and trauma survivors.

WHEN I WAS nine years old, my family moved into a newly constructed home in a pleasant Seattle suburb. Within a few days, I began to notice an unsettling number of spiders creeping along baseboards, dangling in closets, and loitering under furniture. I convinced myself that the assault could only be because our digs had inadvertently razed some kind of spider civilization, and these guys were out for revenge. I remember being unable to sleep, spooked by the sight of an eight-legged nasty clinging to the ceiling, waiting to pounce. I would insist that my father leave the stairwell light on so I could track its every move, certain that under the cover of darkness the little monster would sneak into my bed and burrow into my ear canal, where it would lay its sticky spider eggs and spawn a whole new arachnid dynasty. I stuffed wads of toilet paper into my ears as a first line of defense.

Fast-forward 30 years, and I find my repulsion firmly entrenched, seemingly for good. On a recent business trip, I glimpsed a spider behind the nightstand in my hotel room. I summoned the concierge, who duly chased the evil critter into the hall with a broom. "No problem," he smirked when I apologized for my wimpiness. "Happens all the time."

There's a proven treatment for phobias called exposure therapy, better known as "facing your fears." I merely have to immerse myself in a bathtub with hundreds of spiders, let the insects crawl freely over my naked body, and voilà! I'll be cured.

Luckily, New York University neuroscientist Joseph LeDoux, the world's preeminent fear guru, agrees that this

#5

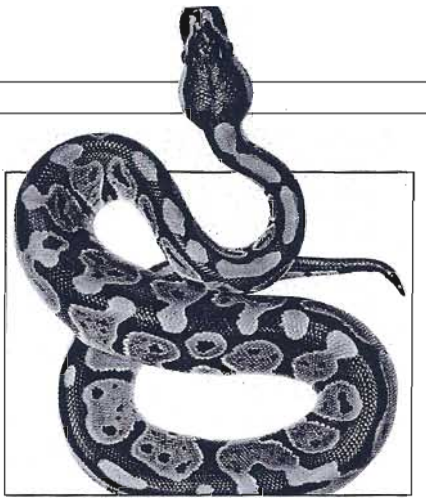
tactic might not be the most efficient remedy. Imagine forcing an aviophobe onto a plane—a severe panic attack could trigger a midair rerouting to the nearest loony bin. But LeDoux may have uncovered a better way. After a two-decade-long pursuit into the depths of the brain, LeDoux has shown that it's possible to eliminate deep-seated fears. All you have to do is remove the memory that created it.

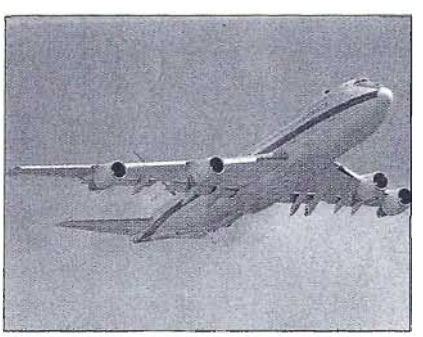
Last year, in a landmark experiment in rats, LeDoux opened a path to doing just that. He showed that it's possible to obstruct the memory of a specific traumatic event without affecting other memories. He also demonstrated that when the memory was stifled, the fear it roused vanished as well.

This sudden ability to produce selective amnesia stunned the scientific community. It also offers unimaginable promise. It could relieve soldiers suffering from post-traumatic stress disorder (PTSD) or rid sexual abuse and rape victims of haunting memories. My spiders would be fair game, as would LeDoux's enduring aversion to snakes. Other researchers have been quick to adapt LeDoux's findings. One has already begun experimenting on human subjects, and a startup company has emerged that plans to eliminate fears in the comfort of your own home. All you need is a mail-order box of pills and the accompanying DVD.

THE SHOCK OF DISCOVERY

Down the corridor from LeDoux's office, near a paper sign reminding students of the lab's Wi-Fi password ("fearisgood"), heavy glass doors open to reveal the fear factory. Inside, 300 plump white rats live like rodent royalty. Each gets its own transparent acrylic cage and is fed a continuous supply of filtered water and top-notch rat chow. Their cages, neatly aligned on stainless-steel wire shelves, are scrubbed regularly and ventilated with oxygen-rich air. When we enter, we have to wear surgical masks to keep from sullying the rats with germs we might be tracking in from the outside world. According to Marie Monfils, a postdoc here, these rats are treated exceptionally well because happy, healthy, easygoing rats make ideal test subjects when it comes time to scare the holy crap out of them.





NOTHING TO FEAR BUT... According to a recent poll of American adults, we're a nation of ophiophobes (50 percent of the population reports being "very afraid" of snakes), acrophobes (fear of heights, 36 percent), arachnophobes (fear of spiders, 27 percent) and aviophobes (fear of flying, 18 percent).

To understand why rats—and other animals, including humans—get scared, you have to start at the amygdala, the place where sensation and memory join forces to spawn the venerable beast we call fear. The amygdala is buried in the forebrain directly behind the eyes. LeDoux first started researching the amygdala in the late 1970s with early experiments that investigated how rats adapt to danger.

In one experiment, LeDoux played a tone to the rats and then dispensed a mild electric shock. After a few repetitions, the tone alone made the rats freeze—a classic Pavlovian response. He had expected this, but at the same time he wondered what was actually occurring inside their brains when they froze. He injected a dye that mapped out the connections in the rat brains and found that the auditory thalamus—the part of the brain that receives signals from the ears—connects directly to the amgdala. He then surgically cut the pathway that connects the auditory thalamus to the amygdala, repeated the tone, and found that the rats no longer feared the sound.

Somehow, the amygdala was forming and storing what LeDoux labeled a "fear memory" that preempted all other brain activity whenever it recognized the offending input. The rats were essentially oblivious to their freezing behavior, responding to the tone without the use of their higher brain functions, precisely the way I might squeal like a schoolgirl at the sight of a spider before I can reason that it's not going to eat my left arm.

The study revealed that when it comes to fear, the "thinking" part of your brain is instinctively subordinate to the amygdala. Your fears forestall your thoughts, and the amygdala is the reason why. It takes a new input, checks it against your fear memories and, if there's a match, initiates a response.

Without the fear memory, though, the chain falls apart: If my brain can't remember why I'm afraid of spiders, then I won't be afraid of spiders. Yet

FROM TOP: DALY & NEWTON/GETTY IMAGES; JOHN FOXX/GETTY IMAGES; ISOTCK; DON FARRALL/GETTY IMAGES

selectively eliminating a memory would seem to be impossible. LeDoux suspected it was not.

THE YOUNG BRAINIAC

LeDoux is the hippest nerd I know. His salt-and-pepper hair is smartly slicked back, and a soul patch crowns his chin. He's wearing flip-flops, black jeans and an embroidered lime-green shirt with its square-cut shirttails untucked. The rockabilly look is fitting when you learn that he spends most of his spare time jamming with his band, The Amygdaloids, playing guitar, singing, and writing lyrics. Of course, one can only be so hip: Most of their songs are about neuroscience.

We're sitting at a round conference table in his office on the 11th floor of NYU's Center for Neural Science, where LeDoux is giving me the Fear 101 primer. The 58-year-old's Cajun accent, though refined, still lingers from an upbringing in Eunice, Louisiana, where he raised prize-winning cows, bulls and horses and aimed to become a priest. "I went to Catholic school, and the nuns thought of me as their pet project," he recalls. "I made rosaries and was the alter boy. I used to hold mass in my bedroom by myself, just to practice. But in eighth grade, the hormones kicked in and I started thinking more about girls than religion."

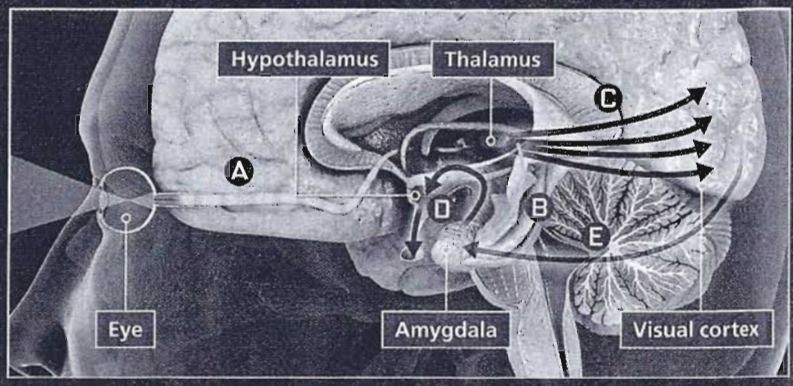
He first started tinkering with brains at his father's butcher shop. "In those days, they would slaughter the animal by shooting it," he says. Pops tasked the young LeDoux with digging through cow brains, a local delicacy, to retrieve the bullet, because "you wouldn't want to chomp down on a piece of lead." While poking around in the mush, LeDoux remembers pondering its purpose. "I'd reach in there and would always be thinking about what each part does."

LeDoux was one of only three people from his 1967 graduating high-school class to leave the bayou for the big city—Baton Rouge. He enrolled at Louisiana State University and begrudgingly obliged his parents' desire for him to study marketing. After all, they were paying the tuition. But his budding interest in the mind led him to study consumer psychology, where he mused about how it might be handy for understanding consumer behavior. (At one point, LeDoux wrote a letter to B.F. Skinner asking the eminent psychologist what he thought of the concept. Skinner replied, scolding it as unethical. Today you'd be hard-pressed to find a single major ad agency that doesn't have a consumer psychologist on staff.)

LeDoux went on to get a master's degree in marketing. But a course he took taught by LSU psychologist Robert Thompson that examined the roots of memory convinced him to become a lab scientist. He applied to Ph.D. programs in biological psychology—12 in all, to ensure that he got accepted somewhere. (His grades weren't stellar, LeDoux says: "I got hooked up with people in college who showed me the good life.") He ended up at the only school that accepted him, the State University of New York at Stony Brook.

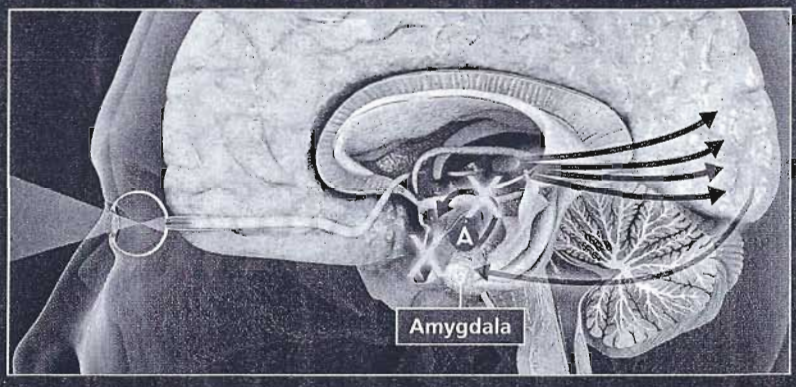
At that time, scientists scoffed at the idea that emotions and fear dwelled in some kind of tangible neural mesh

WHAT FEAR DOES TO THE BRAIN



Say you're afraid of mice. When the eye sees one skitter, it transmits the data to the thalamus [A], which sends the information straight to the the amygdala [B] and the visual cortex [C]. The amygdala rapidly associates the image with a fear memory and tells the hypothalamus [D] to prime the body for action. Meanwhile, the visual cortex goes through the higher-level processing of the image, but rationalization (it's just a mouse!) is too late [E] to overcome the amygdala's immediate repsponse.

HOW ONE DRUG FIGHTS FEAR

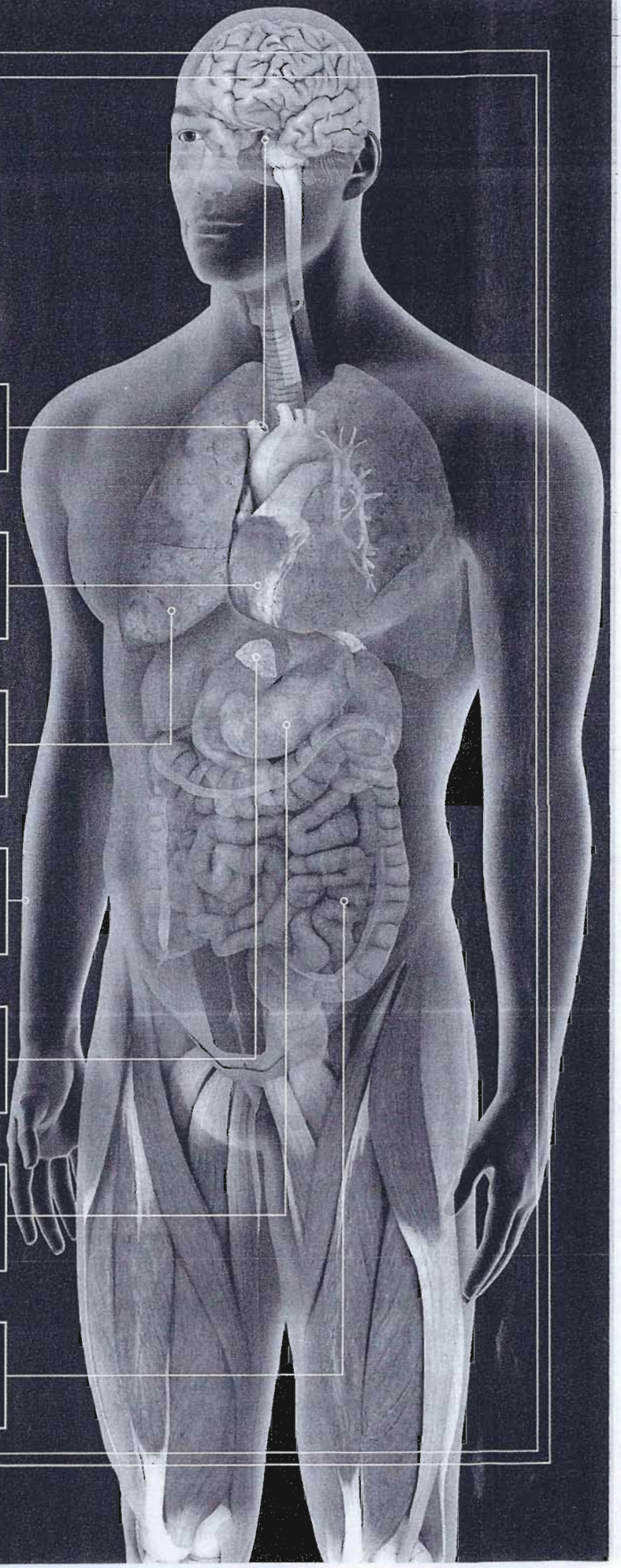


A drug called d-cycloserine (DCS) helps to inhibit long-held traumatic fears. The drug boosts NMDA receptors in the amygdala, which helps it to form new memories. Watching a video of what you fear while under the influence of DCS writes new, strong memories to the amygdala that aren't associated with a traumatic event. Thus, when you see a mouse again, the amygdala doesn't initiate a fear response [A].

AN ATLAS OF FEAR

Fear sets your body in motion, readying you to deal with a threat. But the long-term effects of anxiety and stress can cause serious harm

BY SABA BERHIE



EYES
Fight-or-flight hormones like norepinephrine dilate your pupils to improve vision.

HEART
Your heart pumps faster, increasing blood pressure to accelerate the delivery of oxygen. Prolonged high blood pressure increases your risk of heart attack or stroke.

LUNGS
Your breathing rate increases as your lungs take in more oxygen. Long-term stress responses exacerbate asthma, and hyperventilation can trigger a panic attack.

SKIN
Sweat glands start working to cool the body down. But long-term stress can suppress wound healing, making the body prone to infection.

HORMONES
The adrenal glands secrete cortisol, a stress hormone. Too much cortisol corrodes bones and muscles and weakens the immune system, diminishing an immune response.

STOMACH
The stomach stops digesting so the body can divert energy elsewhere. Slow digestion may result in an increase in stomach acid, causing nausea or inflaming an ulcer.

INTESTINES
During a stress response, blood is shunted away from the intestines. Continually suppressed digestion can trigger irritable bowel syndrome.

hidden in the brain. They believed that emotions were complex psychological phenomena that, for the most part, had little to do with what LeDoux imagined as rogue bits of brain circuitry. But he suspected that he could understand human emotions by starting small. Because fear was easy to isolate—a raw and universal emotion that spanned all species—it seemed like a sensible thing to tackle first.

