WOMEN'S EXPERIENCES OF HYPNOTHERAPY AS PSYCHOLOGICAL SUPPORT FOR HIGH-RISK PREGNANCY

by

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Submitted in fulfilment of the requirements for the degree of

MASTER OF ARTS

in the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

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November 2013

ACKNOWLEDGEMENTS

My heartfelt thanks to:

- Michelle for her support, motivation and insight in this field. You deserve much more recognition than I can ever give.

- All my family and friends who supported me and believe in me.

- The participants who sacrificed their time and allowed me to share in their most private moments.

- Dr Madri Jansen van Rensburg for her expert guidance and motivation. You make it all feel so easy.

I, Werner van der Westhuizen declare that WOMEN'S EXPERIENCES OF HYPNOTHERAPY AS PSYCHOLOGICAL SUPPORT FOR HIGH-RISK PREGNANCY is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

WERNER VAN DER WESTHUIZEN

Contents

LIST OF FIGURES

LIST OF TABLES

SUMMARY

In this study, the use of hypnotherapy in high-risk pregnancy is explored from an ecological systems perspective through two case studies. Each case study is described in detail. They explore the experiences of two women during their pregnancy and giving birth, with specific reference to the pregnancy risks and their use of hypnotherapy. The study provides the reader with an in-depth understanding of the use of hypnotherapy before, during and after birth.

KEY TERMS

Prenatal psychology; perinatal psychology; preterm labour; caesarean birth; high-risk pregnancy; hypnotherapy; HypnoBirthing®; hypnosis; case study; ecological systems

CHAPTER 1

INTRODUCTION

1.1 Introduction to the research study

This study was undertaken to explore the use of hypnosis, and in particular the HypnoBirthing® approach in high-risk pregnancy. The researcher was particularly interested in how women experienced this approach as a psychological intervention to help them deal with the various complications of high-risk pregnancy and the extent to which they experienced HypnoBirthing® as beneficial. The study followed a case-study design that involved data sets of a mixed nature. It focused on a qualitative approach to capture in-depth information on the lived experience of, not only the pregnant woman, but also other key stakeholders, such as healthcare providers. The study consists of two case studies. The participants underwent HypnoBirthing® sessions as an intervention to help them during pregnancy, childbirth and immediately after childbirth. Their participation in the research study took place a few weeks after they gave birth, and the sessions were concluded by that time. They were introduced to the researcher by their respective HypnoBirthing® instructors, who were aware of the study being conducted. Their lived experience of HypnoBirthing® in high-risk pregnancy was the main interest of the study. Data were collected mainly through in-depth interviews, but also included document review of records and information on the medical background to each case that contributed to the understanding of each unique case study on the biological, psychological and social level. The study contributes to understanding the uses and benefits of the HypnoBirthing® approach with high-risk pregnancy and, therefore, enables practitioners to be especially mindful of these factors when

designing hypnotherapeutic interventions aimed at reducing the risk of complications during pregnancy.

Pregnancy is a normal life-developmental experience, which involves biological, psychological and social changes. These changes can be stressful. When a pregnancy is complicated, and carries higher risks than normal for the mother or foetus, stress is increased and can have detrimental effects. Psychology, in recent years, has recognised its role in the psychological health of the unborn and infant, and the field of prenatal and perinatal psychology has developed in this domain.

Hypnosis has historically been recognised as an effective aid to pregnancy, especially for its anaesthetic or analgesic effects during childbirth. Research in hypnosis has also advanced in its understanding of the mind-body connection and, increasingly, there is understanding that hypnosis facilitates mind-body communication (and healing). This understanding has contributed to using hypnosis for the treatment of conditions traditionally considered to be medical. The HypnoBirthing® approach therefore, shows potential for extending medical care beyond the traditional use of anaesthetic or analgesic for childbirth. It could be used to address the psychological and biological aspects of pregnancy that are considered to be high risk. The literature study explores these concepts in greater detail, providing both an explanation of the development and use of hypnosis in pregnancy and a rationale for the therapeutic use of hypnosis to address aspects of high-risk pregnancy.

