Early Use of Psychotherapy in Prevention of Preterm Labor: The Application of Hypnosis and Ideomotor Techniques with Women Carrying Twin Pregnancies

Author: Cheek, David B, MD, FACOG

Publication info: Pre- and Peri-natal Psychology Journal 10. 1 (Fall 1995): 5-19.
ProQuest document link

Abstract: None available.

Full Text: Headnote ABSTRACT: Conscious and unconscious fears appear to be the cause of preterm labor. These can be discovered and removed during brief telephone communications using hypnosis and ideomotor techniques at any time from the onset of painful Braxton Hicks to the irreversible situation where cervical dilatation has exceeded four centimeters or the membranes have ruptured. Two examples are offered to demonstrate the methods successfully used to help two women carry their twins to viability. The author's research appears to justify the contention of veterinary studies that the fetus of lower animals triggers maternal expulsive labor. The hypothesis is presented that pyramiding maternal fear starts a sequence of events that can culminate in expulsive preterm labor when premature infants conclude that they are not wanted. An important feature of treatment is the reestablishment of maternal-fetal telepathic communications that are stopped when a pregnant woman loses hope of having a living child. INTRODUCTION In spite of improving prenatal care for the majority of pregnant women in America, the incidence of preterm birth which was 7 percent in the 1970's rose to 9.41 percent in 1981 and 10.6 percent in 1989. About 300,000 infants are born weighing less than 2500 grams each year in the United States. Approximately 40,000 infants die each year before their first birthday and two thirds of these weighed less than 2500 grams (5 pounds 8 ounces) at birth (Miller, 1994). Anything that could lower the rate would save enormous agony and expenses for the parents of immature infants. I believe preterm labor is preventable when pregnant women are healthy, their infants developing normally and the fetal membranes are intact. I want to point out that bed rest, magnesium sulfate, ritodrine, terbutaline (tocolytic drugs) and calcium channel blockers have been used for many years with far less than satisfactory results in preventing the progression from painful Braxton Hicks (1871) contractions to expulsive labor and delivery of immature infants. The incidence of preterm deliveries in my practice between 1946 and 1956 was 6.8 percent in spite of my knowledge that emotional factors were involved in each case. Verbal reassurance and hypnotic relaxation made no difference. My fetal mortality from prematurity was about the same as that of my colleagues in a similar practice at that time. The factors responsible for preterm labor lay below conscious awareness and were not reached by verbal interchange. After incorporating use of ideomotor search methods with hypnosis in my final 12 years of clinical obstetrical practice, my incidence of preterm births dropped to 2.6 percent and all my premature babies weighed more than four pounds; all survived. There is an underlying pattern of development in the sequence of events leading to a change from painless Braxton Hicks contractions to those starting at the two horns of the uterus and progressing downward to dilate the cervix and expel the fetus. This became clear during my research on the unconscious factors in preterm labor: 1. The pregnant women becomes unconsciously alarmed about the safety of her infant. 2. She has recurring troubled dreams that are not remembered on awakening. 3. She is awakened eventually by painful contractions that previously have occurred unnoticed. These are initially only painful concentric contractions. They continue to squeeze out used blood and allow ingress of fresh blood carrying oxygen to the fetus and will not threaten the fetus unless the mother panics. 4. But a pregnant women will be alarmed because recurring pains mean labor to her at a time that would endanger her unborn infant. She will report her distress to her midwife or obstetrician. 5. Her midwife or obstetrician will be afraid that inaction might be interpreted as malpractice in the event that a premature infant is born. It is considered legally imperative to commence immediate bed rest which now is being reported to be more likely to start, rather than stop, preterm labor (Saunders et al., 1985). Monitoring of the contractions,