In the 30 years since grad school, as a professor at Cornell University Medical College and later at NYU, LeDoux has become the undisputed King of Fear, having written two acclaimed books and published dozens of groundbreaking studies based on the simple premise that memory and fear are, in fact, inextricable soulmates.

ELIMINATING MEMORIES

LeDoux populates his lab with kindred thinkers, resourceful polymaths who can draw from multiple disciplines to arrive at unforeseen solutions. There are people like Monfils, who explains to me how she programmed rats to forget their fears while she cradles one of the rodents in her arms, stroking its white coat as if it were a cuddly housecat. This rat, it should be noted, is one she has "modified"—the top half of its cranium looks like it has been sliced off, and in its place sits an implantable microchip that lets Monfils watch its brain activity in real time on her laptop PC.

"YOUR MEMORY OF AN EVENT IS ONLY AS GOOD AS YOUR LAST MEMORY OF IT," LEDOUX SAYS. EVERY MEMORY CAN CHANGE.

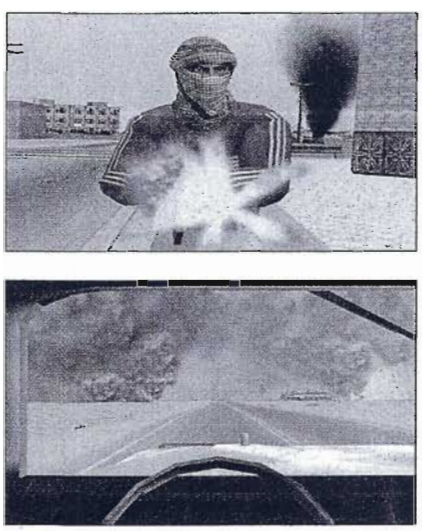
In a study published in *Nature Neuroscience* last year, LeDoux's team repeated the tone experiment, except this time there were two tones: a high-pitched beep and another like a digitized cricket. The rats heard both tones 20 times and then got a shock. This sequence was repeated three times, enough for the rats to learn to fear the tones as before. Now it came time to break the memory and, hence, the fear. While only the cricket tone played, the rats were injected with U0126, a chemical that prevents long-term memories from forming. Twenty-four hours later, when the rats heard both tones again, they froze only after listening to the beep. The drug had flushed away any memory of getting shocked after hearing the cricket noise—and no memory meant no fear.

The study joined a growing chorus of research demonstrating that memories aren't immutable objects encased in museum glass. Rather, they are living, changing things and can be manipulated whenever evoked. "It sounds like science fiction, but long-standing memories are vulnerable to change," says LeDoux.

More important, it also proved that a *specific* memory could be altered or erased (remember, it eliminated just the rats' fear of the cricket, not the beep). The rats remembered getting a shock after hearing the cricket tone, and so they froze whenever it was played. U0126 blocked that fear memory, but only because the drug was dispensed when the rats were prepared to get the shock again. "Your memory of a specific event is only as good as your last memory of that event," LeDoux says. Thus, every time you dredge up a memory, good or bad, it's susceptible to change. (Incidentally, this is how neuroscientists account for "alien abductees" who pass lie-detector tests. The victims recall their close encounters so exhaustively and so often that the repeated recollections gradually alter the memory until the fabrications become indistinguishable, neurochemically speaking, from truths.)

News of LeDoux's experiments spread, and the neuroscience community quickly took notice. The conventional practice of "talk therapy" suddenly seemed tedious and of dubious efficacy. Why would I want to spend hours of couch sessions with my shrink when a shot of an amnesia-inducing compound into my brain at the exact moment I'm remembering my childhood spider invasion would make me fearless in an instant?

"When you recall something, you don't recall what originally happened; you recall what you recalled the last time you recalled it," explains Roger Pitman, a professor of psychiatry at Harvard Univer- (CONTINUED ON PAGE 82)



VIRTUAL THERAPY Researchers are testing memory drugs to help veterans who suffer from post-traumatic stress disorder. Virtual-reality simulations [left], aided by a drug that helps memory formation, work to disassociate thoughts of battle from the real trauma of warfare. In the future, videos of heights (for example) could help cure ordinary fears [right].

CREATIVE TECHNOLOGIES AT THE UNIVERSITY OF SOUTHERN CALIFORNIA (2)

#6

Healing Traumatic Childbirth
Visualization in body-centered hypnosis vs Drugs to erase memory
by Gayle Peterson, MSSW, PhD

When you recall something, you don't recall what originally happened; you recall what you recalled the last time you recalled it...Roger Pitman, Prof. of Psychiatry, Harvard University

The quote above is taken from the January 2008 issue of Popular Science in an article explaining the use of a drug, d-cycloserine (DCS) to treat victims of traumatic stress disorder. But what the article reveals about the brain shows us that it is not as much a memory-erasing drug, but a drug that blocks fear in the amygdala of the brain, while inputting other data into the visual cortex of the brain. Sensationalist reporting would have us believe that the drug *eliminates* memory. In actuality, it *changes* it.

This is what occurs in the treatment of traumatic childbirth experience when women undergo visualization in the context of body-centered hypnosis to separate fear from an upcoming childbirth. Take for example, the case of Deborah, whose mother lost two babies in childbirth before giving birth to herself and then to her sister by cesarean.

Deborah grew up hearing the stories of her mother's traumatic loss, which overshadowed her own delivery with dread and fear. Deborah experienced a cesarean for failure to progress after 2 days of labor. When she came to me for help with a vaginal birth after cesarean, it was evident that her mother's birth history had become her own and Deborah suffered from second generational post-traumatic stress related to giving birth and parenting. Her history of her mother's losses in childbirth as well as her own cesarean presented stressors which were triggered by childbirth at this stage of family life.

Even if DCS was available for treatment, certainly it would not be given to a pregnant women. And the long-term effects of such a drug could show detrimental side effects in the future. (The potential negative effects of dissociating versus mastering/coping with trauma or possible over- use of such a wonder drug are topics for another time.)

I saw Deborah for treatment only 3 times (one hour sessions) in the last month of pregnancy and once on postpartum follow-up. The first session (Birth Counselor Interview) revealed the roots of her history of fear surrounding childbirth. The second session (visualization in context of body-centered hypnosis) addressed this fear by reviewing emotionally her mother's losses in childbirth and her own cesarean with her first child. By evoking the emotional state of fear that surrounded these traumatic events, I was able to create a safe environment in which Deborah could release her grief and cry for the dead babies in her mother's womb. I could then help her respond with sadness for her mother and review the fact that her own son, though subject to many hours of labor, came out strong and healthy! The third prenatal session focused on accepting healthy pain in labor, reinforcing a separation from her mother's traumatic labors. Deborah went on to have a vaginal delivery with her second child. In her postpartum session, Deborah was asked if she thought about her mother's childbirths. She reported that it did not cross her mind, even though it had plagued her during her first labor. She also reported that this

was the first vaginal delivery in her family since her mother's losses. In her final postpartum session, Deborah reported,
My mother had two cesareans, my sister had two, and I had one before I came to work some things out here. This is the first vaginal birth out of 6!

Together, Deborah and I created a new memory of these traumatic, historical events that lived in her body. Because she learned these events within a state of fear, she had to re-enter that living memory and change it. Scientists refer to this as *state dependent learning*, whereby we must re-learn a new response to an event by remembering the original event and changing our orientation to that event. Re-entering the emotional state, we are able to change how we respond to the traumatic event. If successful, we attain a sense of mastery regarding the trauma, and fear is no longer associated with the new experience, which now becomes the new memory of that event.

Joseph LeDoux's new research on blocking memory with DCS is claimed to eliminate the fear associated with the trauma. One of his research team member's describes it as working with rats that are *programmed to forget their fears.* In other words, the fear is blocked chemically in the brain, and then new input to the visual cortex is stimulated, likely giving a new context (association) to the memory. This sounds like great new research, but hey not so fast! If these memories are altered, rather than actually *removed*, what is the difference between how Deborah's memory and association to childbirth changed without a drug? And although rats may not need to feel a sense of a continuous sense of self through time, what might be the adverse effect of random reconditioning without understanding and psychological participation on the human?

For Deborah, visualization in the context of body-centered hypnosis evoked past emotional associations of trauma during childbirth. Creating a bridge through the secondary visual cortex and the limbic system to create a new memory and evoking the context of her son's live birth (successful birth) took only one session. Roger Pitman's statement

When you recall something, you don't recall what originally happened; you recall what you recalled the last time you recalled it

As well as Joseph LeDoux's
Your memory of an event is only as good as your last memory of it

This latest brain research is laudable, but not necessarily an easy fix with a new drug. When it comes to childbirth, the use of visualization in the context of body-centered hypnosis is a successful treatment for trauma and can improve birth outcome without lengthy psychotherapy. It is important that we stay open to all avenues of application when it comes to new research on the brain, rather than only believing in a new drug. Although good for the pharmaceutical companies, it may not be the best way to reprogram humans!

MAP 21 #6 #7

Lying down with a Horse and a Crocodile: The Papez–MacLean theory of brain evolution

Paul D. MacLean is head of the Laboratory for Brain Evolution and Behavior at the National Institutes for Mental Health near Washington, DC. Building on the earlier work of James W. Papez, MacLean has identified three distinct evolutionary stages in the development of the human brain. There is an ancient, basically reptilian brain, hardly touched by evolution, and found in prehistoric reptiles as well as in turtles, alligators and lizards today. In humans, this brain is located at and near the top of the brain stem. Encircling it is the old mammalian brain, consisting of the limbic system. We share this with lower mammals in general – rats, rabbits, kangaroos, horses, etc – whether monotremes (egg-laying), marsupials (pouch-bearing) or the more common placentals. Finally there is the new mammalian brain or neocortex, which is highly developed in primates, most especially *homo sapiens*. This wraps itself around the mammalian brain in a pattern of brain-within-brain. 'Speaking allegorically . . .' says MacLean, 'we might imagine that when a psychiatrist bids the patient to lie on the couch, he is asking him to stretch out alongside a horse and a crocodile'.

These three 'biological computers' are noticeably distinct in their structure and chemistry, which is revealed by the Golgi method of staining brain tissues. While the functions they perform are duplicative and overlap, they differ markedly in style. For the purpose of this comparison the two old brains will be amalgamated and compared to the neocortex.

The older brains seem involved in the ancestral lore of the species, ie hierarchies of dominance–submission, sexual courtship and display, follow-my-leader rituals, mass migration, ganging-up on the weak and the new, defending territory, hunting, hoarding, bonding, nesting, greeting, flocking and playing. The neocortex, in contrast, seems more adept at learning new ways to cope and adapt. If the limbic system is removed from monkeys, they do not seem incapable of any specific movements, rather they cease to resemble monkeys in their behaviour. The whole capacity to imitate the 'monkeyish style' is lost; all rituals cease. They will try to eat garbage, even burning matches, and to copulate with chickens. Jung would say they have lost their 'collective unconscious' (see Map 10).

While these older brains learn, remember and trigger motor activities, they seem 'id like' in their strivings, less unconscious than unable to verbalize their meaning beyond emotive expressions. The limbic cortex registers basic affects, hunger, thirst, etc, specific affects, pain, shock, repugnance, and general affects, those not tied closely to specific stimuli but motivating behaviours such as searching, aggression, protecting, caressing, rejoicing and sorrowing. These persist long after circumstances that incited them. In short, the limbic system has some 'intelligence of feeling'. If the limbic cortex is irritated by epilepsy, rabies infection, or experimentally stimulated, sudden gusts of rage, panic, pleasure or 'Eureka!' sensations can sweep over the organism, which may snarl, salivate, attack, or become addicted to pleasurable self-stimualtion. Such areas seem almost exclusive to the older brains, which also mediate the autonomic nervous system, the body's involuntary internal responses. In contrast the neocortex deals much more with voluntary movements, and with external and environmental events.

These three brains appear to have been successively *superimposed* upon one another. Unlike the claws that evolved into hands and the gills which evolved into lungs, each brain appears to have made some 'new starts' and replicated older functions. For example, the anencephalic monster is a baby born without a neocortex, yet strangely some have lived as long as four years, waking, sleeping, [illegible] creatures which respond 'in-

The human brain is in reality three brains, the reptilian, the old or paleomammalian and the neomammalian or neocortex, each successively superimposed over the earlier in a pattern of brains-within-brains. The structure of these older brains is part of a shared inheritance from the crocodile and the horse (or reptiles and mammals generally). The reptilian brain consists of the matrix of the brain stem, the midbrain, the basal ganglia and much of the hypothalamus and reticular activating system. It shows greatly enlarged furrowed structures and turns green in dye tests because of large amounts of dopamine, a transmitter substance. This brain is a slave to precedent and seems to contain the ancestral lore of the species.

The old mammalian brain consists of the limbic system and comprises two nearly concentric rings, one for each hemisphere, folded in upon a central core. Limbic means 'hemming in' or 'bordering around'. The whole is enclosed by the cingulate gyrus above and the parahippocampal gyrus beneath. The limbic brain registers rewards and punishments, is the seat of a variety of emotions and controls the body's autonomic nervous system. Over the limbic or mammalian brain lies the neocortex or 'thinking cap', a convoluted mass of grey matter which, spread out, reaches the size of a hearthrug. It is this latter brain, which, evolving with extraordinary rapidity, produced homo sapiens. Perhaps like the antlers of the Irish Elk or the shells of some turtles we are 'top heavy'. Is there chronic dissociation between our brains?

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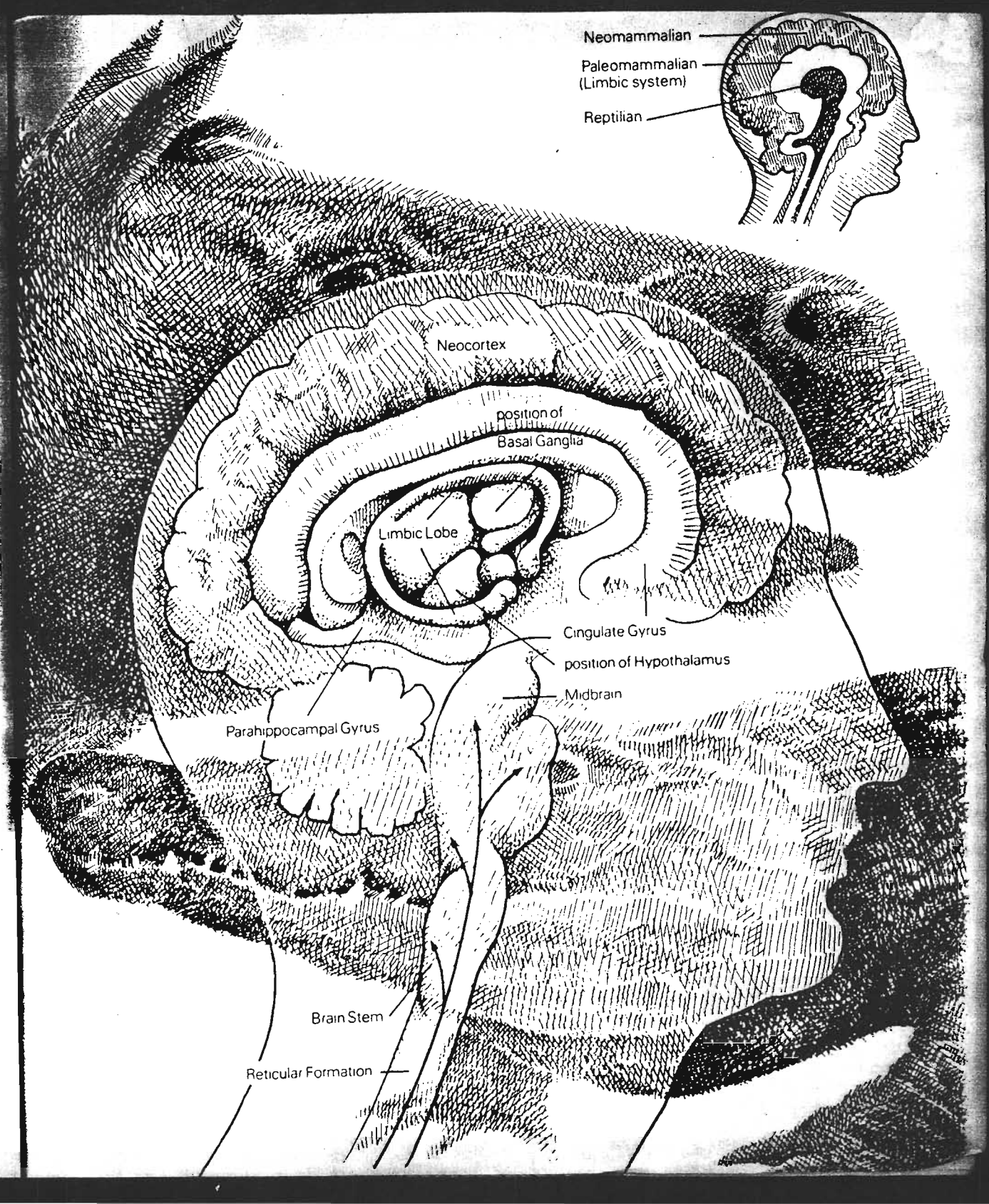
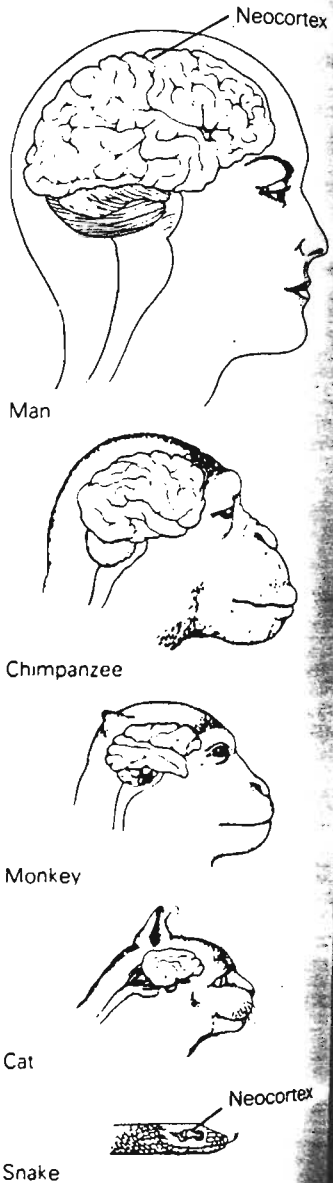