1.2 Research questions

According to Grinnell and Unrau (2005), research questions should be formulated clearly, unambiguously and as early as possible in the life of the project, but they become more concrete and focused as the study progresses. In this study, the research question was formulated as a main question with several sub-questions that expand on the umbrella question. The following research questions were formulated:

Main research question:

- What are women's experiences of hypnotherapy (specifically the HypnoBirthing® approach) as psychological support offered during high-risk pregnancy?

Sub-questions:

- What are the expectations of women experiencing high-risk pregnancy about their pregnancy, birth and parenthood?
    - What are their fears and anxieties?
    - What are their hopes and wishes?
- What are the expectations of women experiencing high-risk pregnancy about what would be helpful to them in terms of psychological support and hypnotherapy during their pregnancy?
- What are the experiences of women with high-risk pregnancy of themselves throughout the pregnancy, in terms of their ability to cope with stress, anxiety and other fears?
- What are the experiences of women with high-risk pregnancy concerning hypnotherapy (HypnoBirthing®) as a means of psychological support?

- What did the women experiencing high-risk pregnancy find particularly helpful during pregnancy, birth and postnatal?
- What did the women experiencing high-risk pregnancy find not helpful during pregnancy, birth and postnatal?
- How effective is hypnotherapy (HypnoBirthing®) in cases of women experiencing high-risk pregnancy in treating the actual physical complications?
- How does the data inform the hypnotherapeutic (HynoBirthing®) process and results?

1.3 Objective of the study

The objective of the study was to explore, through the experiences of pregnant women, how hypnotherapy, and in particular the HypnoBirthing® approach, can be useful to them when dealing with a high-risk pregnancy. Selltiz, Wrightsman and Cook (1965) emphasise three methods by which exploratory research may be done, namely a review of literature, a survey of people who had practical experiences of the problem being studied, and an analysis of insight-stimulating cases. All three are relevant in this research study, which involved exploring existing literature and conducting case-study research with participants.

1.4 Relevance of the study and expected benefits of research results

It is expected that the results obtained from the study will enable the researcher, or other mental health practitioners, to start developing treatment protocols for the use of hypnosis with high-risk pregnancies. Whilst medical treatment has traditionally dominated this field, the field of prenatal and perinatal psychology is emerging strongly as a holistic mind-body

approach to the treatment of conditions which were previously thought of as purely in the medical domain. At the same time, therapeutic hypnosis such as the HypnoBirthing® approach shows potential for the treatment of many conditions thought to have a strong mind-body connection. The results of the research may, therefore, enable women to find alternative or supplementary treatment to manage high-risk pregnancies. Not only could it enable women to have more choice of treatment options, or enhance current treatment options, but it may save the lives of unborn children placed at risk through complications during pregnancy or childbirth.

1.5 Overview of methodology

The researcher experienced significant difficulty in recruiting participants for the research; the main challenge being the preconceived ideas that people hold about hypnosis as being mystical or mysterious. Whilst a number of participants were interested in participating in a study regarding high-risk pregnancy, most were not prepared to undergo hypnosis as a psychological intervention to support them in dealing with the risk. The researcher intended to conduct the hypnotic intervention himself and to set up quantitative data-collection measures to measure the outcomes. However, the only participants that were recruited had already undergone hypnosis, and in particular the HypnoBirthing® process, as an intervention to help them during pregnancy, and the data collected was limited to what could be collected in retrospect.

The research employed a case-study design in which a complex data set was compiled and analysed. Purposive convenience sampling was utilised to identify potential research participants and, from the 14 potential participants identified, two main cases were followed

in this study – Felicity[1] and Danelle[1]. Initially, the participants' experience of high-risk pregnancy and birth seemed very unique, but deeper exploration of their experiences uncovered unexpected commonalities. Data were collected mainly through in-depth interviews, whilst some quantitative data were also collected. Since the data mainly consisted of transcripts from in-depth interviews, the data were mainly analysed using thematic qualitative analysis. Whilst the data for each case study were collected and analysed independently of the other, a comparative analysis was also conducted in which cross-cutting themes and differences were identified and discussed.

1.6. Overview of chapters

The dissertation is structured according to the following chapters:

- Chapter 1 describes the rationale for the study and an overview of the methodology used.
- Chapter 2 explores the literature on pregnancy and the use of hypnosis. This includes an overview of the theoretical paradigm used for the study.
- Chapter 3 provides a detailed description of the methodology used, and includes sections on the research design, sampling, data collection, data analysis, ensuring quality in the research and ethical considerations.
- Chapter 4 reports the results of the research for case study 1.
- Chapter 5 reports the results of the research for case study 2.