hospitalization for treatment with tocolytic drugs have not proven their value but they are used basically out of fear of not doing enough. His or her concern will be amplified if the women carrying twins are in danger of going into labor before term. 6. Active treatment increases the patient's apprehension and thus contributes to a continuation of painful Braxton Hicks contractions. 7. Realization that none of the treatments are relieving her pain makes the pregnant women stop communicating with her fetus. Fetal-maternal telepathic communication is an innate bonding process used by all happily pregnant women. It stops if the woman feels she may not be able to have that baby. 8. One or both fetuses eventually becomes alarmed because the mother is not normally active. She is on bed rest with the constant companion of a uterine monitor. It senses her anxiety and her telepathic silence as indicative of not wanting to be pregnant. 9. Now the fetus feels the need to escape from what it considers an unfavorable environment. It has no knowledge of its mother's external world. It activates the process that is normally saved for labor at term. The reason, however, is very different from that of a baby looking forward to birth. The premature fetus will secret messenger proteins that traverse the placenta into the maternal circulation to trigger the mother's release of prostaglandins and oxytocin. Labor begins (McDonald, 1991, Nathanielsz, 1992, 1994). 10. The process from initial distress to the time of beginning expulsive labor may take a few hours for a particularly distressed pregnant women but usually is measured in days or weeks before the fetus or fetuses become troubled enough to start their mother into labor. 11. The sequence can be stopped at any time with combined hypnoanalytic techniques between the beginning and the moment fetal membranes have ruptured or the cervix has dilated beyond 4 centimeters. Psychological Intervention Women whose unconscious fears have been addressed and removed during the first trimester are not likely to go into premature labor. Most obstetricians, however, do not use hypnosis to explore prenatal and birth imprintings that can strongly influence a woman's attitude toward childbearing. Intervention usually starts after the above train of events has begun. The work is easy if the first telephone call occurs before the frightened patient has called her midwife or doctor. It becomes progressively harder after active treatment has begun. Intervention after effacement and beginning dilatation of the cervix requires a constant vigil and repeated calls to ensure safe conduct for the remainder of the pregnancy. The concern and interactions of innocent friends and relatives can overturn otherwise constructive therapy. The two cases reported here are excellent examples of relatively easy intervention. More complicated examples will be reported subsequently. Three telephone calls were all that were needed for the first case and seven with the second, more vulnerable patient. Use of Spontaneously Occurring Hypnoidal Behavior Hypnotic intervention by telephone during emergencies is made easy because the caller is alarmed and is essentially in a hypnotic like state when she picks up the telephone to report her problem (Cheek, 1969). The therapist needs to phrase all semantic communication in positive terms. Positive leading questions are used rather than neutral ones. It is important to change the hopeless-helpless feelings a frightened mother usually projects during the first conversation. She needs to eliminate her feelings of being a bad patient in trouble and take on the role of the protective and powerful mother. She is urged to recommence loving orders to her twins. Efforts are made to give her the ability to use self hypnosis and the means of checking her sleep ideation on awakening each morning. She needs training to develop analgesia for her abdominal and pelvic muscles to guarantee a short and easy labor when "the babies are ready to be born." Finally, I try to get the mother to hallucinate the date of her delivery, the weights of her babies and the length of labor. Ability for her to do this reflects her confidence in carrying to term. REPORT ON TWO WOMEN IN PRESUMED PRETERM LABOR Women carrying twin pregnancies are diagnosed very early in the first trimester since the explosive use of ultrasound in the 1970's. Diagnosis will often be made within the time frame when about 17 percent of pregnancies have started off with twins. The less well implanted twin will expire and be resorbed within the first trimester without the mother knowing about it. Such women are, for this reason, spared a certain amount of emotional distress. Slightly more than 1.2 percent of all pregnancies end with delivery of twins. With present day ultrasound evaluations, women who conceive their twins normally will have more than 20 weeks to wonder about and dream about the possibility of going into labor prematurely. They