MacLean's thesis, ably elaborated and supported by Arthur Koestler (see Map 27), is that the human brain as a whole suffers from a lethal 'design error', a quasi-schizophrenic split between reason and emotion, precipitated by inadequate coordination between the neocortex and the two older brains. Such error consists less in falling short of some arbitrarily imposed ideal, than of the recognition, common in evolutionary biology, of those impasses and dilemmas which have halted the evolution of whole species and doomed some to extinction. For example, spiders, scorpions and other arthropods developed their brains around their gullets, and so confront a dilemma. Their brains cannot grow without impeding their capacity to swallow, yet they need brains to find food. This conflict has led to the compromise, not reconciliation, of sucking blood or other fluids, a form of 'phylogenetic senility'. Similarly the koala bear, like other marsupials, lacks a corpus callosum, the nerve fibre which joins the left and right hemispheres of most mammalian brains. The koala, a victim of inadequate cerebral integration, has yielded before countless rivals, and survives only in Australia where he is left, in Koestler's words, 'clinging to his eucalyptus like a discarded hypothesis'.

The human brain is well integrated laterally by the great cerebral commisure which joins its hemispheres, but can the same be said for its vertical integration between the two older brains and the neocortex? This neocortex started to grow prodigiously in the second half of the Pleistocene age, that is about half a million years ago, an unprecedented rapidity and degree of evolutionary change, that could well have thrown the brain out of balance. We suffer, MacLean believes, from 'schizophysiology', a constitutional dissociation between newer and older brains. MacLean argues from studies of limbic epilepsy where seizures confine themselves to the limbic system. Just as epileptic seizures do not cross from one brain hemisphere to another when the corpus callosum is cut, so the mammalian brain appears to contain its disturbances as if cut off. Seizures induced by irritating the limbic cortex of monkeys have confirmed this. Anatomically, MacLean has shown the vertical connections between the limbic systems and the neocortex are relatively few, indirect and slow to react.

If MacLean were correct about this dissociation between our outer cerebral thinking-cap and our inner visceral awareness, would not Dissociated Man know his environment better than himself, and haunt his own body like the ghost in the machine? The growth curve for science and technology would grow exponentially; while ethics remained with Confucius, Buddha or Christ. Two major religions might share a myth of ethical harmony and innocence until a fatal choice was made by Representative Man using *reason* instead of *ethical sensibility*, an 'original sin' that dooms posterity to persistent error (see Map 4). Tradition in this culture might locate precise thoughts in the mind, but vague emotions in the heart, breast, bowels, blood, nerves or viscera (which are indeed controlled by the limbic or mammalian brain). Famous psychoanalysts might rightly insist that deep within us is a quite different, dumb, dark yet powerful mind, binding us to some ancestral superego, and which, full of resistances, fastens tenaciously on symbols which express its feelings. Such a culture might be split between cerebral conceptions of science and the expressive arts, the two barely on speaking terms. The first would dismiss as 'not meaningful' all emotive utterances, the second would boast of 'intellectuals', a term excluding Albert Einstein, and which appeared to consist of deathless prose mounted precariously upon passionate premises. Plausibly this culture might divide itself internationally into political blocs, the first celebrating the either/or of individual choice between empirical propositions, the second espousing the dialectical movement of conflicting values. All the confident



The development of the neocortex or 'thinking cap'.

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'Let the biologists go as far as they can and let us go as far as we can. Some day the two will meet.'
'The Origins of Psychoanalysis'
Sigmund Freud

'Gay Talese in "The Kingdom and the Power" pointed out that where one sits in the "New York Times' newsroom is never a casual matter . . . How did these highly educated people learn to behave this way – from reading Llewellyn Evans' description of a hierarchical struggle of black lizards living on a cemetery wall?'
'Evolutionary Trends of the Triune Brain' Paul D. MacLean

promises that Reason and Enlightenment would for ever banish superstition, mysticism and residual religious beliefs would stumble over that other quality in the depth of the human mind, that 'heart' which, in the words of Pascal, 'has its own reasons, of which reason knows not'.

To a considerable extent it would be a war of metaphors, between the straight line of progress, the linearity of causes and effects, and the conception of a circle, cycle, mandala, a meeting of Alpha and Omega. This is powerfully suggested by comparing the motor–sensory cortex (see Map 19) wherein the genitals keep a respectable distance from the head, face and tongue, with the limbic (mammalian) system where the anal–genital, oral and olfactory areas come nearly full circle into close proximity, reminding more than one investigator of Uroboros, the self-devouring snake of paradox (see Map 22). But it is important not to fall into the ancient error of positing a demon within, or even the Victorian nightmare of the beast in man. It only compounds error to consider either the inner brains or the outer cortex as 'savage' or 'repressive' respectively. Animals are, in any case, far less lethal and genocidal than human beings, and they respect surrender signals from their own species while humans kill already vanquished fellows in cold blood. We have to bring the brains together, a process MacLean sees as involved in creativity, wherein dissociated brains are bisociated (see Map 27).

If the answer is to combine the brains, then championing Natural or Cerebral Man is one more symptom of the original pathology. This pathology starts with free-floating anxieties and accumulating affects which the rational neocortex is helpless to control, since ultimate concerns are insoluble by technical reason. Anxieties and incohate yearnings cannot find objects and outlets for their own discharge, but turn instead to pseudo targets falsely concretized, like Jews blamed for the Great Depression. 'Better a terrible end than an endless terror', as the Brownshirts used to say. But paranoid vindictiveness, scapegoating and obsessional rituals only add guilt and frustration to incubating rage. If technical reason were enough, could not those with phobias and obsessions calm the mounting panic in their own nervous systems when the dreaded objects approached? As it is their bodies won't obey. The ultimate holocaust is reached when such absurd hypotheses as the genetic inferiority of Jews, join with the technologizing and organizing powers of the neocortex to make the incredible true by systematic murder. We have reached the point where we are powerful enough to 'redeem' visceral prejudices by mutilating society to fit them.

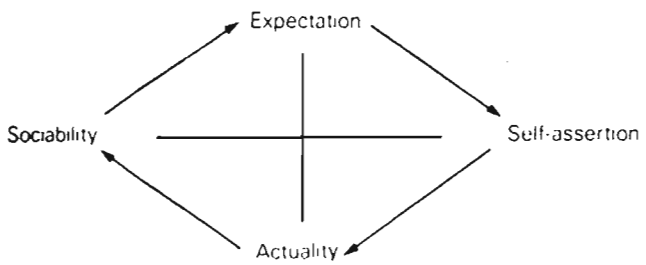
But *is* MacLean right? I prefer to think of anatomy as tendency rather than destiny. If we can but discover a logic of emotions, the few connections between the neocortex and the older brains may yet prove enough. To this we now turn.

MAP REFERENCES
Creativity, 26–31; Genocidal man, 15, 22, 50, 56–8; Hierarchical view, 33, 38, 41, 47, 55; Limbic lobe, 22; Older brains: as holarchies, 47; as unconscious, 9, 10, 15; Splitting, 5, 12, 23–4, 48–50.

...way in the Limbic System

The limbic system is concerned with attention, emotion, learning and resulting memories. It mediates messages received from the outer environment on their way to the neocortex, suffusing these with moods ranging from rose-coloured anticipation to dark disappointment, as when an anxious mother meeting a train sees her son's resemblance in every passing boy. Despite many problems in isolating functions within the limbic system there is general agreement upon its homeostatic and equilibriating principles of operation. Investigators have tentatively identified areas mediating between rage–fear, fight–flight, pleasure–pain, expectation–actuality, tension–relaxation, etc. For example, when the upper limbic ring is stimulated in monkeys, grooming, courtship, sexual and affectionate responses occur, while stimulating the lower limbic ring evokes revulsion and antagonism. But the chief concern here is with mounting evidence that the limbic system can 'oscillate' or 'run away'. These terms are borrowed from cybernetics and general systems theory, and refer to a mode of pathological feedback by which the system instead of regulating itself as through a thermostat progressively destabilizes and disintegrates itself instead (see Map 45).

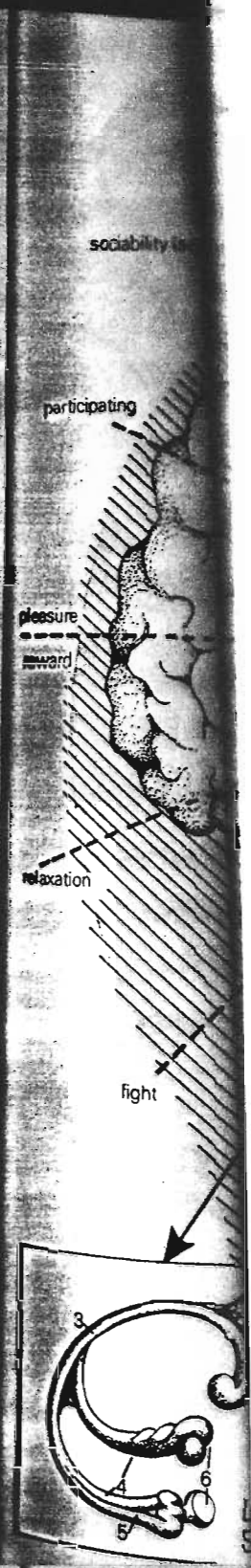
If we take just two dimensions from Map 22 and draw a feedback loop thus.



The expectation which I assert changes the social actualities which changes my expectations . . . Normally the poles of expectation–actuality, self-assertion –sociability are mutually restraining and in complementarity. But suppose I joined a gang in which my popularity (or sociability) depended on how mercilessly I clubbed old women who frustrated my expectations of snatching their purses. In this event sociability–self-assertion as a single dimension of my system goes into 'runaway'. Within the limbic system Karl Pribram found a capacity for 'rebound' or 'answering effect', while E. Gellhorn found that in disturbed states one division of the autonomic system could trigger responses in its opposite. This is essentially similar to the oscillations between 'true' and 'false' selves (see Map 14). We have only to consider the other dimensions of limbic equilibria described on the map opposite, and we could characterize most known forms of psychological and social pathology as oscillations which cause different dimensions to 'run away'.

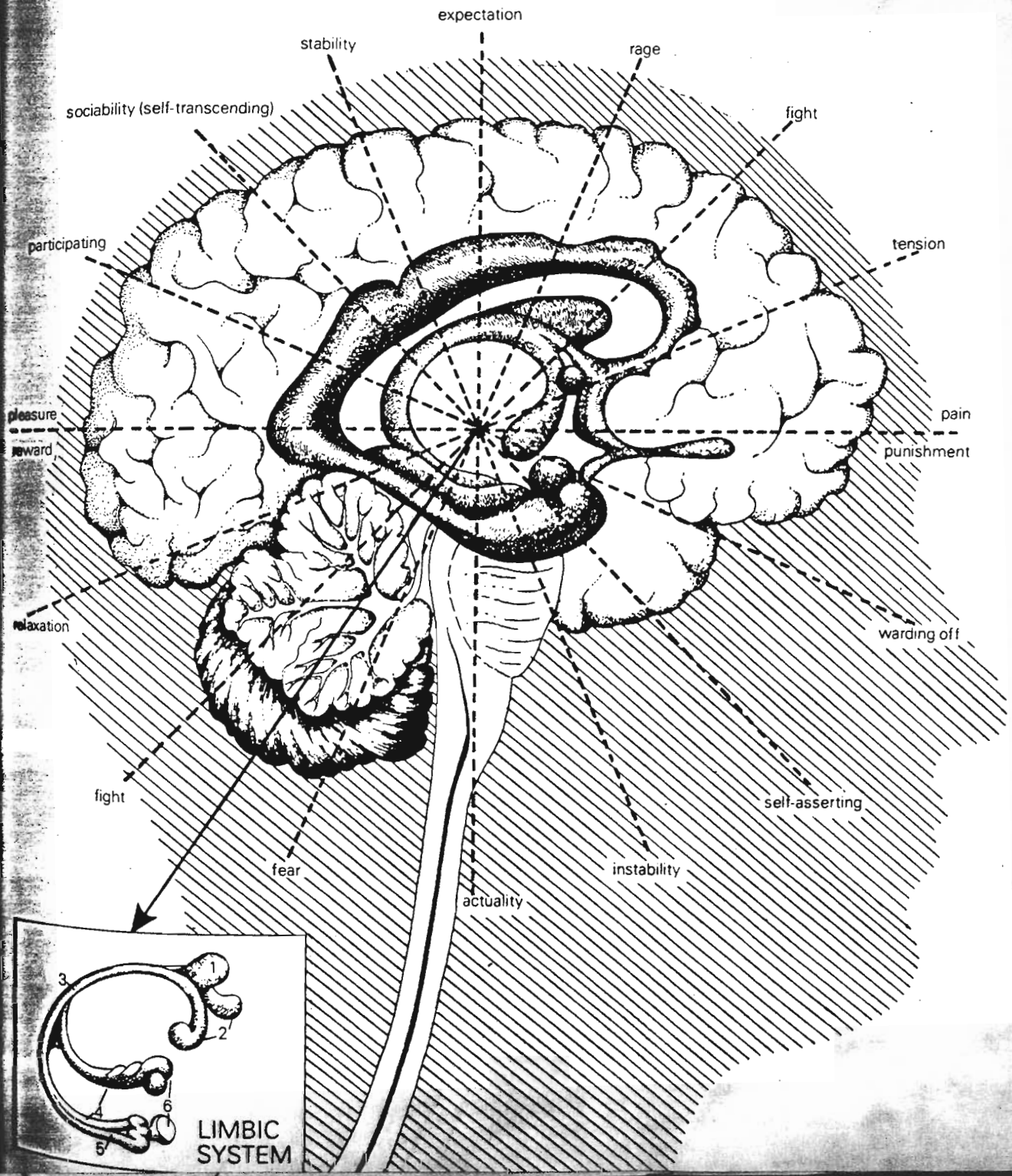
Whence the origin of such disturbances? Is it the anatomical dissociation between the limbic system and the neocortex discussed in Map 21? Perhaps, but clearly the two brains operate on quite different principles, which are more than the differences between 'reason' and 'emotion'. By habit, not necessity, we think in linear terms of cause and effect, subjects-acting-on-objects, and the exclusive options of the computer's on/off switches. In contrast, the limbic system is in dialectical balance and operates on cybernetic principals which encompass all variables involved in a rational–emotional synthesis. The Triumph of the Will, Classless Millenias, Eternal Vigilance and being stronger-than-the-bottle are all symptoms of linear, neocortical excess that sends the limbic system into 'runaway'. The heart has its own reasons . . .' which Reason sends haywire.