[1] Pseudonyms are used for all research participants in the study in order to maintain confidentiality

- Chapter 6 provides a summary of the results of the research and a comparative analysis of the two case studies, making reference to similarities and differences in the findings.
- Chapter 7 consists of the conclusions drawn from the findings, as well as recommendations regarding the use of hypnosis in high-risk pregnancy and further research on the subject.

CHAPTER 2

HYPNOSIS, HYPNOTHERAPY AND HIGH-RISK PREGNANCY

2.1 Pregnancy

Pregnancy marks a period of significant transition for the woman and her partner and is often perceived to be one of the most important years in a woman's lifetime (Zwelling, 1988). Pregnancy is not only a physical experience, but a psychological and sociocultural experience that affects all those around the pregnant woman. For the woman, the physical experience of pregnancy includes hormonal changes and physiological changes in her body, such as fatigue, morning sickness, breast tenderness, increased weight gain and reduced libido. At the same time, she may experience an altered body image, interest in the development and growth of the foetus and an interest in labour, birth and the practical aspects of parenting. Socially, the woman and her partner may be preparing to take on parental roles and withdraw from some usual interests. Family relationships are also affected (Shilling, 1988), although the roles and responsibilities of men, women and family members vary greatly across different cultures. Usually, a reorganisation of the family system takes place, with changes in the roles and responsibilities of family members (Ewy-Edwards, 1988). Parents often struggle to cope with the changes in lifestyle that a new infant brings, such as having too little time as a couple, less time to socialise with friends, additional economic pressure and a loss of sleep. All of these changes add stress to the marital relationship, resulting in an improvement in some

relationships, whilst other marriages decline as marital dissatisfaction grows from the changing roles.

Whilst normal pregnancy already involves major transitional changes in the lives of women and their partners, high-risk pregnancy is typically accompanied by high levels of stress and anxiety, which may exacerbate the condition that produces the risk and provide for a negative experience of the pregnancy, birth and first steps as new parents (Polomeno, 1988). Part of this negative experience includes feelings of helplessness and powerlessness as the pregnant woman resigns herself to the treatment offered by the medical community. Complications in pregnancy may be a source of further stress and, with high-risk pregnancy, stress also increases. As many as 20% to 25% of pregnancies can be labelled high-risk pregnancies, which means that the health of either the woman or the foetus (or both) is at risk. Hospitalisation to deal with complications increases stress levels due to the separation from home and family (Penticuff, 1982). Briefly, stress increases with each disruption or complication during the pregnancy, and psychological support can be considered a critical component in preparing the pregnant woman (and her family) for coping with the normal stress of pregnancy and birth, as well as with the added stress of complications and high-risk pregnancy (Kemp & Page, 1986).

Within the scope of pregnancy and childbirth, hypnosis is probably best known for its application of analgesic or anaesthetic effect during childbirth to control pain, a use that is well supported in literature and discussed in more detail in Section 2.3.5 below.

2.2 Prenatal and perinatal psychology

The Association for Prenatal and Perinatal Psychology and Health states on the home page of their website (The Association for Prenatal and Perinatal Psychology and Health, n.d.) that prenatal and perinatal experiences are "formative for both babies and parents, and tend to establish patterns of intimacy and sociality for life". The association emphasises that what is at stake is the quality of personal relationships and, therefore, society itself, and they state that "womb ecology becomes world ecology".

White (2007) states that prenatal bonding is an important concept in the HypnoBirthing® approach, and one of the reasons why it is recommended that pregnant couples join the programme as early as the second trimester of pregnancy. The involvement of the father as ongoing emotional support is considered vital to both the mother and the baby in the prenatal and perinatal period in order to reduce stress.

The above provides a context for the relevance of this study as an enquiry into the psychological experiences of women of the HypnoBirthing® approach during the prenatal and perinatal period of their pregnancy and birth. The emphasis is on their lived experiences and not the field of prenatal and perinatal psychology *per se*.

