Use of the Telephone and Hypnosis in Reversing True Preterm Labor at 26 Weeks: The Value of Ideomotor Questioning in a Crisis

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Full Text: Headnote Abstract: A physician with a history of four previous spontaneous abortions stopped the progression of preterm labor and gave birth to a healthy baby at term. Repeated troubled dreams are the cause of painful Braxton Hicks contractions. These are innocuous until an alarmed mother breaks off telepathic communications to her fetus. This starts a sequence of events beginning with expulsive labor, rupture of membranes and birth of a compromised baby. Preterm birth is preventable. The process can be reversed. The telephone is a valuable means of capitalizing on spontaneous hypnotic behavior in a crisis and for continued vigilance until the patient has full confidence in her ability to continue the pregnancy. There is a general tendency for obstetricians to avoid the valuable therapeutic use of a telephone when they are first called by a frantic patient who believes she has started labor prematurely and may lose her baby. They miss a prime time. Hypnotic-like, literal thinking occurs spontaneously just prior to the moment a frightened person picks up a telephone to call for help. Advantage can be taken of the high level of suggestibility and uncritical acceptance of ideas that are the characteristics of hypnotic behavior at that moment but are quickly lost. Authoritative directions and positively slanted questions have great power for accessing and removing the influence of past traumatic events during a time of physical or emotional crisis (Cheek 1969 a,b). Too often these are interpreted as indicative of preterm labor. Delayed treatment and growing alarm of the pregnant woman can lead to expulsive uterine contractions, cervical dilatation, ruptured membranes and eventual birth of an immature infant. Ordering the woman to relax and report back in a couple of hours will only intensify her fears. They may become overwhelming if she is immediately ordered into a hospital. THE DEFINITION OF PRETERM LABOR For continuing painful uterine contractions to qualify for the diagnosis of preterm labor, the woman must have reached 20 but less than 37 weeks of gestation, her cervix must be effaced and starting to dilate. The woman presented in this paper was definitely in preterm labor. JOHN BRAXTON HICKS (1825-1897) This classic description of normal uterine contractions could be given to pregnant women at their first consultation. It might decrease their alarm if they awaken some morning in the third trimester with abdominal pains. Hicks (1871) was a gifted English Obstetrician. "After many years' constant observation, I have ascertained it to be a fact that the uterus possesses the power and habit of spontaneously contracting and relaxing from a very early period of pregnancy... . "If the uterus be examined without friction or any pressure beyond that necessary for full contact of the hand continuously over a period of from five to 20 minutes, it will be noticed to become firm if relaxed at first, and more or less flaccid if it be firm at first. It is seldom that so long an interval occurs as that of twenty minutes: most frequently it occurs every five or ten minutes, sometimes even twice in five minutes. However, in some cases I have found only one contraction in thirty minutes. The duration of each contraction is generally not long, ordinarily it lasts from two to five minutes. When the uterus is irritable or has been irritated it lasts longer than this. Under particular circumstances it may assume an almost continuous action analogous to that which is noticed after long obstructed labor. "In a general way the pregnant woman is not conscious of these contractions. ... But occasionally it happens that the uterus is more than usually sensitive and that the contractions are accompanied by pain, and then on examination it is found that each pain she complains of is coincident with a contraction." TREATMENT OF PAINFUL BRAXTON HICKS CONTRACTIONS The treatment of painful Braxton Hicks contractions can be completed with one conversation aimed at discovering what dream or daytime alarm made normal contractions feel uncomfortable. True premature labor, however, requires more