The limbic system is equivalent to the old mammalian brain, bounded above by the cingulate gyrus (Map 21). Here seen in exploded view, the upper and lower rings of the limbic lobe clutch the thalamus like a claw. Across this 'cellar of the brain' has been superimposed eight of the dimensions which various investigators believe that the limbic system holds in balance, to maintain an equilibrium of mood and emotion. These include rage–lear, thought to be mediated by the amygdaloid bodies, fight–flight, which has been precipitated by stimulating the rear areas of the hypothalamus and pleasure (reward)–pain (punishment) located in the septum pelcidum and certain areas of the lower limbic ring respectively. The hippocampus has been found to mediate differences between expectation–actuality. So long as these differences remain minor the hippocampus inhibits the reticular activating system (Map 19), but no sooner do major differences emerge than the RAS is released to awaken the entire cortex to these discrepancies, thereby influencing tension–relaxation.



1. Septum Pelucidum
2. Mammillary Bodies
3. Fornix
4. Hippocampus
5. Parahippocampal Gyrus
6. Amygdaloid Bodies

MAP REFERENCES
Dialectics, 3, 22–3, 53–5, 57–60; Runaway, see: catastrophe theory, 56; 'infernal dialectics', 47; oscillation, 14, 22, 34, 43, 48–51, 56–8, 60; schismogenesis, 48–50, 57–60.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#8

Prenatal Bonding, Prenatal Communication, and the Prevention of Prematurity

Gayle Peterson, M.S.W., L.C.S.W.

Prenatal bonding and communication with the unborn has been documented in recent research by Dr. Thomas Verny.[1] Prenatal bonding and attachment has been suggested by many authors (Cheek, Chamberlain, Verny, Mehl, Peterson, and others presenting at this conference).[2] This paper will focus on the issues facing the modern day mother which contribute to complication of pregnancy, including prematurity, and on specific guidelines for preventing prenatal complications. I will use case examples to illustrate some of the factors that make motherhood difficult in this culture, the emotional factors which prevent prenatal bonding, and the use of hypnotherapy in resolving complex emotional patterns which prevent prenatal attachment.

For the past 20 years sociologists have proclaimed the "family" to be in a state of crisis.[3] By 1990 it is predicted that 50% of all families will not be original biologically intact families (US vital statistics). Blended families and single parent families continue to be on the rise in our country.

The socioeconomic and emotional work of motherhood has in the past been largely supported by family. Our society is neither child-oriented nor particularly supportive of the nurturance of the child. With the breakdown of family support in the realm of mothering, all mothers are affected on a cultural-biological level, regardless of the family status at the time of pregnancy. Likewise, single mothering is more and more a choice that women are making, notwithstanding the emotional hardship of such a decision.

Our culture impacts our biology. Motherhood is a conflicted endeavor in our society.[4] Women are at the nexus of many factors which impact the experience of pregnancy and birth. The notion of "equality" has been used against women in a patriarchal society. Pressure to achieve

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success in career, assume greater power within the family structure, in addition to the questionable stability of the family itself all mitigate against enjoyment of motherhood. Ambivalence about motherhood is rampant both in the pregnant woman and society at large. Pregnancy and birth constitute the bridge to motherhood. Pregnancy and birth have become more complicated, because women are experiencing the stress-points of our times and because the "family" is in a state of crisis.

My work as a psychotherapist is to address the ambivalence which prevents prenatal bonding. It is my way of supporting women across the bridge to motherhood in a society which devalues the feminine.

It is common for prematurity and miscarriage to be presaged by feelings of guilt and uncertainty in the mother.[5] I have already identified the causes of this ambivalence to be largely culturally induced. How and in what manner each individual mother carries these feelings is naturally influenced by her own personal history. As a psychotherapist, I create a healing relationship with the client and use specific hypnotic technique for resolving the fear and guilt which preclude prenatal bonding and attachment.

The first case example is Sarah, a 35-year-old woman pregnant with her first baby. She was a single mother suffering from depression and conflict about having a child, which was unplanned. She was a member of a spiritual community and unable to set limits on the physical labor she was expected to perform in service to her community. She felt unworthy. At 30 weeks of pregnancy she threatened premature labor.

Nonmedical treatment for preventing premature labor included hypnosis sessions for bonding to her baby prenatally, thus motivating her to take care of herself physically, increasing the chances of bringing her baby to term.

In her first session, Sarah cried as we went inside the womb to look at her baby. She felt she did not deserve the baby, that she was not a good enough mother, and would be unable to take care of her child. Given her fears, it was understandably difficult for her to feel close to her baby. Guilt got in the way. She also said that if she had the baby soon, she would be able to do more physical work at the ashram, which in turn would make her feel more worthy.

I used three approaches in helping Sarah create a bond with her baby:

1) The development of a nurturing bond between Sarah and myself which would provide the foundation for increased self-esteem. This in turn offered her energy to begin taking care of herself.
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2) The development of an inner confidence in her capacity to mother, and to give to and look forward to receiving from this child.
3) The continued use of hypnosis tapes we made during the pregnancy which reframed her "resting" as "work." These tapes also carred the subliminal messages for carrying the nurturance of our relationship into her daily life and for carrying her pregnancy to term.

By the second session Sarah had altogether stopped having contractions. She became increasingly cheerful, happy to see me, and looked forward to seeing me in between visits. She progressed to the point where she could visualize her baby inside her womb–a sign of bonding. She was able to "talk" to her baby and feel an attachment to the baby and even feel a little excitement about motherhood. At 38 weeks she delivered a viable, healthy baby girl.

Before identifying guidelines for creating a prenatal bond between mother and unborn child, I will give one more example for illustration. This case relates to guilt imposed on women through the modern technology of amniocentesis.

Women who have had abortions and carry guilt from these experiences tend to be at greater risk for both prematurity and miscarriage. It is not the abortion itself that contributes to this tendency but rather the woman's unresolved feelings that render her vulnerable. Specifically, these feelings of guilt impair her ability to relate and bond to the child prenatally. This is also true when women have lost newborns or young children through birth defects, drowning, and other catastrophes. In these cases the woman may feel that she has failed to effectively care for and protect her child. The guilt the mother feels may commonly give rise to ideations of self-punishment which surface during a subsequent pregnancy.

Leanna was a 38-year-old woman pregnant for the second time, two years following a late abortion of a Downs' Syndrome baby whom she had affectionately named "Rose-petal." Leanna was experiencing extreme nausea at 12 weeks of pregnancy and was having difficulty giving herself adequate nutrition and rest. She was also suffering from insomnia.

Though she was clear about wanting this baby and had recently entered into a happy and stable marriage, Leanna could neither enjoy

her pregnancy, nor allow herself to become attached to this child because of her feelings of guilt for Rose-petal. Under hypnosis she revealed that she felt she should be punished by losing this child and that she did not deserve a healthy baby.

Her nutrition was poor, which is often the case when women harbor self-blame and ideation of punishment. They neglect their own bodies and their pregnancy can be threatened with high blood pressure, toxemia, prematurity, and other prenatal complications. Leanna's anxiety was contributing highly to her nausea and lack of sleep.

During her second hypnosis session Leanna had initial difficulty getting relaxed. She was unable to "see" any image of her baby at all. The only images that came up were those of Rose-petal after birth. Rose-petal had lived for several hours beside Leanna before she died. Leanna could not project herself into the future. She could not envision herself with a baby or progressing beyond five months of pregnancy.

Leanna's profound guilt about making the choice offered by a technological society (amniocentesis, abortion) left her alone with the guilt and emotional pain, which was expressing itself in nausea and sleeplessness.

I began speaking softly to her about nature, about her womb as a garden, about the eternal rebirth and brilliance of nature all around us. I spoke about the grass that shoots up wherever and whenever it can—even through sidewalk cracks—sprouting life anywhere it got the chance. I talked to her about the gardener who makes choices about what will grow in his garden—and what weeds, beautiful and alive as they are, he will make the choice to take out. I spoke of how nature knew no judgement. The gardener was not punished for the choices he made in his garden, nor was the beauty of weed-life denied. Nature continues to grow in every place and at every opportunity possible. It knows no blame—just joy for the chance to grow life again and again.

Developing this metaphor, I watched Leanna notably relax and let go of body tension. She was then able to "see" her baby growing on the inside—the beginning of her attachment and bonding to this new child. Her nausea and sleeplessness disappeared.

The above example demonstrates several issues. Women are put in the extreme position of carrying sole responsibility for the choices made available by our society. The fact that the technology exists is also an inference that to abort a Downs' Syndrome baby is considered the "best" choice, perhaps, for society. It is the woman herself, the mother—harvester of tomorrow's children, that bears the respon-

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sibility that a technological society places squarely on her shoulders. The example of Leanna also cries out for the emotional support needed by women in this day and age. Stress is created for women who bring forth children and bear all the personal responsibility in a society that does not respect, honor, protect, or support motherhood. The problem Leanna faces is a societal one–yet it is one we have let her and other women face alone.

Naturally, we cannot expect women to be free of ambivalence in motherhood in this society. And we cannot expect them to bond and to nurture the children of the future unless they too are receiving the nurturing and support they need.

CONCLUSION

Guidelines for developing and strengthening the prenatal bond between mother and unborn child include:

1) A one-to-one therapeutic relationship which nurtures and supports the woman. This relationship must be nonjudgemental and contribute to her confidence in her ability and right to mother her baby.
2) Identifying what emotional causes create difficulty in developing the bond between mother and unborn child.
3) Doing the work of healing past ghosts which cause guilt and self-blame, using hypnosis and the therapeutic relationship.
4) Use of hypnosis to create images of the baby inside the womb and allow for dialogue to take place between mother and unborn child.
5) Use of hypnosis and the therapeutic relationship to envision the full development of the pregnancy through term, birth, immediately postpartum, and one year postpartum.

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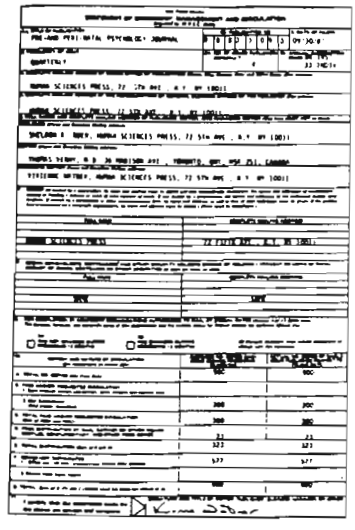

An Anthropologica Infant Death Sync the Possible Role Promoting Infant

James Joseph McKenna, P

ABSTRACT: This research m consideration of the evolution of that especially in the first yea physiological regulatory effect o breathing are reviewed and use sensitized to parental breathin environment will have access. tween fetal experiences and inf clinical, experimental, and dev includes cross-species and cross- breathing cues (movement, sound, infants to override breathing cont

This model and the testabl parent-infant cosleeping neces the infant; only a careful ana determine this. Rather, the p suspected to be involved in SI breathing cues (a novel experi must be considered as one of t for some victims. This model research model which assume but as a complementary rese (environmental) factors are th actional model is justified by physiological synchrony are b parent-infant contact was alm of life wherein a high degree

James Joseph McKenna is an Claremont, California, and an of Pediatrics, Child Psychiat School of Medicine, Irvine, C

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#9

ORIGINAL CONTRIBUTION

Hypnosis and Conversion of the Breech to the Vertex Presentation

Lewis E. Mehl, MD, PhD

Objective: To evaluate the effectiveness of hypnosis to convert a breech presentation to a vertex presentation.

Design: Prospective case series compared with historical, matched comparison group.

Subjects: One hundred pregnant women whose fetuses were in breech position at 37 to 40 weeks' gestation and a matched comparison group of women with similar obstetrical and sociodemographic parameters derived from databases for other studies from the same time period and geographical areas.

Intervention: The intervention group received hypnosis with suggestions for general relaxation with release of fear and anxiety. While in the hypnotic state women were asked for the reasons why their baby was in the breech presentation. As much hypnosis was provided as was convenient and possible for the women until they were delivered of the baby or the baby converted to the vertex position.

Main Outcome Variables: A successful conversion for the intervention group was scored when the baby spontaneously converted to the vertex position before delivery or successful external cephalic version. The conversion rate of the intervention group was compared with the comparison group who received standard obstetrical care without the opportunity for hypnosis.

Data Analysis: Parametric testing of statistically significant differences in the rate of conversion between the two groups.

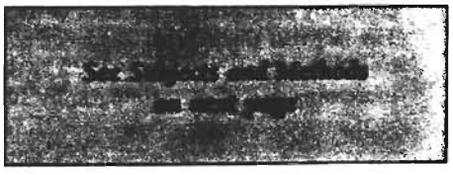
Results: Eighty-one percent of the fetuses in the intervention group converted to vertex presentation compared with 48% of those in the comparison group. This difference was statistically significant.

Conclusions: Motivated subjects can be influenced by a skilled hypnotherapist in such a manner that their fetuses have a higher incidence of conversion from breech to vertex presentation. Psychophysiological factors may influence the breech presentation and may explain this increased frequency of conversion to vertex presentation.

(Arch Fam Med. 1994;3:881-887)

PRIOR TO the 32nd week of pregnancy, the incidence of breech presentation may be as high as 50%.[1-3] After the 32nd week, the combination of fetal growth and a decrease in amniotic fluid causes the fetus to be constrained by the uterine walls. As the fetus accomodates itself to the shape of the uterus, the majority of the earlier breech presentations spontaneously convert to the vertex position. By 40 weeks' gestation, study estimations of the prevalence of the breech presentation vary from 3.0% to 3.5%.[1-3]

The conventional explanation for the fact that the majority of presentations are vertex at term is because of the interrelationship between the decreased proportion of amniotic fluid and the piriform shape of the uterus, with the roomier portion being the fundus. The combination of the breech position and the flexed lower extremities is bulkier than the flexed upper extremities. The head also becomes the



From the Department of Psychiatry, University of Vermont College of Medicine, Burlington.

SUBJECTS AND METHODS

SUBJECTS

Because of the low prevalence of the breech presentation at term, women whose fetuses were in the breech presentation were actively solicited from childbirth educators, midwives, family physicians, and advertisements in areas frequented by pregnant women (maternity clothing stores, bookstores with large childbirth sections, laundromats), and in local publications read by pregnant women. The aim was to provide hypnosis for 100 patients near term (36 weeks' gestation or more) whose fetuses were in the breech presentation. These women would be expected to be motivated to be good hypnotic subjects because they were volunteering to be hypnotized. Many of these women mentioned the undesirable prospect of cesarean delivery if the baby remained in the breech presentation as a motivation for volunteering to participate. A descriptive flyer of the study was provided to all referral sources.

One hundred women were referred from practicing obstetrical care providers or from the advertising literature disseminated in the community. The first 73 women were from the San Francisco Bay, Calif, area (1987-1988) and the remainder were from the Tucson, Ariz, area (1989-1991). Only patients who were at 36 weeks' gestation or more were entered into the study. Subjects began hypnosis at 36 to 42 weeks' gestation.