have been advised of this risk because of the legal importance of obtaining "informed consent" for their obstetrical care. This is not the fault of the midwife or obstetrician. There has been a burgeoning use of in vitro fertilization and implantation of multiple fertilized ova into the tubes or uterus of women who have failed to become pregnant the usual way. There are a growing number of preterm threats and preterm deliveries by such women. Invasive treatment at the hands of fertility experts does not always follow a hypnoanalytic evaluation of possible unconscious reasons for infertility. Kroger (1952) and I have found that many women do not ovulate or they repeatedly abort before their first missed menstrual cycle. They have had a continuing conflict between their conscious desires and their unconscious fears about childbearing, the stress of labor or the fear of being abandoned by their mate. The therapeutic intervention with the two women being presented here was made easy because their first call came at an opportune time. The first call came before treatment had been given; the second, after treatment had seemed helpful in the hospital. Both women had read about emotional factors initiating preterm labor and had found that free consultation was available to them in the book Having Twins by Elizabeth Noble (1991). CASE I Alice. First call 2/13/91. Total number of calls: 3 Delivery: C.S.: 5/29/91 at 36 weeks. A: 5 pounds, B: 4 lbs 8 oz. Alice is 30 years old, pregnant with twins at 16 weeks. Cramping abdominal pains began an hour after her midwife called to tell her that the ultrasound this morning showed twins and that she would now be at risk for going into preterm labor. D.C.: "Were you having any pain when you went in for the ultrasound?" Alice: "No, I was feeling great." D.C.: "Tell me about the pains. How often do they come and how long do they last?" Alice: "They are not terribly strong. The last two were 20 minutes apart and lasted about a minute." D.C.: "Have you talked to your midwife since the pains started?" Alice: "Yes. she sounded upset. She told me to stay in bed and to call her back in an hour so she can decide whether or not I will have to go to the hospital." "Doctor, I'm really scared. My husband has just started graduate school. He has a small scholarship fund but I have to work. I can't quit my job. I don't know what he will do when he gets home and I have to tell him my story." D.C.: "It sounds as if these are the same contractions you have been having all during your pregnancy. They're called Braxton Hicks contractions and they are absolutely necessary to supply your babies with oxygen and nutrition. They squeeze out old blood and fresh blood comes in when the uterus relaxes. Normally you pay no attention to those contractions until your baby is ready to start labor for you at term. I think you have already told me why you have been paying uncomfortable attention to them. You have had a number of things worrying you. Is this your first pregnancy?" Alice: "No, that's what makes it worse. I have had three miscarriages. I wanted children as soon as we were married but Bob said we had to wait. He was very angry when I got pregnant the first time. I started bleeding and lost that one at 6 weeks. The same thing happened with the other two pregnancies. He keeps saying he isn't ready to have children. I'm afraid he will leave me when I tell him we have twins and I may have to go to the hospital." D.C.: "We may not be able to stop the pain, Alice, but I know that this type of pain will disappear if you can stop being frightened. Right now that might be hard for you until you can talk things over with Bob." "Do you know that babies in the uterus keep very much in touch with their mother all during the pregnancy? Little babies get frightened and discouraged when they know their mother is suffering. Labor is always started by the fetus inside it's mother's uterus. I don't want your babies to decide they are not wanted because that seems to be what happens just before women go into preterm labor. Twins can go along for many weeks with a mother having painful contractions as long as she does not panic." "Were you talking to the baby you thought you had before you knew there were two?" Alice: "I have wanted to but I've been afraid to think about not having a baby again for the fourth time. I wanted to be sure I could have a baby. Now I'm afraid for both babies." D.C.: "Well do it. Give them names and talk to them the way you will be talking to them after they are born. It will mean so much for them to know you are thinking about them." "Now let's see what you have do to stop the pains and get on with your life. We need to set up a way of getting information about what started the pains and what you can do to keep those babies happy the rest of the time with you. I want to get finger signals that are like nodding or shaking your head to agree or disagree while you listen to someone. Just think the word 'yes,' over and over, until you get one of the fingers on your free