2.3 Hypnosis and hypnotherapy

2.3.1 Definitions

The Penguin Dictionary of Psychology (2009, p.360) defines hypnosis as "… a hypnotic state … [*that*] represents an extreme pole on the scale of suggestibility". It continues to define

hypnotherapy as "… any psychotherapy that makes use of hypnosis …" and hypnotism as "… the practice or study of hypnosis …." As a phenomenon, hypnosis continues to be clouded in mysticism and confusion and often conjures up images of a person under the direct control of a hypnotist; a perception that is reinforced in the public media by the practice of hypnosis on stage for entertainment purposes.

Yapko (2003) draws our attention to the very wide range of definitions often used to describe hypnosis, which include that hypnosis is guided daydreaming, a natural altered state of consciousness, a relaxed hypersuggestable state and a dissociated state of awareness. Araoz (2005) adds that hypnosis is the experience of a new dimension of self, based mainly on the use of fantasy and imagination. This form of concentrated attention allows the person to engage in new of thinking and experiencing new possibilities of self control.

Araoz (2005) then states that hypnosis in the the therapeutic context (hypnotherapy) helps the client to attain individual goals by accepting them as imminently attaintable and possible, while hypnoanalysis facilitates the connection of current distress with past experiences, helping the client to develop a greater awareness of factors that may have shaped his or her personality. Beebe (2014) adds to this that hypnosis and hypnotherapy are terms that are often used interchangeably, but draws the following distinction: While hypnosis refers to a procedure during which a person experiences suggested changes in perception, sensation, thought or behaviour, hypnotherapy or clinical hypnosis "is an integrative mind-body technique using hypnotic suggestions for a specified, therapeutic purpose mutually identified between a hypnotherapist and a client". Beebe (2014) continues to identify three standardised protocols for hypnotherapy interventions, namely Hypnobabies®, the LeClaire Hypnobirthing Method and HypnoBirthing®: The Mongan Method. In this study, both

participants attended the HypnoBirthing®: The Mongan Method programme, which is hereafter referred to as HypnoBirthing® for the sake of brevity. Beebe (2014) suggests that the use of these standardised intervention packages may offer better control of treatment conditions and therefore yield more interpretable and comparable results for research purposes. According to Beebe's (2014) explanation, HypnoBirthing® constitutes a standardised protocol of hypnotherapy.

Based on the distinctions drawn above, the researcher adopts the use of the terms hypnosis and hypnotherapy as appropriate when referring to the HypnoBirthing® approach, but accepts that hypnoanalysis constitutes a psyhotherapeutic application that extents beyond the scope of the HypnoBirthing® approach.

2.3.2 A brief history of hypnosis

In the 16th century, a Swiss medical doctor named Paracelsus discovered the mercury cure for syphilis and was also the first physician known to have used magnets for healing (James, Flores & Schober, 2000). He healed patients by passing magnets or a lodestone over the body of the patient and apparently achieved great success with this method. During the 17th century, an Irishman named Valentine Greatrakes healed people by laying his hands on them and passing magnets over their body. He was known as the Great Irish Stroker and was famous for stroking or massaging problems out of the body.

In 1725, a Jesuit priest, Maximilian Hehl, also used magnets to cure people. One of his students, a young medical doctor from Vienna, took this practice back to Vienna. He was Franz Anton Mesmer; hence the term mesmerism. In those days, a major form of medical treatment was bloodletting, which involved opening a patient's vein and letting the patient

bleed for a while. Mesmer would make passes over the cuts with his magnets, and the bleeding would stop. One day, Mesmer could not find his magnets and compensated by using a stick and was surprised to achieve the usual success. He concluded that it was not the energy of the magnet that caused the healing, but the energy of the patient, and he called the phenomenon *Animal Magnetism*. Mesmer eventually moved to Paris and became very successful; so much so that his success attracted the jealousy of traditional medical doctors who insisted that he was a charlatan. After an investigation, he was discredited and left Paris to return to Vienna, where he continued his practice of mesmerism or animal magnetism. From 1795 until 1985, the notion of energy as a form of healing was left out of mainstream Western medicine and psychology.