COMPARISON GROUP

A comparison group was developed through the retrieval of subjects from a database that was used previously to study alternative childbirth and birth risk.[12-15] Prenatal records and hospital delivery records were available from that database. The dates of delivery in the database encompassed births from 1970 to 1993. The dates of delivery in the intervention group encompassed deliveries from 1987 to 1991. To determine whether this difference in dates would affect the comparison, the number of spontaneous conversions from breech to vertex presentation after 36 weeks' gestation by 5-year periods from 1970 through 1990 was tested. There were no significant differences in spontaneous conversion rates for any of the 5-year periods. This allowed for the selection of women for matching from any year of the database, thereby enabling better matching on other variables believed to be important. There were no differences in the incidence of breech presentation at term by 5-year periods. As an incidental finding, the rate of cesarean delivery for the indication of breech presentation progressively increased during each of these 5-year periods. The fact that the general incidence of breech presentation did not change from 1970 to 1990 despite the increasing use of ultrasonography suggested that the ability of clinicians to diagnose the breech presentation has been relatively stable over time. There were no significant differences in the gestational age at delivery between the comparison and the intervention groups. I have observed that, since 1972, the standard of care in the San Francisco Bay area has been to offer women whose fetuses are in the breech presentation after 36 weeks an attempt at external cephalic version (ECV). I observed the same practice in Tucson. It was my impression that all women in these areas (including those in the intervention and comparison groups) would be given this option in accordance with the standard practice of the region.

To achieve uniformity of date of assessment, women were considered as eligible for assignment to the comparison group if their fetuses were diagnosed as breech at 36 to 37 weeks' gestation (the time at which subjects would have been referred for hypnosis). It was noted whether their fetuses were in the breech presentation at delivery. Women were matched for geographic area, age, socioeconomic status (determined by type of insurance), parity, race, and obstetrical risk status. Matching for parity was considered important because parity affects the incidence of breech presentations.[1-3] Obstetrical risk was scored by means of the Popras System for Prenatal Risk Assessment; risk scores were required to be equal. The types of insurance included uninsured, Medicaid, Medicaid with co-pay, low-level private insurance (hospitalization only), and high-level private insurance (outpatient and inpatient). To complete the 100 cases, relaxation of strict matching was necessary for age, parity, and race for some subjects.

Seventy-four subjects were strictly matched on every parameter. Relaxation of strict matching did not result in any significant differences between the two groups. Identifying data of the comparison group were generally not known to me. It was assumed that skill in diagnosis of breech presentation was equal among practitioners for both the intervention and the comparison groups. Both groups of patients were attended by fully trained, licensed physicians or midwives.

For both groups, the delivery record documented the mode of fetal presentation at delivery. For a case in the intervention group to be credited as a success for hypnosis, the baby had to remain in a vertex position until delivery even if the physician or midwife thought that the baby had turned from the time of the clinical examination. For each woman, I examined the fetal position by external abdominal palpation prior to each hypnosis session. If I disagreed that the fetus was in the breech position, the case was not included in the study unless ultrasonography confirmed the fetal position as breech.

All of the women agreed to spend up to 10 hours with me and to practice at home with an audiocassette. Participation of subjects was approved by the Research Review Board of Resources for World Health, Tucson.

THE INTERVENTION

Not knowing in advance the extent to which hypnotherapy would be successful for abnormal fetal presentation (if at all), my goal was to provide as much hypnosis as possible within my and the women's time constraints until the baby converted to a vertex presentation, the woman believed she had done enough hypnotherapy, or she was delivered of the baby. Each session was usually 1 hour (my standard appointment time), but if I had time and believed it would be beneficial, the standard 1-hour session was extended.

THE PROCEDURE

The subjects were interviewed for 10 to 20 minutes prior to hypnosis to gather information on how they had learned about the study and who had referred them, to answer any questions they might have about hypnosis, and to allay any unrealistic fears or concerns. Women sometimes had misperceptions about the nature of hypnosis that resulted from watching television programs or stage hypnosis. No attempt was made to do formal psychotherapy, although spontaneous psychotherapy did occur, as will be illustrated in the case examples.

A nondirective style of hypnosis was used. Having practiced hypnosis for almost 20 years, I conducted all of the sessions. (Sample videotapes or audiotapes of an actual session are available on request by sending a blank videocassette or audiocassette for duplication.) Each session was audiotaped and was sometimes also videotaped. The women were given copies of the audiotape and encouraged to listen to them daily at home. The women varied in how often they listened to the tape, and their compliance with listening did not appear to be related to the success or failure of the hypnosis.

The structure of the hypnosis consisted of an induction with images of nature and suggestions to relax body tension. Truisms (a term in hypnosis referring to a statement that is made to seem logically, inherently true, but that may be actually lacking in fact or substantiation, and is rendered true through a progressive statement of facts that the subject would not question, linking these truths to the conclusion that the hypnotist wishes the subject to accept) were given about how sometimes the tension in the lower uterine segment prevents the baby's head, the heaviest part, from settling down into the pelvis. When relaxation occurs, gravity would be expected to do its work and the baby would turn its head down. Women were instructed to "give up" consciously in trying to turn the baby down and to realize that now the unconscious would take over the job, knowing that if there were a good reason why the baby should remain in the breech position, the unconscious would know this and would avoid accepting any of my suggestions to turn the baby's head down. In this way, it was suggested to women that the baby's position was outside of their conscious control and not a matter about which to feel guilty if hypnosis was not successful. "Trust in nature," "trust in the body," and "trust in the unconscious to do the right thing even if it is contrary to what we think we want" were common phrases used.

A time was allotted for the use of questions and answers, ideomotor responses (which represent finger signals that mean "yes," "no," or "don't want to answer," and that are developed during the hypnosis and are presumed to represent communication from subconscious levels), or other techniques to ask the women if they had information on a deeper level about why the baby was breech. No leading questions were used; rather, the instructions were to let any response emerge even if it did not make any sense.

The sessions always ended with further self-esteem building suggestions and instructions to remember that they were always doing the best they possibly could and to trust in nature and the body to make the right decision about the baby's position.

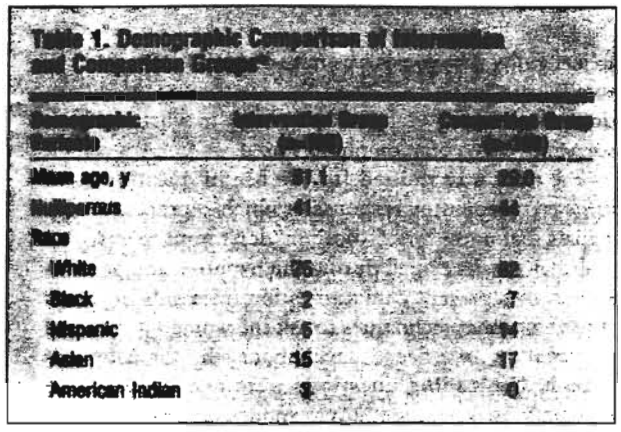
EXCLUSIONS

Subjects were excluded from the study if elective medical intervention to manually convert the baby to vertex presentation occurred less than 5 days after the first hypnosis session. This cutoff was developed from discussions with another obstetrician-hypnotherapist (David Cheek, MD, oral communication, July 10, 1992) and other consultant obstetricians who believed that hypnosis could work up to 5 days after the session. The belief was that if ECV was done within 5 days after the hypnosis, one could not determine that hypnosis had failed because insufficient time had been allowed to observe its effectiveness.

Hypnosis was claimed as an effective intervention when the baby spontaneously converted to the vertex position at any time after the first hypnosis session and remained in the vertex position at delivery. If ECV was successfully completed on the fifth day after hypnosis or later, the woman remained in the study, but this success was not attributed to hypnosis. Rather, ECV was considered as the procedure that converted the breech presentation to the vertex. I had no control over which subjects were offered ECV or when. Over one third of the subjects joined this study after a failed attempt at ECV. There was no exclusion for the number of prior failed attempts at ECV. All 100 subjects in the intervention group were followed up until delivery.

STATISTICAL ANALYSIS

For nonparametric testing, the Mann-Whitney Wilcoxon Test[16] for significance was used. For the analysis of racial differences between groups, a 2×4 table procedure with log-likelihood estimates for which χ^2 statistics can be generated was used.[17] For parametric analysis, a standard t test was used (t test procedure from Systat Inc[17]).



*Data are expressed as percent unless otherwise specified. Differences were not significant.

heaviest part at term. It would seem that gravity would tend to pull the heaviest part down.

Some investigators speculate that psychological processes can affect uterine shape and change the likelihood of the breech presentation for an individual woman. The lower uterine segment receives opposing innervation to the body of the uterus.[4] When the body of the uterus tightens, the lower uterine segment tends to relax and vice versa. Cheek and Rossi[5] have observed that anxious and fearful women have a higher incidence of the breech presentation than other women. They hypothesize that fear, anxiety, and stress can activate sympathetic mechanisms, which result in tightening of the lower uterine segment, thereby preventing entry and engagement of the fetal head. Studies have shown a relationship between maternal emotional stress and fetal hyperactivity.[6-8] When mothers in these studies were stressed, anxious, or fearful, they reported more fetal movements. Such hyperactivity could prevent the natural settling of the baby's heaviest part, a process usually driven by gravity.

To my knowledge, there are no published reports on the use of hypnosis in treating abnormal fetal presentation. Hypnosis has been shown to assist in the prevention and treatment of premature labor.[9-11] This article reports the use of a hypnosis intervention to affect the rate of spontaneous conversion of breech fetuses to the vertex position in a series of 100 women whose fetuses were in the breech presentation near term (at least 36 weeks' gestation).

RESULTS

Table 1 presents the demographics of the two groups. Relaxation of strict matching did not result in any significant differences between the groups. The age of mothers ranged from 19 to 43 years. Forty-one percent of the women in the study group were nulliparous. Racial backgrounds are presented and are not statistically significantly different. All women were fluent in English.

Seventy percent of subjects received less than 4.5 hours of hypnosis time with me, and 28% had only one session. Success was defined as spontaneous conversion of the fetus to a cephalic presentation prior to delivery or ECV. Failure was defined as the baby remaining in the breech position until delivery or successful ECV. The length of gestation at which women began hypnosis did not affect the results.

Eighty-one fetuses spontaneously converted to a vertex position. Thirty-two of the women had unsuccessful attempts at ECV by their health care providers, including those where version was attempted prior to hypnosis. Five women had successful ECVs of their fetuses more than 4 days after hypnosis, and 14 had breech deliveries. **Table 2** shows the time after initiation of hypnosis at which the fetus converted to a vertex presentation. The comparison group had a conversion rate of 48%. The difference is highly statistically significant. Of the women in the comparison group whose fetuses converted, 26% of the conversions were spontaneous and the remainder occurred after attempted ECV. Fifty-two percent in the comparison group remained in breech position at delivery.

Subjects' responses during hypnosis sessions were recorded. Notes were reviewed for the predominant verbalizations made by the subjects while they were in the hypnotic state. The tabulation below summarizes these statements made in response to the question "Why is this baby breech?" and their frequencies of occurrence. Some subjects did not verbalize at all. Others gave more than one reason. Nevertheless, this list provides some indication of what bothers women (as expressed in hypnosis) who are experiencing abnormal fetal presentations. Because no psychotherapy was attempted, nothing is known about the psychodynamics of these women.

Statement	No.
Fear of delivery	43
Fear of baby's dying	11
Fear of motherhood	47
Fear of baby's being deformed	21
Fear of precipitous delivery	9
Free-floating anxiety	21
Anxiety regarding death	27
Anxiety about parenthood	22
Belief she should be punished	6
Belief she would have a breech like her mother	16
Belief her baby would be breech because she was breech	16
Severe stress from husband/partner's having affair	6
Severe stress from death in family	3
Severe stress from husband/partner's not wanting baby	36

In classifying the women's utterances listed above, fear was differentiated from anxiety by being related to a definite potential event, with anxiety being a more free-floating dysphoria with constant baseline agitation and arousal. Fear would be expected to come and go. This

Time After Onset of Hypnosis, d	Converted Spontaneously to Cephalic Presentation and Remained Cephalic at Delivery, No.	Breech Delivery or Converted by ECV,* No.
<4	16	0
4-7	19	7
8-13	35	5
14-20	8	5
≥21	3	2
Total	81	19

*ECV indicates external cephalic version.

differentiation is consistent with that reported in the psychophysiological literature.

There were no significant differences in infant outcomes, except for the intervention group's having significantly fewer cesarean deliveries as a result of having fewer breech presentations. There were no significant differences in birth weight, infant Apgar scores, or incidence of neonatal resuscitation.

REPORT OF CASES

To further enrich the presentation of these findings, three vignettes are provided that are representative of the more commonly occurring situations.

CASE 1

Ms T was a 32-year-old woman, pregnant with her first child. She was married to an upwardly mobile investment banker. Their income was over $200 000 per year. Ms T worked as the manager of an art gallery and was career oriented. Her baby had been in the breech presentation since the 32nd week of pregnancy. She was 37½ weeks pregnant at entrance into the study.

Ms T was seen for three sessions, each lasting 1½ hours, 4 to 5 days apart. She did not verbalize while in a trance but was able to respond with ideomotor signaling. She was an excellent hypnotic subject and entered a deep trance at each session with partial amnesia on awakening.

During hypnosis, her ideomotor responses indicated a fear that motherhood would disrupt her career; stress from her husband's initial negative reaction to the pregnancy and his continued lack of enthusiasm about fatherhood (how could he be enthusiastic, she would report later, when work consumes his every conscious moment?); anxiety about the recent accidental death/possible suicide of a close cousin; and fear that delivery would be excessively painful and damaging to her. I also perceived a large degree of denial of the unhappiness in her marriage.

Suggestions were given and stories were told to Ms T to help her come to terms with motherhood. Suggestions were aimed toward facilitating a realistic acceptance of her husband's attitude and acceptance that she would not have his involvement in parenting in the manner in which she had hoped. During hypnosis, anxiety reduction was facilitated by creating the image of her cousin with whom she could engage in an imaginary dialogue for the purpose of "saying good-bye." Delivery was reframed as healthy pain and not damaging.

The baby turned to the vertex position 4 days after the third session.

CASE 2

Ms H was pregnant with her third child, the first from her current marriage. She was a PhD clinical psychologist. She had one hypnosis session after which the baby converted to the vertex position (within the same day). During hypnosis, knowledge that her husband was having an affair surfaced, which had been previously denied from consciousness. Ms H had previously refused to allow herself to believe the overwhelming evidence that came before her eyes. As she allowed herself to acknowledge the validity of her perceptions, the shape of her abdomen visibly changed during the session, becoming less peaked and more flattened. The remainder of the session concerned discussion of how Ms H would come to terms with her knowledge of her husband's affair. (In this session, minor psychotherapy was done, because of the patient's comfort with psychotherapy and in response to an acute need.)

CASE 3

Ms M was pregnant with her third child. She had grown up Jewish but had converted, declaring herself a born-again Christian. This created stress with her Jewish husband who wanted to maintain Hebrew traditions. Ms M came for two hypnosis sessions. In the first session, it was discovered that underneath the surface conflict, Ms M was terrified of delivery. Her mother had given anxiety-filled accounts of Ms M's birth and of how both had almost died. We were able to reframe her mother's descriptions as more histrionic than actual. Ms M's faith in Christ was used to develop faith in the birthing process as a natural event, blessed and watched over by Christ. Her sense of Christ as a resource for labor was strengthened, especially in that she could call on Jesus to brave the pain of labor much as he had transcended the pain of the crucifixion by welcoming it as his own personal sacrifice rather than fleeing it as he had been tempted to do the night before his arrest. Birth was relegated to a lofty ideal of noble suffering. Constant reframing gave

Ms M the idea that she could handle birth and the pain of labor and that this pain was noble and Christian to endure.

In the second session, these concepts were further reinforced and Ms M's husband's alcoholism was discovered. A treatment program was later recommended for him.

Key to Ms M's treatment was the complete acceptance of her Christian faith and the avoidance of the bait that she continually offered to fight with her about her biblical-based religious beliefs. She was able to go beneath these surface matters to the deeper fears and terrors of the birth process. Prenatal bonding was facilitated through the creation of visualized conversations with the baby inside. These exercises also contributed to the relaxation of her fears about giving birth.

The baby converted to a vertex presentation 2 days after her second session.

COMMENT

No published data could be found on the relationship between emotions and fetal presentation. Literature exists on the effect of maternal anxiety during pregnancy on the fetus and newborn. Van den Berg[6] has reviewed and summarized that research. Peterson et al[12] found relationships among psychiatric diagnoses, defense styles, anxiety, and life stress with the need for cesarean delivery, the need for oxytocin augmentation, and the occurrence of fetal distress during labor in a prospective study of 270 women. Mehl et al[9] prospectively studied 64 consecutive women and found that the psychological factors of fear and anxiety-stress, support from the woman's partner, poor maternal self-identity, negative beliefs about birth, and lack of support from friends and family predicted deliveries that required obstetrical intervention (cesarean or vacuum assistance or oxytocin augmentation/induction). The use of hypnotherapy was found to play a statistically significant role in preventing negative emotional factors from leading to cesarean section or oxytocin augmentation or induction.