hand to wiggle a little or tingle." She was not able to do this at first so I asked her to look around for some string to attach to a button, or a paper clip. I told her that the object would begin swinging in a straight line or a circle if she repeated the word "yes." I said that she would get a different swing for a "no." After that she was to call me back and we would go to work. Alice called back an hour later sounding excited. She has stopped having cramps and the pendulum was working well. She had already asked if her babies were all right. The pendulum told her "yes." She said, "I have just called my midwife. She was happy to hear that the pains had stopped." D.C.: "That is great. Now watch the pendulum but don't move it purposefully while I ask 'Does your inner mind know you can have these twins at term?' " Alice: "The pendulum says 'yes' but how do I know it's telling me the truth?" D.C.: "Answer that yourself. Ask the pendulum, 'Are you telling the truth?'" Alice (After a 15 second pause): "Well, (laughing) it is certainly definite about that 'yes' swing." It was possible now to help Alice slip into a light trance state using visual imagery with her eyes closed. The pendulum slipped from her fingers. She was able to get finger signals for "yes, no and I don't want to answer." D.C.: "Does your subconscious mind know why you started the bleeding and cramps with your first miscarriage?" Alice: "My 'yes' finger lifts but I don't know why it's lifting." D.C.: "Relax a little bit and wait. It takes a little while for a thought to get up to where you can recognize it and talk about it. When your inner mind knows what started your first miscarriage, your 'yes' finger will lift. As it lifts, just say the first thing that pops into your mind." Alice: "The thought came to me while you are talking about it. It was my husband's attitude. When he got angry because I was pregnant it made me feel he didn't love me and I didn't want his baby. I know that's crazy. He is always very loving and supportive. It's just that he is afraid right now." D.C.: "That feeling must have stuck with you though at a deep unconscious level. It's time to let go of it. see which finger lifts when I ask "Would you be willing now to forgive Bob and carry his babies all the way to term?" Alice: "My 'yes' finger has lifted." D.C.: "Lots of males are frightened and upset when their wife first reports being pregnant. It's the idea of responsibility, worry about money-lots of things. Their wife almost always interprets this the way you did. Their body can reject 'his baby' with a miscarriage. He's not to blame; you're not to blame. This is the way a subconscious mind works. Bob will be thrilled when he sees those kids." Alice: (Laughing) "My 'yes' finger is agreeing with you." D.C.: "I am going to be here. Call me back tomorrow about this time but call me any time if you start having cramps again." Third communication 24 hours later: Alice: "I feel fine. My midwife checked me this morning and told me my cervix is closed and I can keep on working. Bob surprised me. I think he's glad to know we will have two babies." I heard no more from Alice. She knew that she could call any time. Follow up 10/30/91. I called to learn the outcome. Alice seemed very happy to hear from me. She said her father-inlaw died and her husband had to go to the funeral. She was very nervous being alone so close to the time the babies were due. Her blood pressure went very high and her midwife called in a doctor who decided to do a caesarean section at 36 weeks under epidural block. Baby "A" weighed 5 pounds 1 ounce; baby "B" weighed 4 pounds and 8 ounces. Both girls are doing well and she is nursing them. Comment Alice needed very little reassurance. She had always wanted children. Her husband had been very attentive and supportive during the rest of her pregnancy. She asked for help at the optimum time, before the usual active treatments for presumed preterm labor. Her active participation in naming and communicating with her twins was, I believe, a major contribution to the successful prolongation of her pregnancy. Ideomotor questioning enabled her to keep in touch with the status of her twins. Discovery that her subconscious mind knew the babies were all right and that her husband was now supportive and wanted to see the twins was probably the most valuable asset for her. CASE II First call: 2/15/95: 5:30 RM. Total number of calls: 7 Delivered: C.S. 3/09/95 at 35 wks. A: 4 lbs 1 oz B: 5 lbs 2 oz Betty calls because she has just returned from 4 days of active treatment for preterm labor in the hospital and is very worried because she is only in her 31st week of pregnancy with twins. Her expected date of confinement is April 17. She saw my name and telephone number in Elizabeth Noble's book Having Twins and understood that she could call me. Cheek: "It is definitely right to call. Tell me what happened before you went to the hospital." B.P.: "I was feeling great last month when my husband had to go to Europe for two weeks giving lectures. I worried a little as the days went