Mesmerism was, however, still practiced. The Marquis de Pusseguyr in France coined the term *somnambulist*, used until today to refer to a deep level of trance in hypnosis. Around 1840, a surgeon named James Braid saw a demonstration of mesmerism and noticed how the subject's eyes are typically fixated in a stare during this process of mesmerism. He concluded that eye fixation is an important factor in causing a trance. He called this neurohypnosis and concluded that no energy transfer is involved in mesmerism, but that it works because of the suggestion that the subject would go into a trance. He wrote the first book on hypnosis in 1843, called *Neurypnology*. At the same time, James Esdaile, a medical doctor in India, wrote a book titled *Mesmerism*. He made use of hypnosis to reduce pain and developed his techniques before chloroform was used as an anaesthetic. Esdaile is reported to have performed over 500 operations with his patients under hypnosis. With the discovery of the use of chloroform for anaesthesia, however, research on mesmerism for pain control stopped.

In 1864, a doctor in France, named Liebault, developed a system of hypnosis. When he cured a patient with sciatica almost overnight, the referring physician and colleague named Bernheim formed a partnership with Liebault, and they started the Nancy School of Hypnosis.

Around that time, a young doctor named Sigmund Freud studied with Bernheim and Liebault, and started to use hypnosis in his practice. Eventually he gave up the use of hypnosis, and concluded that it was dangerous, after a female patient jumped up and kissed him. Furthermore, his gums were apparently ruined by cocaine usage, and his false teeth did not fit very well, causing him not to speak well enough to induce a trance (James et al., 2000). Freud continued to develop his talking therapy, which became known as psychoanalysis. This became the fashion in psychology and completely overshadowed hypnosis. For the rest of the first half of the 20th century, hypnosis remained in the shadows of psychology, until Clark Hull from Yale University published a book titled *Hypnosis and Suggestibility* in 1943. Hull's famous observation about hypnosis was that "anything that assumes trance causes trance" (James et al., 2000, p.15). From this point of view, even visualisation is seen as hypnosis. According to James et al. (2000), Hull was also a strong influence on the young Milton Erickson, who became known world-wide for his unique permissive approach to hypnosis, now simply referred to as *Ericksonian hypnosis.* In contrast to Erickson's permissive, non-directive approach, more directive approaches also developed, such as that of George Estabrook and Dave Elman (1964).

2.3.3 The myths of hypnosis

According to Yapko (2003), there are many myths and misconceptions about the nature of hypnosis and how it is practiced, and these can interfere greatly with the therapeutic process.

The most widely held myth concerning hypnosis is that it is a form of powerful mind control in which the hypnotised person has no free will. Most of the other misconceptions are built on this myth.

As a result of these widely held misconceptions, it has become standard practice to educate clients about the nature of hypnosis and to address myths and misconceptions so that clients can make informed choices about treatment. Known as a pre-talk, this educational conversation addresses the common myths and misconceptions about hypnosis. During this process, the therapist will also probe the client about her or his current knowledge of hypnosis and any prior experiences thereof. Some of the myths that are commonly addressed include the following (Yapko, 2003):

1) Hypnosis is a good thing.
2) Hypnosis is caused by the power of the hypnotist.
3) Only certain kinds of people can be hypnotised.
4) Anyone who can be hypnotised must be weak minded.
5) Once one has been hypnotised, one can no longer resist it.
6) One can be hypnotised to say or do something against one's will.
7) Being hypnotised can be hazardous to your health.
8) Hypnosis can't harm anyone.
9) One inevitably becomes dependent on the hypnotist.
10) One can become "stuck" in hypnosis.
11) One is asleep or unconscious when in hypnosis.
12) Hypnosis always involves a ritual of induction.
13) Hypnosis is simply relaxation.
14) Clinical hypnosis is a specific school of therapy.

15) Hypnosis may be used to recall everything that has happened to you.

It is beyond the scope of this study to explore each of these myths in detail, since the volume of information is overwhelming. A brief, general discussion will, however, provide the reader with a basic understanding of the current thinking on hypnosis.

2.3.4 The scope of hypnotherapy in general

Hammond (1990) provides an extensive list of the uses of hypnosis for therapeutic purposes. In his book, *Handbook of Hypnotic Suggestions and Metaphors*, he indexes a list of conditions and situations for which hypnosis may be used and, to provide the reader with some insight into the vast scope of hypnosis, these categories are presented below:

- Pain management
- Hypno-anaesthesia and preparation for surgery
- Ego strengthening: enhancing esteem, self-efficacy and confidence
- Anxiety, phobias and dental disorders
- Cancer
- Medical disorders
- Obstetrics and gynaecology
- Emotional and psychiatric disorders
- Sexual dysfunction and relationship problems
- Obesity and eating disorders
- Smoking, addictions and habit disorders
- Concentration, academic performance and athletic performance.