No published data could be found that suggest that having had an unsuccessful attempt at ECV affects the likelihood of spontaneous cephalic version thereafter. For this reason, women who had had one or more unsuccessful ECVs prior to hypnosis were not excluded from the study.

To my knowledge, this case series is the first to appear in the literature that suggests that hypnosis can affect fetal presentation. The hypnosis subjects were motivated. It would be expected that a randomly selected population would have lesser results because of greater variability in motivation. This might be measured by recording the number of times the women listened at home to the audiotape provided to them. The fact that women presented themselves for the study implied a certain openness to hypnosis and, in some cases, sympathetic providers. This would exclude certain types of patients, including those opposed to hypnosis on religious grounds, paranoid persons, and those with difficulty trusting health care providers. A key to successful hypnosis may be the quality of rapport between the therapist and client, the degree to which the therapist can influence the client to have faith that the hypnosis will work, and the ability of the therapist to engender a rapid positive transference from the client. Certain personality disorders, along with some personality traits (coolness, distance, unempathetic), would mitigate these factors.

The hypnosis (intervention) and comparison groups were matched for parity and approximate weeks' gestation at the start of the study (36 to 37 weeks for the comparison group; 36 weeks or more for the intervention group). It was not possible to be sure that the method of ascertaining breech presentation was comparable for the two groups. Some diagnoses of breech presentation by palpation may have been erroneous and some may have been missed. Those who underwent ECV presumably had ultrasound confirmation. My extra check of fetal position in the hypnosis subjects would tend to increase apparent "conversions" in the comparison group and thus would not weaken the findings reported here. Likewise, the fact that some hypnosis subjects had the intervention after 37 weeks, and thus were observed for a shorter time than the the comparison subjects, would also tend to bias the results toward the comparison group. Other unmeasured differences between the groups may also have been present.

A further limitation of this case series is the lack of a standardized assessment of anxiety, fear, and stress in both the intervention and the comparison group subjects. Nonetheless, the high rate of spontaneous conversion from the breech to vertex presentation with hypnosis seems to support a mind-body connection in the breech presentation. Studies to elucidate this connection should employ measures of emotional states and, if possible, physiologic ones.

Jordan[18] has written about massage techniques used by indigenous midwives in traditional cultures for ECV of breech-presenting fetuses. Careful reading of these accounts suggests that these traditional practitioners may also be using the art of verbal persuasion. This is common among traditional healers and is very similar to what we call hypnosis.

Based on serial ultrasound examinations and abdominal palpation, Westgren et al[2] estimated the likelihood of spontaneous conversion from the breech to vertex position after 37 weeks to be 12%. The 81% spontaneous breech-to-vertex conversion rate observed with hypnosis in case series reported herein is comparable to the highest conversion rates achieved with ECV in controlled studies of selected groups of women at term.[19] This is all the more remarkable because one third

of the hypnosis group had had unsuccessful ECV attempts at term and 41% were nulliparous, who have a lower likelihood of successful ECV. Furthermore, there is no reason to postulate a risk to the fetus from hypnosis, whereas life-threatening or fatal complications do occasionally occur with ECV.

This case series affirms the need for a controlled clinical trial to determine (1) if I can teach others to achieve the same level of effectiveness, (2) if these results can be duplicated in another population, and (3) if other psychobiosocial factors play a role in the success or failure of hypnosis.

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Chains of Grief: The Impact of Perinatal Loss on Subsequent Pregnancy

Gayle Peterson, Ph.D., MSW

ABSTRACT: This paper identifies women who are at greater potential for medical complications in their pregnancies due to post traumatic stress resulting from previous perinatal loss. The loss may have been suffered by the woman herself during a past pregnancy or she may have inherited heightened anxiety from perinatal loss experienced by her mother. In the latter case, the unresolved grief is transmitted from mother to daughter, affecting physiological, emotional and behavioral patterns in the next generation. Pregnancy presents an opportunity for healing. Given effective prenatal counseling by a trained clinician, perinatal loss issues can be addressed through body-centered hypnosis so that history does not repeat itself. Left untreated, post traumatic stress can produce crippling anxiety for the pregnant woman, contributing to complications of pregnancy, childbirth and even parenting.

> The family who loses a newborn infant (or fetus through miscarriage or stillbirth) endures a deep tragedy. When asked, many families who have experienced perinatal death have said that the death of a newborn hurts as much as the death of an older child, spouse or parent. The loss is different: one mourns unfulfilled life. However, the love and expectations that go into anticipating a life that will not be fulfilled are usually greatly underestimated by those who have not experienced such a loss.
>
> Richard Marshall

Medical research has documented the impact of emotional stress on the outcome of pregnancy and childbirth (Lederman, et al., 1978;

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Levenson and Shnider, 1979; Gotsuch and Key, 1974, Peterson et al., 1988) as well as substantiating a critical period for bonding. (Klaus et al., 1972; Kennel, et al., 1975). The impact of emotional support on the length of labor and facilitation of *maternal-infant* interaction immediately following birth has also verified the importance of the emotional and psychological aspects of medical care during the perinatal period (Sosa, et al., 1980). However, little research has been done on the impact of perinatal loss on subsequent pregnancy and prenatal bonding, despite the fact that it is one of the most emotionally charged issues that a woman may have to deal with during the course of a subsequent pregnancy.

Although some authors have attempted to identify the needs of bereft parents (Benreid and Nichols, 1981; Marshall, 1981) there has been little research done to explore the impact on a subsequent pregnancy, or information about what can be done to help women resolve grief prenatally. The purpose of this paper is to share the importance of addressing these needs during pregnancy, and the use of body-centered hypnosis in the context of a preventive prenatal counseling program as a method of choice to reduce anxiety and resolve loss, making way for the potential birth of another child.

Women who have endured previous perinatal loss have greater emotional adjustments to a new pregnancy, including fear of another loss, which has impact not only on attachment to the unborn fetus but also may precipitate heightened fear and panic states throughout the pregnancy and into the labor process. Little had been done in standard prenatal care to help this special needs population. In my clinical experiences, it is evident that women who have endured loss in the perinatal period are at greater risk for future miscarriage, prematurity and complications of childbirth. As these women approach a subsequent pregnancy, attachment and loyalty to the previous child resurfaces, often making it difficult for the mother to form an attachment to the next pregnancy. When loss remains unresolved, disruption in bonding and attachment can affect not only the immediate maternal-infant relationship, but can have substantial impact on successive generations.

Women who have absorbed the impact of their mother's unresolved prenatal loss during their own childhood are particularly vulnerable to high levels of anxiety and fear during pregnancy, childbirth and the ongoing maternal-child relationship. These women tend toward significant expectations of loss in their own pregnancies, childbirths and parenthood.

IDENTIFYING AND TREATING SECOND GENERATIONAL LOSS

I would like to focus first on the women who suffer second generational unresolved perinatal grief. This is the least recognized impact of perinatal loss and thus usually goes untreated during the course of a pregnancy. When grief over a lost child or pregnancy remains significantly unresolved, disruption of bonding may cascade through generations. Symptoms of survivor's guilt can be identified in women who experienced a sense of responsibility to "fill in for" or "make up" the loss for their own mother. The following cases will illustrate two examples of how second generational issues of unresolved maternal loss can have impact on a woman's pregnancy, childbirth and attachments to subsequent children.

Dorothy was a 39 year old mother who came to me for preventive, prenatal counseling, described elsewhere, (Peterson, 1990; 1991; 1992) for help in preparing for a vaginal delivery after a cesarean delivery three years previously. During that pregnancy Dorothy had been two and one half weeks over due with her son. After the membranes were ruptured with no ensuing labor, pitocin was used to induce contractions. However, her cervix did not dilate beyond two centimeters during the subsequent 24 hours. Eventual signs of fetal decelerations prompted delivery by cesarean section.

In her initial interview Dorothy revealed her mother's prenatal and childbirth history (a routine part of the preventive counseling program). Her mother, who had given birth vaginally to two stillborn babies, became the patient of a physician who agreed in advance to perform an elective cesarean. Eventually her mother became pregnant and gave birth to Dorothy and two years later to her younger sister, both by cesarean. Her younger sister had also had two live births by cesarean. Dorothy's statements in her initial interview reveal her feelings of survivor's guilt:

> Everytime I think about it, I want to die. Those two boys that died . . . must have been so horrifying for my mother. The upcoming birth is frightening me, I'd like to try to have a vaginal birth but I don't trust my body to do it. Cesarean looms as our saviour . . . not such a bad thing. My mother is totally against it (vaginal birth). My baby . . . I'm so afraid she's going to die.

Five previous cesareans were the history of childbirth in Dorothy's family. She was afraid for her child and for the pain her decision would cause her mother if she tried to deliver vaginally. Dorothy re-

ported feeling her mother's unresolved grief throughout her childhood. She felt a need to make many of her own decisions about mothering her son based on her mother's fears. Anxiety and guilt kept Dorothy from a sense of being her own person and enjoying her motherhood, especially when making decisions regarding the safety of her own children. To some extent, Dorothy's bond with her son was laden with guilt that she had the boy her mother had lost. Her mother's loss of two infant sons affected her bonding with Dorothy, making normal separation and individuation difficult throughout their relationship.

The body-centered hypnosis session (done in the second hour of the four hour preventive counseling program) presented an opportunity to release Dorothy from her mother's pain and to further her own development as a separate person. During the hypnosis, Dorothy had difficulty seeing anything but her two dead brothers in her womb. Before she was able to visualize the upcoming birth of her own baby, she needed to work through these losses, and to give these ghost children back to her mother. She wept as I helped her. This session gave Dorothy the opportunity to release her mother's grief from her pelvis and to imagine her own baby safe inside her womb. Once she was able to perceive and talk to her own baby, she could visualize the childbirth.

It was noteworthy that Dorothy's mother reacted negatively to Dorothy's successful vaginal birth, — the first vaginal delivery in two generations since her mother's stillbirths. Her mother found it difficult to celebrate her daughter's success, and expressed some disapproval afterwards. This indicates the pressure Dorothy felt in her family system to validate her mother's unresolved loss through replication in her own life experience. Her statements at her postpartum visit illustrate the belated individuation that her vaginal birth engendered.

> I think my mother didn't want to be there (at the vaginal birth). I understood that she had to distance . . . but I was not afraid, I just kept pushing and the baby came right out . . . I made up my mind to do it . . . and I felt so powerful . . . It was a great birth experience.

Dorothy was able to begin to see her life's possibilities without the spectre of grief restricting her growth. The pregnancy presented a window of opportunity for resolving past generational grief and facilitating healthy development.

The next case illustrates the anxiety which may be carried into a second pregnancy, interfering with the experience of both childbirth

and ongoing maternal-child relationship. Jill was a 38 year old mother who came to me for preventive prenatal counseling following her son's birth three and a half years previously. She was pregnant with her second child, and reported feeling anxious about the childbirth. Her first birth had been a forceps delivery which she described as "horrifying." She reported that her mother had miscarried her first pregnancy and had a stillbirth with her fourth. Jill's statements from her initial interview described the anxiety she suffered and the ongoing impact of her mother's perinatal loss:

> I was the third living child . . . I'm afraid that if I have another child I'll lose one like my mother. I have the fear of that happening to me . . . I don't sleep nights because I'm so afraid . . . I had a really severe postpartum depression last time . . . and problems with bonding and realizing I was a mother . . . both my husband and I have a terror of (the depression) happening again.

The flavor of unresolved grief was evident in Jill's childhood as she described the manner in which her younger brother's ghost was kept alive: *"We always kept the memory of him alive . . . we'd say that it was Michael's birthday, and he'd be so many years old today . . . "*

In addition, Jill suffered extreme anxiety about her son's readiness for a sibling. I believed that she was projecting her own experience of her brother's birth and death onto her son's anticipated experience of his future sibling. She expected her son to feel abandonment and want to hurt or kill the baby — perhaps emotions she had felt in her own childhood following the death of her brother, Michael, and the ensuing experience of her own mother's grief and depression

Jill's body-centered hypnosis session focused on normalizing her fears regarding her son's adjustment to a new baby. I focused on hypnotic messages and metaphors for seeing her two healthy children in the future. She responded positively to these suggestions. She was able to see that she was giving her son a "gift of brotherhood." This helped to release the unresolved grief that was held in her family and in her own body. No postpartum depression was reported at her six months follow up visit. Her statements at the postpartum visit reflected a generalized "lift" in her spirits as she described her childbirth experience and referred to the hypnosis session which we had taped and to which she had listened throughout the last months of her pregnancy:

> When I went into labor there was no fear at all . . . I already felt bonded to the baby because you gave me the feeling she would live and grow up. I had such a good time . . . listening to your tape. I felt it was really O.K. to let go. It was such a positive experience . . . It was so much fun. I really wanted to do it again.

Jill also reported sleeping better, and enjoying her two children interacting with each other. She related that her son was adjusting well to the new baby and that she was enjoying motherhood "so much more than the first time." It seemed clear that her unresolved grief issues about her own brother and her family's continued and unresolved grief over their loss had impeded Jill's ability to enjoy and bond to her own children. Again, the pregnancy presented an opportunity for lifting the anxiety and depression stimulated by unresolved grief in the previous generation, allowing Jill to be more present and emotionally available to her children.

DEALING WITH PRESENT PERINATAL LOSS IN A SUBSEQUENT PREGNANCY

The following case illustrates the benefit of adequate grief resolution before the next birth. Nancy was 31 and had recently experienced an early miscarriage when she came to see me for help conceiving and maintaining her next pregnancy. Eighteen months previous to her miscarriage she had given birth to a son prematurely, at five and a half months gestation. He had lived seven hours before he died in her arms. During our short term work she was also currently in individual therapy. She was frightened of trying to get pregnant again because she felt she could not bear another loss. She also expressed feelings of disloyalty if she were to love another child. I saw Nancy for three sessions prior to conception, and two sessions during her next pregnancy.

In our second meeting, body-centered hypnosis for releasing her grief took the form of a regression back to her son's birth. We also spent time with her images of a "ragged" womb, which needed healing. During this process she was able to experience her son as having lived for seven hours. This helped to reframe her sense of loss, as she came to appreciate the hours spent with him. She spoke to him of her guilt at not being able to protect him, expressing love to him and wondering if he had felt pain. Near the end of the session, her statements indicated a sense of peace, and the beginning of being able to make way for another child:

> I never thought of him as having lived before . . . but he did and he was so strong. The doctors were surprised he hung on so long . . . maybe so I could say 'goodbye' . . . He brought my whole life into a different relief . . . I've changed so much . . . but I can hear him saying to me, now . . . go ahead, Mom it's O.K. (referring to having another child).

The next week Nancy reported that her womb "no longer looked ragged." The second hypnosis session focused on healing and Nancy was able to see her womb as smoother and pinker than before. She responded positively to hypnotic suggestions for implantation and metaphors for preparing the womb, readying it for a new baby. Visualization of her family with the new baby was also suggested.

Nancy returned nine months later, at 22 weeks of pregnancy. She reported minor anxiety about fear that came up when she went to the bathroom in the night. This was the time in her first pregnancy when she had discovered she was in premature labor with her son more than two years earlier. Her anxiety was also no doubt correlated with the fact that this was the exact time in the pregnancy that she had given premature birth. She responded positively to hypnotic metaphor and images of "a garden with adequate drainage, which assured that the roots remained securely implanted and nourished."

Nancy gave birth at home to a healthy, full-term baby girl. She reported having had a wonderful childbirth and no postpartum depression at her six months follow up. She expressed feeling very bonded as a family which consisted of her baby, step-daughter, and partner.