work and frequent telephone conversations. Thoughtful follow up is needed to protect the patient from the impact of pessimistic friends, relatives and caretakers. They can easily undo tenuous confidence and can innocently block further progress. Discouraged fetus has already initiated the neuroendocrine interchange responsible for the beginning of expulsive labor at term (Nathanielsz 1994). TREATMENT AFTER THE ONSET OF PRETERM LABOR Reversal of true labor is possible as long as the membranes are intact and the cervix less than four centimeters in diameter. The patient presented here had an added problem of previous fetal losses. She had been in a hospital for five days, undergoing medical treatment that had failed to relieve her distress. My continuing connection with the problem was by telephone. I had no communications with the patient's obstetrician who might have shown less than enthusiastic acceptance of my intrusion. I supported existing treatment. My part was to serve as a support person and a teacher of hypnotic techniques that could be presently helpful and possibly useful in the future for her role as physician and mother. CASE HISTORY: "J" (Initials and Names are Fictitious) 3 P.M. September 7, 1992 This message was on my answering machine from a midwife who had attended a work shop I had given in her city in another state. "Please help this dear lady. She is now at 26 weeks and is really scared. She has been in the hospital for five days. Right now she is having hard contractions every six minutes as well as bladder spasms. Her cervix is effaced and dilating but the membranes are intact. She has a catheter in her bladder and a monitor connected to her uterus. Her doctor has her on magnesium sulfate but it isn't doing anything for her. Here is her room telephone number. She is expecting your call. I have to go off duty now." 3:30 P.M. When I was able to make contact, her husband answered and gave the telephone to her with the flat sounding comment, "Here's that other doctor from Santa Barbara." "J." was breathing hard. A strong contraction had just ended. This was not a good time for an introductory conversation. I was, however, able to take advantage of the altered state she was in. D.C.: "Your midwife asked me to call. She hoped that some hypnosis might help to stop your labor. Have you had any experience with hypnosis?" "J": "No. ... Just a minute." I could hear her asking her husband to leave the room. "Yes, Jane told me about you and said you would help me stop these pains. Nothing seems to be working." D.C.: "All right, I'm here to help you do that but first we need to set up a communication system that allows us to know things that you do not know consciously. Please hold the receiver in your left hand or on your shoulder. I want to set up unconscious finger signals on your right hand that can allow us to see what has been preventing your treatments from working. Finger signals are comparable to nodding or shaking your head as you listen to someone. We do not think "I'm going to nod," we just nod unconsciously. We never nod just once. All thoughts seem to be repetitive. You will get a tugging sensation or a sort of vibration in one finger. Try it. Keep on thinking 'yes yes' over and over until you feel it." "J": (After a 30 second silence) "Well, my index finger seems to feel different, sort of tingling a little." In the same way, she selected her middle finger for "no" and her little finger for not wanting to answer a question. D.C.: "Are you afraid in any way, either for yourself or your baby?" "J": "I don't need a finger for that question. I know I have been worrying about this little boy because of all these treatments. I think my doctor feels I'm really going ahead to lose him because of my four miscarriages." D.C.: "You know, your baby might be upset about that, He might be thinking you don't want him. Babies seem to feel their mom doesn't want them if she is scared or angry about something on the outside. A fetus has no idea what is going on outside. Have you been talking to your little boy?" "J": I'm glad to hear you say that. I talked all the time to Chuck, my boy that came after the first two miscarriages but I've been afraid to do that ever since my doctor put me in the hospital this time. I guess I've lost my confidence." D.C.: "You must have known intuitively with Chuck that he was listening to your thoughts. Little guys inside a uterus also talk back but mothers are usually too busy to pay attention. Tune in to him right now and let your fingers respond to his answer to this question, 'Are you O.K. in there?' Your subconscious mind will pick up the answer. Tell me which finger lifts." "J": After a 20 second period of silence she says, "My 'yes' finger is lifting. Do you think I can count on that? My finger lifted by itself. I couldn't control it." D. C.: "I have learned to trust the answers given by fingers, as long as a person does not consciously think what the answer should be. Your finger signal gives very important