by, wondering what I would do if something went wrong. Nothing happened. After he got back I decided to enroll in an aerobic class February 10th." "I was still feeling good when I went to the class. I just need more exercises. The woman leading the class did not want to have me there. She said, Tou might go into labor.' I told her that I was used to exercising and would stop if I thought it was too strenuous. So I stayed and felt perfectly OK. As I left, she was looking worried. She said, 'Now go right home and rest. You should really talk to your doctor.' I laughed at her and told her not to worry." "At 4 A.M. the next morning (Saturday, 2/11), I woke up feeling abdominal pains. They were coming about 15 minutes apart at first but when they began coming every 4 or 5 minutes, I called my doctor who told me to come right over to the hospital. It sounded to her as though I could be starting into labor and she wanted to stop it because I am only 31 weeks along." D.C.: "It sounds from what you are telling me that your aerobics teacher scared you and you began worrying about your twins while you were asleep. That can make the normal contractions become painful. Did you sleep well that night after the aerobics class?" B.P.: "No. I tossed and turned all night until I woke up with the pains." D.C.: "What happened when you got to the hospital?" B.P.: "They put me to bed with a monitor to keep track of the contractions and gave me injections of terbutaline to stop the labor. The doctor said my cervix had not dilated and that was a good sign. During the next five days the contractions became less frequent and less painful. I came home this afternoon. I am not having any pains now but I wanted to call in case they start up again." D.C.: "Have you had any experience with hypnosis?" B.P.: "I have not been hypnotized before but I am very much interested in the subject." I explained about the use of finger signals and Betty slipped into hypnosis easily while she was wondering which finger would life for a "yes, no, and I-don't-want-to-answer." D.C.: "Please don't try to think the answer to this question. Wait until a finger lifts. 'Does the inner part of your mind know these twins are both O.K. in there?"" B.P.: "My 'yes' finger is lifting." D.C.: "Have you given names to the two little ones?" (I wanted to see if her present attitude was basically optimistic.) B.P.: "Oh yes," she replied. "The first one is Anushka. That is a Russian name. It sounded good to us when we were first talking about having children. The second one is Karishna, an Indian name. We were just talking about some day when we start a family. That was before I knew I was pregnant. We could not think of a good boy's name. We had no idea that we might have twins some day because there are no twins on either side of our families." D.C.: "You sound like a couple of great parents. I feel very sure that you have just been uncomfortable with the normal contractions your uterus has been doing all the time before your aerobics teacher got scared. You knew what you could do physically. Anyhow, you are not in labor but let's stop the pains." "You could go on having painful contractions like that until April without doing any harm to your babies but it would make every one happier if you forgot the contractions and paid all your attention to your twins. That is what they need right now." Betty sounded relieved at this explanation. Apparently no one had clarified this point to her. Her nurses and medical caregivers had treated her as though she were in actual labor and they were struggling to keep her from giving birth too soon. D.C.: "From now on, I wish you and your husband would do even more talking to those twins or just thinking nice thoughts to them. They don't need to hear you; the communication is really telepathic. Tell them they are safe and will be welcomed when they finally decide to be born in April." "When you go to bed at night, take a few moments to ask your 'yes' finger to lift when you know subconsciously that your sleep will be restful and your dreams pleasant. In the morning you should take a few seconds to ask for your fingers to answer the question, 'Was my sleep restful and comfortable last night and this morning?' I want you to call me if your 'no' finger lifts." Sunday, February 19, 1995 I called to see how she is doing. Betty was surprised and happy to hear from me. She said, "Our telepathy must be working because I woke up at 5 this morning having those pains again. There were 12 the first hour, 9 the next hour, 8 the third hour and then 9. I was going to call you because I was sure that if I told my doctor she would send me right back into the hospital." D.C.: "Do you have any idea what started you paying too much attention again to your uterus around 5 this morning?" B.P.: "No I don't. I just remember waking up with the cramps but I could have been troubled by what a doctor said at the shower my friends gave me yesterday. I was having a very good time." Toward the end of the party a woman doctor asked, 'Does all this going on shock you at all?' I