Nancy had sensed that her miscarriage was related to her inability to let go emotionally of her first baby. Feelings of disloyalty at the imagined bond to another child were painful, and might have remained so had she not taken the opportunity to resolve some of this grief before *conception* . . . . It is noteworthy to observe the difference in Nancy's level of anxiety in her next pregnancy (relatively low), following pre-conception work, compared to the ongoing anxiety, still present in the two previous clients, Dorothy and Jill, when our initial contact was during rather than before pregnancy. These cases suggest that perinatal grief, when not treated, continues to have impact on future pregnancies and maternal-infant relationships. It is important for prenatal care-givers to recognize anxiety related to past

perinatal loss in a woman's personal obstetrical history, and to be aware of the possibility of previous generational loss on a present pregnancy.

Body-centered hypnosis in the context of preventive prenatal counseling, as described elsewhere (Peterson, 1990, 1991, 1992), is a primary method of choice in dealing with the resolution of perinatal loss.

GUIDELINES FOR DEALING WITH PERINATAL LOSS IN PRENATAL COUNSELING USING BODY CENTERED HYPNOSIS AS A METHOD OF CHOICE

1. Incorporate anxiety rather than attempting to minimize or lessen it.
2. Don't avoid using the previous child's name. Make a place for the previous bond and "seed" possibilities of moving on, making room for the next child.
3. Recognize/acknowledge the fear related to previous loss, *and* the desire related to future experience. Hold the space for both.
4. Be aware that the time of loss, *when* it occurred in the previous pregnancy will be *charged* in a subsequent pregnancy. Ongoing contact with a caregiver (prenatal counselor) is important during this period.
5. Acknowledge client attachment to the last child. Address disloyalty issues related to the next child. Be aware that "survivor's guilt" could be projected onto the second child, making bonding difficult.
6. Be aware that facing the possibility/reality of a healthy, normal child can take a great deal of courage. Validate that it takes courage to attach/bond again.
7. Look for ways to help the client leave the loss behind. But *pace* the therapy appropriately to the woman and her specific situation and needs.
8. Support commitment, but do not insist on prenatal bonding, during the birth visualization: settle for facing/meeting the baby, but not necessarily greeting it!
9. Emphasize the resiliency of life in the context of a non-blaming approach and reframe the loss experiences to make way for the future possibilities of a live birth.
10. Be aware that the client may feel guilt over the failure to protect her child — undermining her confidence as a mother. Seek to accept her, and offer appropriate ways to reframe any sense of failure.

CONCLUSIONS AND RECOMMENDATIONS

As previously discussed, research has documented the effects of emotional and psychological issues on pregnancy and childbirth. However little has been done clinically to create opportunities in standard prenatal care to recognize and address emotional and psychological factors in a short term and effective manner. Perhaps this is due to a lack of appropriate training programs and knowledge of how to design and implement these programs in the context of prenatal care. It is my hope that more prenatal practitioners will become aware of women's needs and seek to refer and/or expand their practices appropriately to address the emotional nature of pregnancy utilizing the appropriate short term preventive, prenatal counseling models described in this paper. Prenatal counseling using the methods described benefit the medical as well as psychological outcomes of pregnancy. Addressing emotional issues during this crucial family transition can offer significant positive impact on the psychological health of family relationships for years to come.

In addition, there has been little exploration into the effects of perinatal loss on subsequent birth and developing human relationships. Clearly women who have experienced pre or perinatal loss are a particularly high risk population, given the increased emotional trauma to be resolved. As is true in the ordinary situation but even more important with this specific group of women, pregnancy offers a window of opportunity for healing and resolution that has been too long ignored. Pregnancy is a period of natural growth and development, fueled by hormonal changes and a normal psychological developmental crisis. It is suggested from the clinical work described, that perinatal loss is an area that warrants further investigation due to the impact not only on physical health and reproduction, but on the disruption to the bonding and attachment processes that usually follow. Further research is needed to determine the impact of perinatal loss on subsequent pregnancy and ongoing human development.

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the Real World

Here's your chance to be a fly on the wall as three couples and a family therapist explore some of the common fears and issues expectant parents deal with. Plus a quiz to find out if your relationship is baby-ready. BY SHARON COHEN

#11

WHEN 3 MAKES BABY

A while back, we invited a group of pregnant women to our offices to tell us what they liked about our magazine and what they wished they'd find more of in its pages. Give it to us straight, they told us. Give us the nitty-gritty, a real-world look at what being pregnant, giving birth and having a new baby in the house are really like. What they wanted more than anything was honest information about the emotional aspects of pregnancy and new parenthood, including the lowdown on the impact on a couple's relationship. /// So early this year we asked three expectant Los Angeles-area couples to take part in a roundtable discussion with *Fit Pregnancy* Advisory Board member Gayle Peterson, M.S.S.W., Ph.D., a family therapist who specializes in pregnancy and parenting. The result was a no-holds-barred airing of some of the fears and issues prospective parents face today. ///All the participants were nervous and excited about having a baby but also optimistic they would be good, loving parents. Given their sincerity and thoughtfulness, we're confident they will be. As for you, we hope what they learned will help you in your own journey toward becoming a parent.

THE COUPLES: Josh and Marina Myler, both 32, met 14 years ago and have been married for 2½ years. Their first child, a boy, is due Feb. 19. Josh is a real estate agent; Marina an actress and writer.

Christopher Miglino, 38, and Mariam "Chandanni" Parris Miglino, 33, have been married for almost four years and are expecting their second child on April 3. They run a multimedia company devoted to yoga, holistic living and spirituality. Mariam lives with their daughter, Shanti, 2, and her parents during the week while Chris travels on business. The couple spend weekends together.

Anthony Jones, 29, and Michelle Alfonzo, 26, have been together for approximately two years and welcomed their first child, Jalen Emilio, on Jan. 20. Anthony runs an entertainment company and works as a DJ on weekends. Michelle is an audit clerk for a medical staffing firm.

OUR MODERATOR: Gayle Peterson, M.S.S.W., Ph.D., is a family therapist and the author of *An Easier Childbirth, Birthing Normally* and *Making Healthy Families* (Shadow and Light Publications). A mother of two and grandmother of three, she has offices in Oakland and Grass Valley, Calif.

Fears and Issues

He's concerned there won't be a balance between being parents and being a couple.

Josh: I'm afraid of not having any time for romance after the baby is born, worried we won't set aside time to go out alone together and keep things interesting. I've talked to couples who swore never to have help because they don't want to miss a single wonderful moment of their baby's life, but I think there has to be a balance.

Dr. Peterson: You're correct—the couple's relationship is the garden in which children grow. That relationship is like a plant: If you don't water it regularly, it dies. This is why it's so important to carve out time to be alone together and to be romantic. Even if you're breastfeeding, you can go out for 2 to 2 ½ hours if you have someone you can trust to care for the baby.

When you have children, three things can happen: You can not have room for them in your relationship; you can have room for children *and* your relationship; or you can have room for children only and not your relationship. Guess which one is balanced?

Marina: I worry about neglecting intimacy too. The longer you go without it, the harder it is to get it back.

Dr. Peterson: That's really true for physical intimacy as well. Besides being tired, new mothers can get "touched out" taking care of a baby, especially if they're breastfeeding. So it's natural for a couple's sex life to decrease in frequency after they have a baby, but it's important to keep it alive. You just have to plan for it because there's so little time for spontaneity anymore. It doesn't sound very romantic, but that's the way it is.

Pregnancy sometimes makes her feel trapped and resentful.

Michelle: Recently, Anthony wanted to go out to a club that I love. He didn't want me to go with him because it would be full of cigarette smoke. Of course, I knew I shouldn't go, but I felt like I was trapped because I was pregnant. I realized I was being jealous; still, we had a fight about it and he left the house.

Anthony: I got upset and angry with Michelle. But then I decided that instead of expressing anger toward her, which tends to make her withdraw, I would try to understand where she was coming from. When I tried putting myself in her shoes, I ended up not going to the club. I came home without her knowing it and slept on the couch.

Dr. Peterson: This is the kind of restriction that comes up a lot after a child is born, and it's important to learn what gets you through it. The "attack-withdrawal" syndrome you described won't get anyone anywhere. When discussing things, you need a "soft startup" instead of a harsh one—this means that even though you both might have strong feelings, you need to start dealing with an issue by attacking less and connecting more. In this case, what worked was Anthony putting himself in Michelle's shoes. You both had to give something up, but the way it turned out helped to bond you as a family.

She worries that having a second child will cause them to lead separate lives.

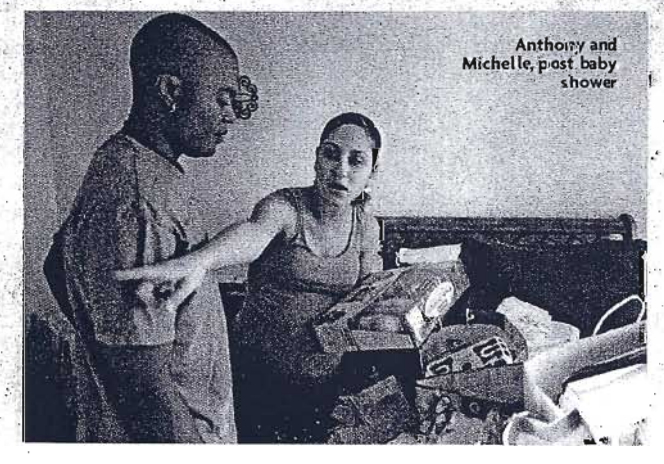
Mariam: My husband's business is his passion, his life, and it's all mixed together. I've had to join his life, or I'd never see him. I don't want separate lives; I want us to be a team. I'm afraid he's so obsessed about making positive change in the world and creating a beautiful life for us that he won't put our family first, moment to moment, day to day.

Dr. Peterson: It sounds like you feel things are unbalanced.

Mariam: I do, and I don't want to just accept it, because I'm afraid we'll drift apart. I'm also afraid that if I don't address it, it will become a big issue in our relationship.

Chris: I don't see it that way; I don't feel I'm going to be uninvolved in our family's life. When we made a decision to have a baby, I accepted the responsibility that comes along with that—it's just as important for me as anything else.

Dr. Peterson: You work together, but you also need "couples time" so that you're not just together for the children and the work. Chris and Mariam, your homework is to find some regular activities to do together, even if it's just once a month. It's the regularity that counts. Spontaneity is for when you don't have kids; plans are for when you do. (CONTINUED ON PG. 148)



Anthony and Michelle, post baby shower

The Miglino household often also includes Chris' son, Julian, 6.

Baby makes 3

continued from pg. 78

Dr. Peterson wants Chris as well as Mariam to enjoy "alone time" with Shanti.

He wants to watch the birth; she doesn't want him to.

Marina: I've heard stories about men who watched their wives give birth and then had a very different relationship with her body. They didn't see it quite the same. That's why I want Josh to stay up by my face when I'm having the baby.

Josh: I understand Marina's concern, but I feel that giving birth and having sex are two mutually exclusive things. I really want to watch the birth and don't see myself being negatively affected. I think it will be the most beautiful and amazing thing in the world.

Dr. Peterson: Marina, hopefully that will assure you. You're going to see and have much more to deal with than childbirth as you go through the life cycle together. And it's important for people to see normal births. The negative fantasies happen when birth occurs behind closed doors. It's also important to know that for a woman, sexuality deepens after giving birth—not immediately, but over time. The ability to be sensual increases because more blood goes to the pelvic area.

She "wants it all"; he thinks that's impossible.

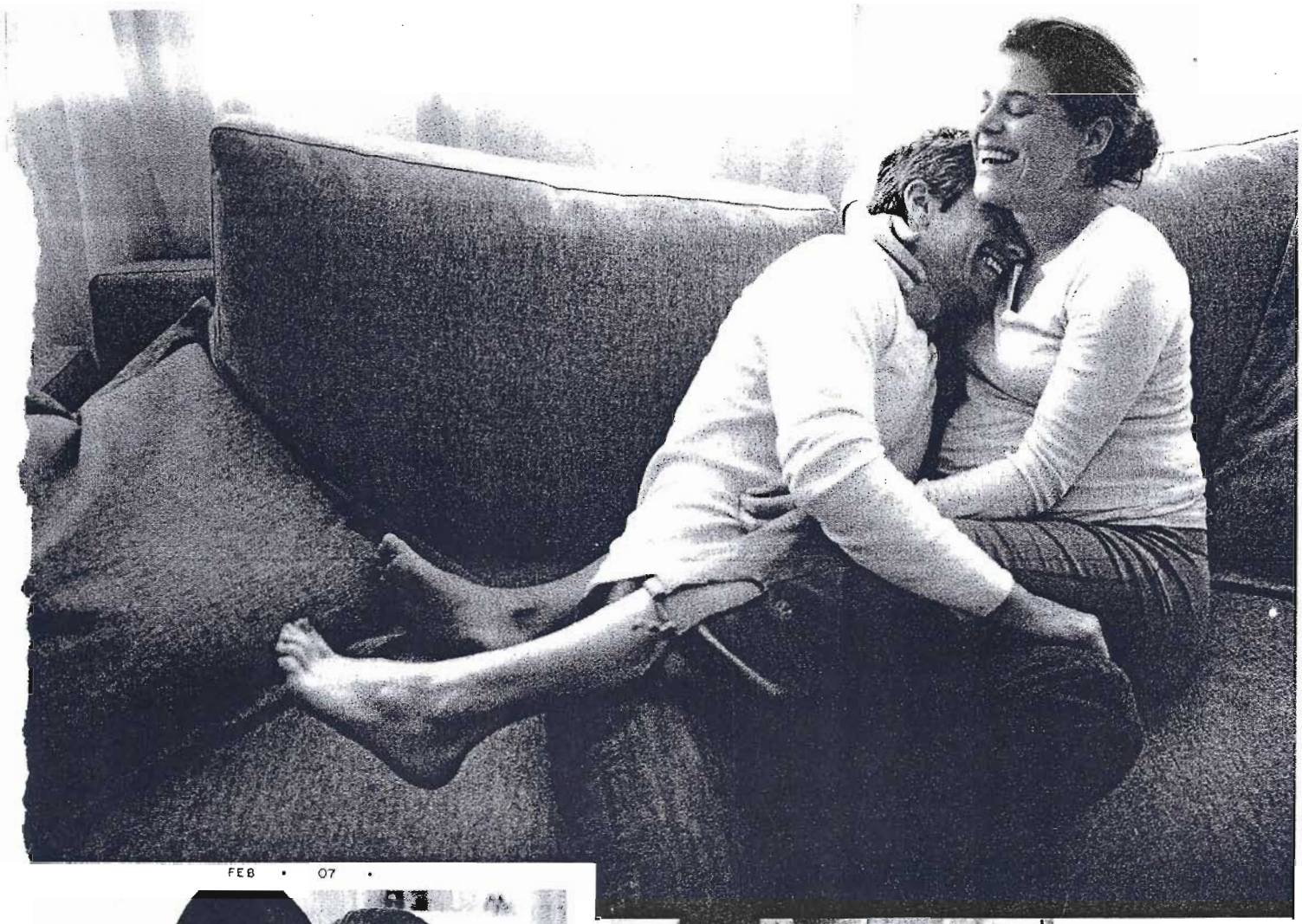
Chris: During Mariam's first pregnancy, everything was cool—we did yoga all the time, traveled, even went to India. Then the baby was born, and we couldn't keep living like that, even though we thought we'd be able to. Mariam found it hard; she felt trapped in hotels with the baby, breastfeeding. So that has become an issue with us; she wants to be involved in everything that is going on. But when you have a child, there's a trade-off—you can't have it all or do it all.

Mariam: It's true, I want to work and travel, but I also know my young children need me. Yet I'm afraid of being stuck in the house alone while Chris is out having an exciting life.

Dr. Peterson: Chris, because you're gone a lot, it's especially important that there are times when you have primary, hands-on caretaking responsibility for the children. That way, Mariam will feel you understand her and what she deals with. If Chris finds a way to help Mariam do the things she wants to do, she feels he's supporting her. That really strengthens your bond. It's important for the children too—it makes them feel secure with both parents.

As you're all learning, the birth of a baby represents the birth of a family. Every stage—such as going from a couple to having one child, then a second—requires negotiation and adjustment. Your challenge as a couple is learning how to stay connected through time and conflict. Family research shows that's what makes all the difference.

Roundtable moderator Gayle Peterson, M.S.S.W., Ph.D. Her website is makinghealthy families.com.