physiological information, way below conscious level thinking. "He is definitely O.K. You are the one with the problem. Now, let's get to work and stop those pains. I am sure you know as a physician that your uterus has to contract and relax. It is supposed to do that all during a pregnancy. Its job is to keep the fetus supplied with oxygen and nutrition, squeezing out the used up blood in order to allow a return of arterial blood between contractions. Worry and fear are the reasons for those contractions to become uncomfortable, usually at night because of troublesome dreams. I think it would be very nice for all of us if those contractions returned to what they were doing so well before the pain began." "J": I was starting to feel another contraction while you were talking just now but it doesn't hurt." D.C.: "Great! I didn't expect you to get back to normal so quickly. Pat yourself on the back." "Before I show you how to turn off pain, though, I would like to help you relax a little. (She is holding the receiver on her shoulder now). Please hold a pen or a pencil between your index finger and thumb of your right hand. Let me know when you have that." "J": "I have one right here. O.K., tell me what to do next." D.C.: "Close your eyes and see if you can imagine a lighted candle across the room from you." She was able to do this easily. I went on with a simple progressive relaxation induction into which was included the suggestion that her fingers would pull apart to drop the pen when she was deep enough to use hypnosis helpfully and that she would say 'now' when that occurred. About 30 seconds later I could hear the pen drop on the floor but "J" did not say anything. She was relaxing so deeply that it was a hard to talk. DEVELOPMENT OF BODY ANALGESIA AS AN EXERCISE FOR GAINING CONTROL Now I asked her to imagine how it would feel if she were a child wading in a cold lake, standing there up to her knees. First there is coldness, then decreased sensation. "When you can feel the coldness of the water your 'yes' finger will lift. When it lifts please say 'now' so I can keep up with you." (It took 20 seconds before she said "now." (Her voice was soft. She was in a good level to move on.) "When you have stood there long enough to get sort of numb, about half as sensitive as normal, your 'no' finger will lift to let you know. "Say 'now' when you are sure you are numb from your knees down because it takes a little while for an idea to get up to your conscious level. It is important for you to know about that lag time, otherwise you will think nothing is happening if you expect immediate numbness when your finger lifts. (It took about 40 seconds before the numbness was acknowledged.) "Good, now go in a little further into the water until it is up to your waist. Your 'yes' finger will lift when you are cold from your waist to your knees and your 'no' finger will lift when you are half as sensitive as normal from your waist down to your toes." "J": (Sounding excited after a 30 second pause) "It's working! I was sure I could not do that but I am really numb!" D.C.: "You are great! Now bring all the sensations back. You won't want to stay numb and you certainly don't want to be cold when you are in labor at term. From now on you can leave out the cold feeling and just be numb. So, press your right thumb and index finger tips together and order all the feeling to come back to normal. When that is complete, your 'yes' finger on your left hand will lift a little to let you know. Wait until you are consciously sure the feeling is back and then pinch yourself again." "J" has moved very rapidly with these exercises. She was highly motivated because of her critical situation. The next step was to press her left thumb and index finger tips together and order her "yes" finger to lift when she would be subconsciously numb again from her waist down. It took about 25 seconds to accomplish this and about 10 seconds to return feelings to normal by pressing her right thumb and index fingertips together. I suggested that she could start something with her left hand and return things to normal with her right hand after this. I asked her to practice this while she is in the hospital until she is able to develop the numbness within 10 seconds of giving herself the signal for analgesia. I explained, "You don't want to take 10 minutes to get less sensitive when your contractions are 3 minutes apart in labor at term." (This exercise involves the patient's thoughts aimed toward a future successful culmination of her pregnancy as a contrast to the previous depressing thoughts about having a baby that is too small to survive). As she came out of hypnosis a few minutes later she sounded elated. She said, "I feel much better. I could feel the contractions while you were talking but they were not strong and did not last as long. I think I'm going to be all right now." (Consciously verbalized optimism must not be trusted. for reasons soon evident.) D.C.: "I'll call you back a little later anyhow to make sure you really get your confidence back. 6:30