said, 'No, I'm really enjoying the party.' She apparently was not satisfied with my answer so she went on, saying, 'I had a patient who went to a party like this away from her home. She was surprised and shocked. She went into labor there. She had to be admitted by ambulance to a strange hospital where she had her baby.' "Then, just before I came home a few minutes later, one of the women noticed that my ankles were swollen. My ankles have not been swollen and were not swollen before I got to the party. They all told me to go home and get my legs up." D.C.: "No wonder you awakened having pains. People can say the strangest things, even intelligent doctors! I have always hated to have my patients given a shower before the arrival of their baby. They usually will say that they looked at all the nice little things given them and thought, 'What will I do with all these things if something happens and I don't have a baby?'" B.P.: "I am sure that must have happened in my sleep this morning." We closed the conversation after she said that her uterus was behaving very well now and she thought she could keep it that way. I asked for a promise, however, that she would call instantly if she has painful contractions again. 2/20/91 I called to see how she is doing. She feels very well and is not having any pains. She is now at 32 weeks. 2/24/91 Betty called, saying, "Don't worry. I'm fine. I just wanted to tell you that my doctor is thinking along with us. Today she said I was doing fine except that the first baby is in breech and that if she stays there we'll have to do a caesarean section. I said that really would not be necessary." "The doctor said, 'Please talk to her, the one in a breech position, and tell her to get around because if she doesn't we will have to do a caesarean section.' She said, 'I'm not worried about baby "B" in transverse because she will turn later. You've got to talk to those kids.' My doctor is very much into mind-body things now." "And- oh, you won't believe this! As I was walking in the parking lot I distinctly heard Anushka talking back to me. She says, 'Mommy, why is that doctor bugging me and you? Why is everybody bugging me to turn around? It is awfully lonely down there. If I have my head in the other direction I can talk to Karishna. Karishna is up here and I am down there. Why should I stay there? I want to be up here and talk to her and stay with her. I promise you that when the time comes we will both move down and we will both be in the right position. We will both make sure that we don't bother you.' Isn't that amazing?" I agreed. I was indeed amazed. I said, "I have heard other stories like that. Each time I am more impressed at how smart and intuitive little ones inside a mother's uterus can be (Cheek, 1992, 1994)." Now, at 32 1⁄2 weeks. She hallucinated the date of labor starting on April 16, 1991. She hallucinated the time of day being 5:15 P.M. Anushka will weigh 5 pounds, 12 ounces and Karishna will weigh 6 pounds and 1⁄2 ounce. Unfortunately this was not to be. 3/9/95 Follow up communication Betty called to thank me for my help. A caesarean was decided upon, March 6, because her membranes had ruptured. Both babies remained 3 days in the hospital but are doing well and she is nursing them both. Their weights were 4 pounds, 1 ounce for Anushka, baby "A," and 5 pounds, 2 ounces for Karishna, baby "B". Comment Again a problem was created by apprehensive doctors and friends. Continuing worry could have eventuated in true preterm labor. Betty's understanding about the mechanisms of Braxton Hicks contractions helped raise her tolerance for pain. Of great help in this instance was her innate and constant communications with her twins. Her realization that dreams can be responsible for complications was helpful, as was also the recognition of her husband's full emotional support. These two examples of telephone therapy with women carrying twins have been given in complete form to illustrate the method of communication and the importance of phrasing statements and questions that envelope the patient with my confidence in her ability to discover and use her maternal resources. I have been consulted by 13 women carrying twins and 3 carrying singleton pregnancies. The remaining reports on women with twin pregnancies are summarized in the table. I have not communicated with their obstetrician or midwife but have supported the treatment choices made by them. My role has been as a colleague and friend to back each patient's desire to be in charge of her body and be able to carry a pregnancy until the infants are safely mature. Six of the 13 sets of twins were delivered by caesarean section. One was clearly indicated due to ruptured membranes and possible risk of a prolapsed cord. A second one was done to avoid possible disseminated intravascular coagulation because one twin had been dead for approximately eight weeks. The remaining four caesarean sections could be questioned in terms of obstetrical judgement as was

the artificial induction of labor in case number 13.

Table 1

Twin Pregnancies

	1st Call	No.	Wks	Delivery		Wks		Outcome	
1 ALICE	2/13/91	3	16	5/29/91	CS	36	F	5	F 4:8
2 RUTH	2/14/91	1	33	3/16/91	CS	37	F	6:2	F 5:9
3 MARY C.	9/09/91	3	24	9/09/91	Vag	36	M	5:14	F 6:4
4 JULIE C.##	1/23/92	4	21	2/29/92	Vag	26	M	2:0	F 2:3
5 LELA J.	6/06/92	5	32	6/29/92	Vag	35	F	5:3	F 4:12
6 AMY S.	4/15/93	4	26	8/20/93	CS	37	M	5:8	F 5:14
7 ANN G.*	9/13/93	6	28	11/10/93	Vag	39	M	6:1	M 6:15
8 MARILYN	1/13/94	7	27	3/29/94	Vag	39	M	7:12	F 5:15
9 JANE W.	3/07/94	1	16	8/15/94	Vag	38	F	6:5	F 4:11
10 PHYLLIS#	5/20/94	6	30	7/02/94	CS	38	F	6:5	M 2:14
11 JOAN C.	1/08/95	3	33	2/13/95	CS	39	M	6:5	M 6:13
12 BETTY P.	2/15/95	7	31	3/09/95	CS	35	F	4:1	F 5:2
13 KATHY H.@	3/07/95	8	30	4/14/95	Vag	35	M	4:2	F 4:2

Note: ##Premature rupture of membranes at 26 weeks both deceased.
*History of Crohn's disease, arrested.
#GIFT, implantation 2 ova. Male expired at 26 weeks.
@Prostaglandin induction because of F at risk of stillbirth because of only two umbilical cord vessels.