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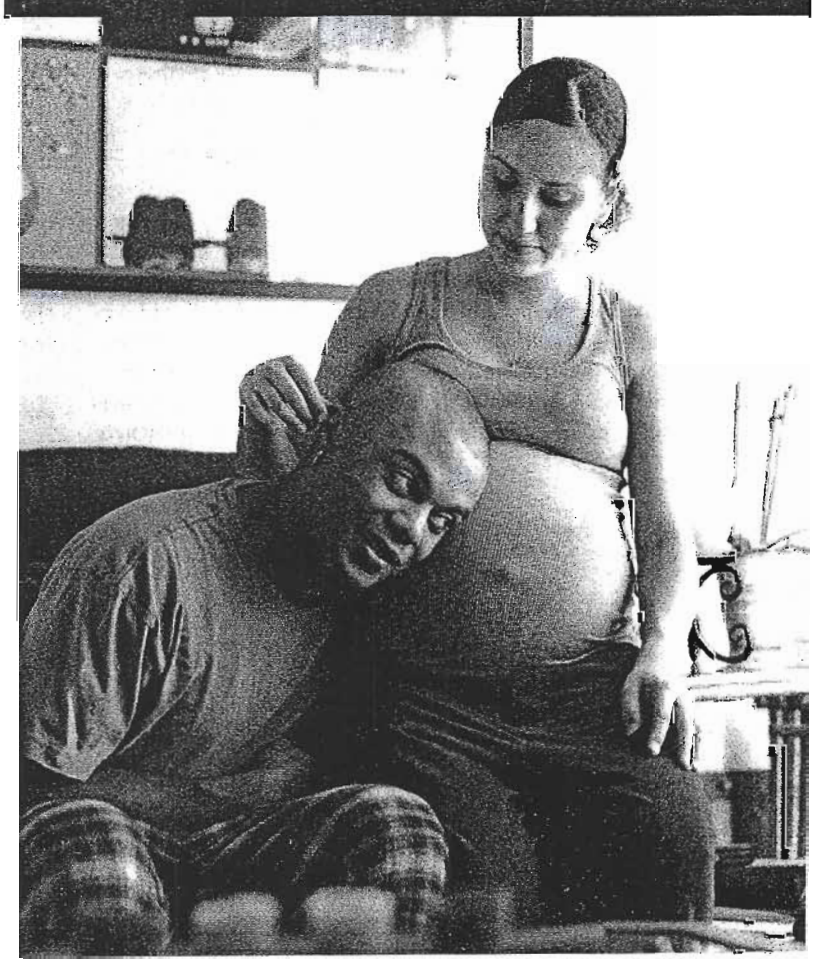
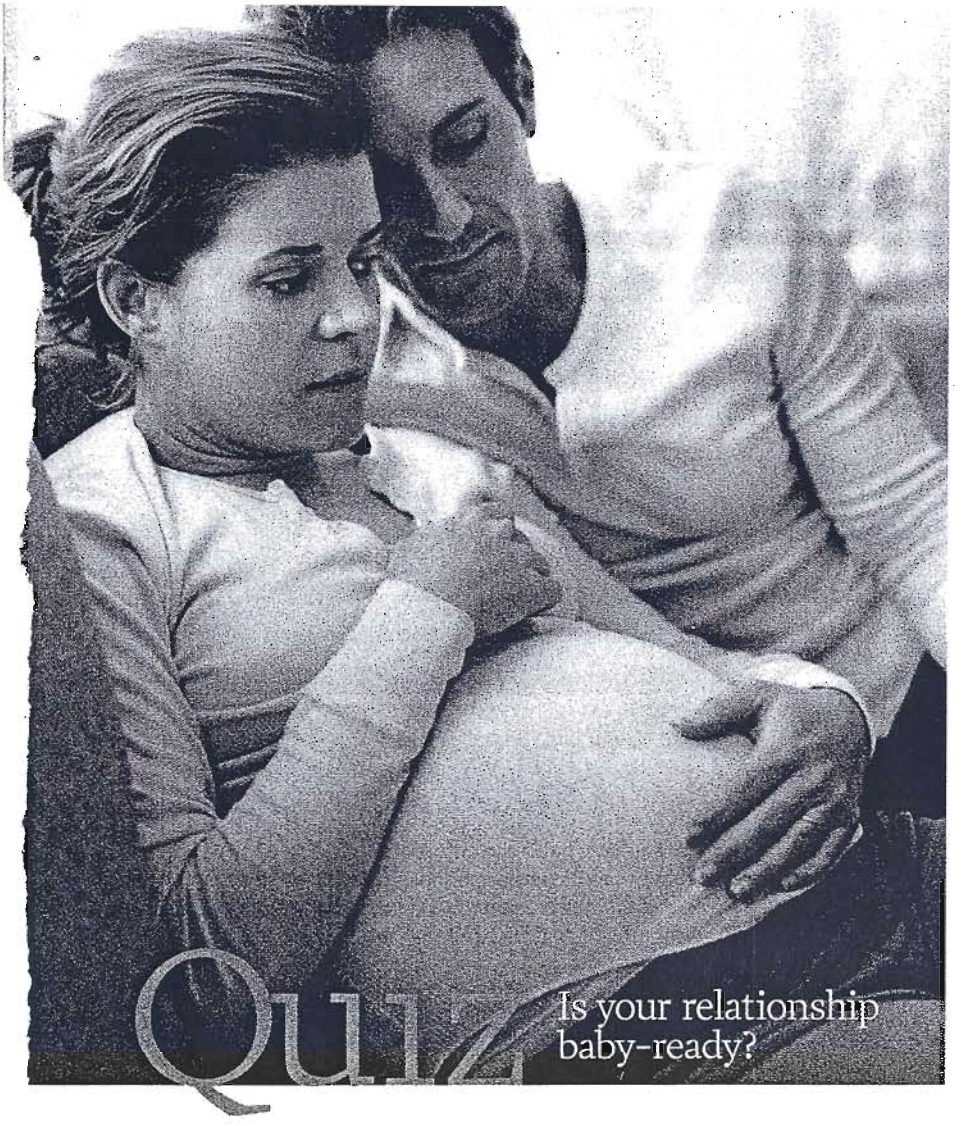


Top: Josh and Marina Myler. Above: Mariam and Christopher Miglino. Right: Anthony Jones and Michelle Alfonzo. All three pregnant women shared a common fear of losing their freedom and identity but are fortunate to have supportive, empathetic partners.

Photographs by Kiina Villani



Quiz

Is your relationship baby-ready?

The quiz below, created by roundtable moderator Gayle Peterson, M.S.S.W., Ph.D., allows prospective parents to identify five major factors that determine the health of their relationship before it's stressed by the birth of a baby: how they make decisions; how well they stay connected when they argue; the amount of family support they have; whether their relationship has healthy "boundaries"; and the warmth of their overall connection. You and your partner should take the quiz separately, then compare answers. (Add up the numbers of the answers you check, then see what your score means.) This allows you to see any major discrepancies. For example, one of you may feel he or she is always consulted by the other about decisions, and the other may not. The information you gain will help you identify the strengths and weaknesses of your relationship, the first step in facing the challenges parenthood will bring.

How often do you complain that your partner does not consult with you about decisions that involve you both?

1___ Always.
2___ Most of the time.
3___ 50% of the time.
4___ Occasionally.
5___ Never.

When disagreements occur, my partner and I:

1___ Get angry and cannot complete discussions.
2___ Get stuck in blaming and withdrawing from each other.
3___ Emotionally shut down and stop talking for at least 24 hours.
4___ Take some time apart but are able to reconnect and talk about the disagreement within 24 hours.
5___ Remain emotionally connected during the argument even if we do continue to disagree.

How would you describe your relationship to your partner's parents?

1___ Cool and emotionally distant.
2___ Stifling.
3___ Overly close.
4___ Close-knit.
5___ Comfortable and supportive.

How would you describe the influence of your partner's parents when it comes to decision making?

1___ Partner always takes his or her parents' suggestions over mine.
2___ Partner always agrees with his or her parents but acquiesces to my point of view if different.
3___ Partner is overly influenced by his or her parents' suggestions but discusses decisions with me before coming to a conclusion.
4___ Partner always opposes his or her parents' suggestions.
5___ Partner and I work as a team in making decisions for ourselves. His or her parents' suggestions are not an issue.

When it comes to verbal expressions in your relationship, which of the following ratios comes closest?

1___ 20% love and appreciation/80% complaints and criticism.
2___ 50% love and appreciation/50% complaints and criticism.
3___ 60% love and appreciation/40% complaints and criticism.
4___ 70% love and appreciation/30% complaints and criticism.
5___ 80% love and appreciation/20% complaints and criticism.

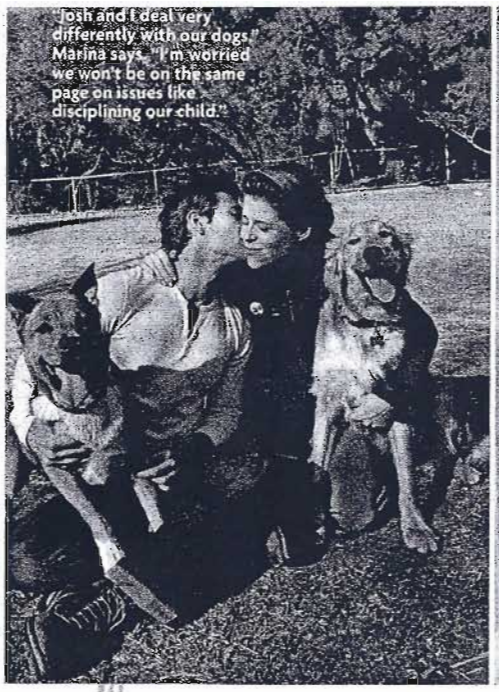
How did you do?

20–25 Congratulations! Your foundation is strong. You are comfortable with each other when it comes to working as a team and honoring the intimacy of your relationship. You both feel appreciated and included in decision making, and you both experience and express warmth.

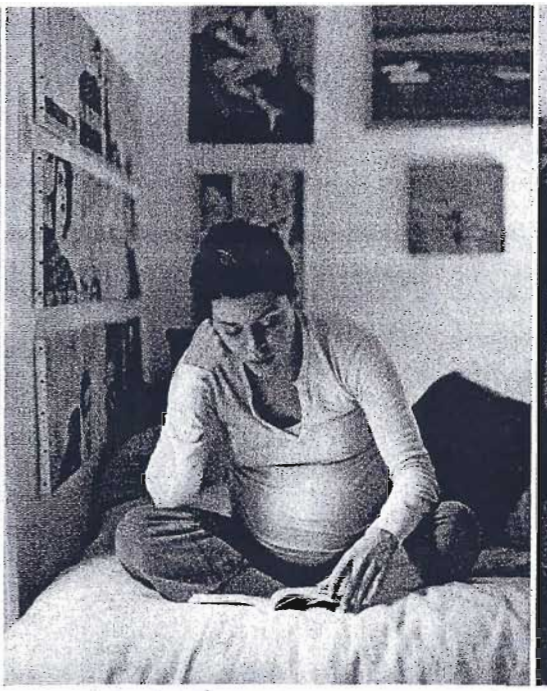
15–19 Not bad. You have some conflict around decision making and need to work on developing a style of interacting that makes each of you feel considered by the other. Your relationship needs some tweaking so as to not be overly stressed when a child arrives.

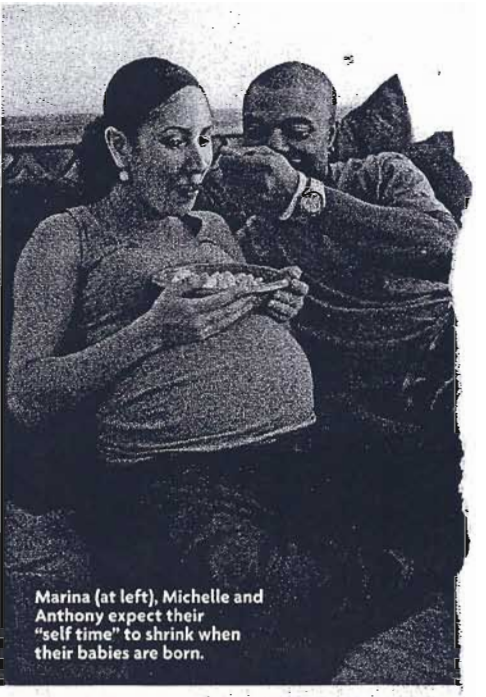
5–14 Needs work. If you are not able to resolve conflicts and remain emotionally connected during arguments before having a child, your relationship will likely falter under the weight of new parental responsibilities. Work on verbalizing appreciation, and learn how to disagree without punishing, withdrawing or attacking.

FOR ANOTHER REVEALING EXERCISE, READ ON>



"Josh and I deal very differently with our dogs," Marina says. "I'm worried we won't be on the same page on issues like disciplining our child."

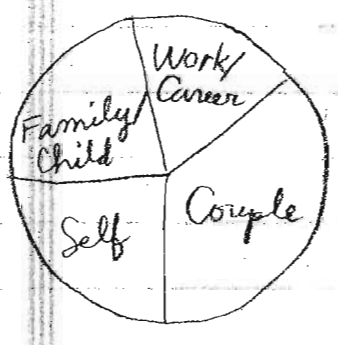


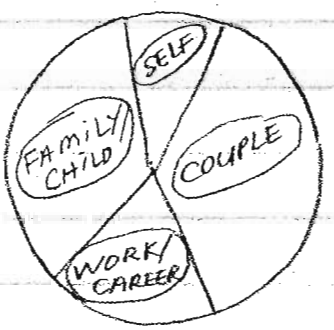


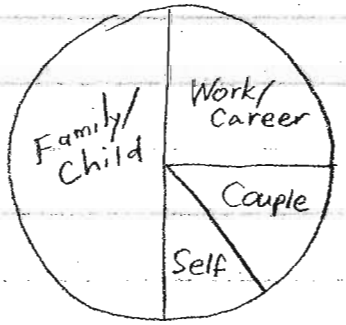
Marina (at left), Michelle and Anthony expect their "self time" to shrink when their babies are born.

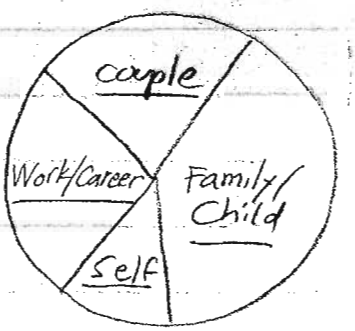
Slicing up the "time pie"

Dr. Peterson had each roundtable participant create a "time pie" that showed how he or she anticipated dividing up the time available after the baby was born. This is a revealing exercise for prospective parents because it indicates whether they have similar or different expectations about how their time will be spent when they are parents. Dr. Peterson also suggested it might be interesting for the couples to create another time pie in six months or so (after their babies are born) and see if and how it changed. Here is what two of our couples' time pies looked like:









JOSH

"I need time for myself for things like exercise, reading and creativity in order to feed other areas of my life. If I don't, I'm afraid I'll lose my sense of, well, self, and that in turn will affect other things. If I give too much of myself to my career, my relationship suffers and then, in turn, my career suffers. I'm a big fan of balance over time."

Marina

"I don't anticipate having nearly as much time for myself as Josh does for himself after our baby is born. 'Self time' even includes things like going to the bathroom, and babies shrink that."

Anthony

"I work six days a week, but I still hope to be able to devote a lot of time to Michelle and our baby and to activities as a family. That doesn't leave a lot of time for myself, but I'm fine with that."

Michelle

"I don't see having a lot of time for myself, but it's still very important to me. Maybe I will discover something else I want to do with my life over the next few years. Whatever that may be, I want to blend our child into my activities."

Dr. Peterson: The difference in the amounts of time Josh and Marina anticipate having for themselves after their baby is born could indicate a potential conflict arising between them. Marina might feel that Josh has too much "self time" and she doesn't have enough. Different expectations about time need to be talked about. On a minute-by-minute basis, "self time" won't be balanced, but over longer periods it should be.

Dr. Peterson: Anthony and Michelle both value time spent as a family, and they have pretty similar expectations about the division between family/child, couple and self time. This doesn't guarantee they won't ever have any conflicts about it, but the fact that they anticipate a comparable use of their time is going to help them.

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