P.M. Three hours later I called back because it is urgently necessary to follow up quickly on good initial reactions to counter the possible rebound idea, "This is too good to last," augmented by questions from relatives or nursing staff. It was a pleasant surprise to hear that not only was "J" comfortable but had been successfully practicing the numbness exercise. She proudly announced that she had been able to extend the analgesia to the level of her armpits. She had also demonstrated this ability to her husband. He had been impressed, she said. D.C.: "All right now, Fd like you to use your clairvoyant ability as a pregnant woman, especially because you are a doctor treating other people. Let your unconscious mind go forward to the time when your son is arriving after an easy, short labor. You will have been relaxing your abdomen, back and pelvic muscles with each contraction, He will come out looking around the room and smiling. When you are there, your 'yes' finger will lift. Say 'yes' so I can tell where we are. "I hope you will be walking around with a midwife or your husband, talking and maybe looking out your window during the labor. Please insist on being up and around instead of in bed in a labor room or on a table in the delivery room. "When you are feeling your son is ready to slip out with the pull of gravity, you will kneel or squat, the way women have done for thousands of years. The midwife will catch your son and put him into your arms right against your abdomen, skin-to-skin, with his head between your breasts. Feel the warmth of his little body. When you can feel that, look across the room and you will see an imaginary chalk board and a nurse writing up the date. Under the date you will see 'M' for male. Under that see his weight in pounds and ounces. If you look below that you will see the length of labor in hours and minutes from the start of 5 minute contractions until the moment he slipped out into the world. "When that total picture is clear, please read it off to me so I can write it down." "J": (After 40 seconds of silence) "Now." D.C.: "What do you see?" "J": Well, the date is December 29, 1992. There is the 'M' and under that is 7 pounds 11 ounces but I cannot get a figure for the length of labor." D.C.: "Sounds good. We can talk about length of labor some other time. Now, please call if you have any pain again during the night or early morning. Troublesome dreams can sneak in without your being consciously aware of them." Note "The ability to hallucinate a positive full term birth of a healthy baby comes easily to a healthy woman in an uncomplicated pregnancy. The specifics are not important. They are usually wrong but I have learned that there is some unconscious negative idea at work when a woman cannot "see" some part of the sequence on the imaginary chalkboard, such as: Date of Delivery: December 29, 1992 Sex of the baby: Male (Already known from tests). Weight of the baby: 7 pounds 11 ounces Length of labor: The December date reflected her unconscious confidence that she could go to term but I was concerned about the omitted response for the length of labor. She knew about labor because of the full term delivery of her son. Was their some reason, then, for "J's" feeling her child would not survive labor? I did not pursue her reason for the omission at this time but I knew there was more work to do. The ability a hypnotized pregnant woman has to hallucinate an optimistic future goal is a valuable diagnostic tool in obstetrics but it has to be complete in all the details before the caretaker can feel comfortable about the patient's mental set. 11 A.M., Tuesday, September 8, 1992, Twenty hours later I called her in order to see if any changes had occurred during the night. "J": Picked up the telephone saying, "Good morning! I slept very well and have had no more pains, but my obstetrician examined me a little while ago. She was pleased to learn that the contractions had diminished in number per hour and were not painful but she said my cervix was a little more dilated and that she had been talking with specialists on preterm labor in Denver. They suggested discontinuing the magnesium sulfate and changing over to injections of terbutaline. I hate that idea! I would like to get up, get out of here and be home with my family." D.C.: "Well, your doctor does not know what you are doing with hypnosis. I think she will stop all the treatments when you show how well you can do with this change in medication. Why not consider this as additional support, sort of like putting on a belt with the suspenders to hold up your trousers?" 6 P.M. September 8, 1992, 27 hours after first contact I called because it is not possible to know at a distance what new threats might appear when a patient, particularly a professional in health work, is confined to bed in a hospital, receiving new medication because the old one was not preventing her cervix from dilating. D.C.: "I'm just checking. How are you doing now?" "J": Well, I'm putting up with the shots. My bladder feels better now.