All the women whose fetal membranes were intact carried to viability. The times for the beginning of threatened preterm labor ranged from 16 to 33 weeks with an average of nearly 27 weeks. Note: In regard to the role played by the fetus in initiating labor I need to report a study that I have been making of the subjective impressions of more than 1500 adults who knew they delivered at term and 16 adults who knew they delivered prematurely and who also knew they had been treated in an incubator for a period of time. In age regression to prenatal existence, the term "babies" reported, with absolute confidence at an ideomotor level, that they started their mother into labor. Reasons given by them were, "It's just time" or "I want to be with my mother (or some sibling)." The reasons were always positive. The reasons were very different from the premature "babies." They were also sure they started their mother into labor because they felt frightened by the mother's change in behavior (bed rest) and her "feeling scared." When asked how they felt on recognizing their mother's feeling, they said they felt scared also and felt they should get out of the uterus because they were not wanted. It was "dangerous to stay." In Table 1, listed with their fictitious names, are the 13 cases that I have consulted with since February, 1991. For those interested in ideomotor techniques there are two recent books available (Rossi and Cheek 1988 and Cheek 1994). References REFERENCES Cheek, D.B. (1969). Communication with the critically ill. American Journal of Clinical Hypnosis, 12, 5-15. Cheek, D.B. (1992). Are telepathy, clairvoyance and "hearing" possible in utero? Suggestive evidence as revealed during hypnosis age-regression studies of prenatal memory. Pre and Perinatal Psychology 7, #2, 125-137. Cheek, D.B. (1994). Hypnosis: The Application of Ideomotor Techniques. Boston, Allyn &Bacon. Hicks, John Braxton (1871). On the contractions of the uterus throughout pregnancy. Their physiological effects and their value in the diagnosis of pregnancy, transaction of Obstetrical Society of London 13, 216-231. Kroger, W.S. (1952). Evaluation of personality factors in the treatment of infertility. Fertility and Sterility, 3, 542. McDonald, T.J. (1991). Nathanielsz, RW. Bilateral destruction of the fetal paraventricular nuclei prolongs gestation in sheep. American Journal of Obstetrics Gynecology 165, 764-770. Miller, EC. (1994). Verbal report during work shop, "Obstetrical Controversies" offered by American College of Obstetricians and Gynecologists, San Francisco, CA, June 23-25. Nathanielsz, RW. (1992). Life Before Birth and a Time to be Born. Ithica, NY, Promethean Press. Nathanielsz, P.W. (1994).

A time to be born: Implications of animal studies in maternal-fetal medicine. Birth, 24 #3, 163-169. Rossi, E.L. and Cheek, D.B. (1988). Mind-Body Therapy. New York, W.W. Norton. Saunders, M.C., Dick, J.S., Brown, I.M., McPherson, K, Chalmers, I. (1985). The effects of hospital admission for bed rest on the duration of twin pregnancy: A randomized trial. Lancet: 2, 73-75, 793-795. AuthorAffiliation David B. Cheek, M.D., F.A.C.O.G. AuthorAffiliation David B. Cheek, M.D., F.A.C.O.G. practices obstetrics and gynecology in Santa Barbara, California. A member of the Board of Directors of APPPAH, he is the author of Hypnosis: the Application of Ideomotor Techniques. His innovative techniques have influenced an entire generation of hypnotherapists. Address correspondence to David B. Cheek, 1140 Bel Air Drive, Santa Barbara, CA 93105.

Publication title: Pre- and Peri-natal Psychology Journal

Volume: 10

Issue: 1

Pages: 5-19

Number of pages: 15

Publication year: 1995

Publication date: Fall 1995

Year: 1995

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: New York

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 08833095

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198682824

Document URL: http://search.proquest.com/docview/198682824?accountid=36557

Last updated: 2010-06-06

Database: ProQuest Public Health