They pulled out the Foley catheter. I think I am getting too much treatment and I'm anxious to get out of here." (How wonderful it would be if obstetricians listened to such intuitive comments by their patient.) D.C.: "How's your baby doing?" "J": "Fine. He's been moving around a lot since I began talking to him. He seems less nervous." (This remark encouraged me. She is now really tuned in again to her baby). She added that her doctor had decided to let her go home the next day and to continue terbutaline treatments. 8 A.M. Wednesday, September 9. 41 hours from start "J" calls. Her voice is faint and troubled. She had been getting injections of terbutalin every 2 hours. Her monitor is now showing increased frequency and strength of contractions in spite of the new treatment. She burst into tears saying, "I can't go on being in the middle. My friends, my doctor, my husband, my mother are all telling me different things." I could get no clear idea of what the major problem was but her "yes" finger lifted to say that her baby was doing all right. She slipped into hypnosis during the interval while answering my question. This seemed to separate her from the urgency of what she had been feeling. I said I would call her back in a few minutes. 8:20 A.M. September 9 (20 minutes later) She was back in control again and the monitor was showing normal contractions. She said, "I really like what we are doing. Then after a pause, she said, "There's something that has to do with Harry" (Her husband). This is the beginning of an important insight. "We had decided to tell my mother that I was back in the hospital and that we wanted her not to call the hospital but rather to call my sister to get information about me." (This suggested that "J" and her mother were not communicating well with each other at the moment. I did not want to get into that subject. I asked if the communication with her mother had reminded her in any way of her mother's alarm during her pregnancy with "J." Her mother almost miscarried "J" and must have been both afraid of losing her pregnancy and aware of a serious problem in her marriage. "J": "My 'no' finger is lifting." (Now she recognized some sort of connection with her mother.) She says, "Harry has been very irritable lately. He had his work and then our son to worry about as well as wondering what was going on at the hospital with me .... I have just thought of something. My father was away in Viet Nam for two years. Things changed when he came back. My dad left my mother right after I was born." After a pause she adds: "and I guess I have been thinking Harry could get fed up with all this trouble and could decide to leave me. My conscious mind says that is a foolish idea because Harry has been devoted and really caring all through this." D.C.: "This is really helpful. If your subconscious mind is balancing nice thoughts against scary ones, the pessimistic thoughts will take priority. It's a psychological fact. I want to ask your fingers, 'Is that the connection, a superstitious belief, that your life will be like your mother's?" "J": My 'yes' finger really popped up with that question." D.C.: "Do you really need to worry about Harry abandoning you now? He is a man but he isn't your father." (The answer to such a question requires setting up conscious understandings to reframe troubled ones.) "J": Well, my 'no' finger is lifting. I see what you mean." D.C.: "I'll call back around noon to make sure you have thought this one through." 11 AM. September 9, 1992 "J" says the connections had become really clear to her now, that she had identified Harry with her father and herself with her mother. She could have been unconsciously feeling that her marriage would end if she had a baby, just as her mother's marriage ended after "J's" birth. This engram could have caused each of her four spontaneous abortions because each pregnancy would have been an unconscious threat to "J's" marriage. It seemed to have been the trigger that started this threat of losing her second child with preterm labor. The resolution of this conflict was not immediate; there was more to do. 3 P.M., Monday, September 21 I had not heard anything. I felt I should call. "J" is home now on bed rest, continuing terbutaline injections and electronic uterine monitoring. (I had hoped these might have been discontinued because they are each indicating her doctor's expectation that something could go wrong again.) She said that strong contractions had begun again but she had managed to control them with self hypnosis and had been very comfortable all afternoon. 10:40 P.M. Seven hours later Harry calls with an apology for it being so late. He said, "J" wants to talk to you." "J": (sobbing) "I guess this bed rest has been hard on Harry as well as me. We had an argument and have made up but I can't stop my contractions. They are hard now." I asked her to press her left thumb and index fingers together and order the numbness for her abdomen as though she were in the water again but to make it warm

water this time. "Ask your 'yes' finger to lift on your right hand when you feel comfortable again and can let your little son have a decent night of sleep." There were a couple of minutes of silence before she said, "Now" to indicate that she was comfortable. I asked her to call again if she needed to. (My purpose here was to shift her attention from the source of trouble to action aimed at preparation for delivery at term.) I talked now for a few minutes with Harry about my belief that "J" could safely use her own judgement about the bed rest and monitoring. I felt he could trust in his wife's intuition. 8:45 P.M. September 28. Now at 29 weeks I called to check on progress. She was spending a little more time up and walking but was continuing the terbutaline. Contractions were occurring two to eight times an hour and were uncomfortable but tolerable. She apologized for not being perfectly comfortable all the time. D.C.: I laughed and said, "J", you have done wonderfully. Painful Braxton Hicks contractions will stop when you get all your confidence back. In the meantime, take my word for it that your baby does not mind your having those contractions. He will only start labor if you quit talking to him and continue to be afraid. You stopped the labor way back in early September. You are just having painful normal and necessary uterine contractions now. They are uncomfortable for you but do not harm your baby. 8 P.M., November 11. Now at 35 weeks "J" calls to report that she had painful contractions again yesterday and this morning but had been able to stop them after recognizing their connection to another brief argument with Michael the day before. At Christmas I received a card from "J," reporting the uneventful and joyful arrival of baby Stephen: Date of birth: December 18, 1992 Sex of baby: Male, Stephen Weight: Six pounds 15 ounces Labor: Eight hours and 24 minutes Labor had been induced at 38 weeks because her doctor was leaving town. Stephen would have been close to the 7 pounds and 11 ounces hallucinated weight if he had been permitted to start labor on his own initiative on the December 29 date his mother had hallucinated in hypnosis on September 7. References REFERENCES Cheek, D. B. (1965). Some newer understandings of dreams in relation to threatened abortion and premature labor. Pacific Medicine and Surgery, 73, 379-384. Cheek, D. B. (1969 a). Significance of dreams initiating premature labor. American Journal of Clinical Hypnosis, 12, 5-15. Cheek, D. B. (1969 b). Communication with the critically ill. American Journal of Clinical Hypnosis, 12, 75-85. 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 Journal, 7 (2) 125-137. Cheek, D. B. (1994) Hypnosis: The Application of Ideomotor Techniques. Boston, Allyn &Bacon. Chapter 16, Sleep Disorders. Cheek, D. B. (1995). Early use of psychotherapy in prevention of preterm labor: The application of hypnosis and ideomotor techniques with women carrying twin pregnancies. Pre and Perinatal Psychology Journal, 10 (1), 5-19. Hicks, J. B. (1871). On the contractions of the uterus throughout pregnancy: Their physiological effects and their value in the diagnosis of pregnancy. Transactions of Obstetrical Society of London: 13: 216-231 (Written long before there were more reliable ways of diagnosing an early pregnancy). Nathanielsz, P. W. (1994). A time to be born: Implications of animal studies in maternal-fetal medicine. Birth, 24 #3, 163-169. AuthorAffiliation David B. Cheek, M.D., F.A.C.O.G. AuthorAffiliation Editorial Note: A former member of the APPPAH Board, the late David B. Cheek, M.D., F.A.C.O.G. published during his lifetime more than fifty articles in the areas of obstetrics, gynecology, psychology and clinical hypnosis. I have Included his own comments about this article in Letters to the Editor. The Fall 1995 issue of this Journal contains a previous article, Early Use of Psychotherapy in Prevention of Preterm Labor: The Application of Hypnosis and Ideomotor Techniques with Women Carrying Twin Pregnancies by Dr. Cheek which amplifies his research and techniques.

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