Each of these categories, as presented by Hammond (1990), contains a vast collection of further specific applications. For the purpose of this study, the researcher will delve into a number of these areas, including obstetrics and gynaecology, ego strengthening, anxiety, fear and pain management – all of which may overlap with the area of prenatal and perinatal psychology and, more specific to this study, high-risk pregnancy. The application of hypnotherapy as a psychological intervention for pregnancy-related health issues is also supported by Beebe (2014) who states that hypnotherapeutic treatment have been used for various childbearing-related conditions, but specifically relevant to this study are conditions of preterm labour, pain control, anxiety, caesarian surgical birth, analgesia and childbirth satisfaction.

2.3.5 The mind-body relationship and applications of hypnosis

The idea that hypnosis, as a psychological intervention, can have an effect on physiological processes assumes a mind-body connection. Barabasz and Barabasz (1992) suggest that the clinical improvement of conditions attributable to hypnosis is likely the result of an interaction amongst a number of cascading psychophysiological events. However, the outcomes of hypnosis indicate a mind-body interaction that goes beyond the general effects of relaxation or expectancy. In support of this position, they cite two studies in which warts were removed selectively from one part of the body by means of hypnotic suggestions, which indicates that the hypnotised person could target physiological changes associated with healing to specific locations in the body. The hypnosis did not create system-wide changes as would be expected in the case of relaxation.

Benham and Younger (2008) state that hypnosis is a powerful psychophysiological tool that has a long history of use with problems that are usually considered to be only physiological.

Interest in the use of hypnosis to produce analgesia was sparked by the Scottish doctor James Esdaile (1808–1857), who is reported to have conducted hundreds of major operations in India with only the use of hypnosis to produce anaesthesia. After Esdaile's death, and with the discovery of ether and chloroform, the interest in hypnosis as anaesthetic initially declined, but around the 1930's, interest in the reduction of pain through hypnosis resumed. Cosser (2001, 2002) explored the use of hypnosis with chronic pain from an ecosystemic perspective, utilising the conceptions of the pain patient and the family to establish treatment goals and conditions. This approach widens the application of hypnosis in the treatment of pain beyond the traditional medical response and establishes the relevance of a psychological approach as a valid treatment adjunct to responding to people's experience of pain. Hypnosis is also widely used to reduce and manage pain during childbirth (Brown & Hammond, 2007; Abbasi, Ghazi, Barlow-Harrison, Sheikhvatan & Mohammadyari, 2009; August, 2009;), as well as to enhance feelings of self-confidence, control and well-being (Simkin & Bolding, 2004). Some of the other uses of hypnosis today include modulating skin temperature of blood flow and the treatment of high blood pressure, asthma, allergic skin reactions, dermatological disorders and irritable bowel syndrome (Benham & Younger, 2008).

Kirsch (2000) attributes much of the therapeutic effect of hypnosis in the medical field to the positive expectations created by the hypnotist, similar to a placebo effect. Kirsch, however, does refer to the use of hypnosis as non-deceptive as compared to the placebo effect, in which case the patient is fooled into believing that s/he is receiving real drugs. Rossi (1993) states that the placebo response demonstrates a mind-body healing factor in many medical conditions, including hypertension, stress, cardiac pain, headaches, diabetes, ulcers, colds, fever, asthma and menstrual pain. In fact, according to Rossi (1993), the placebo response is present in the majority of all healing procedures.

Rossi (1993), however, draws a clear distinction between the placebo response and hypnosis and states that these phenomena operate through very different mechanisms. Rossi (1993, p.18) states that:

> [*H*]ypnotic responsiveness is a specific, innate ability and skill that involves the capacity to access or change one's patterns of mind-body communication by the use of psychological suggestion alone. The placebo response, in contrast, is a more general, automatic mind-body communication that utilizes physical treatment methods to reduce anxiety and facilitate healing by marshalling powerful cultural expectations and beliefs in the treatment method.

Rossi (2003) provides a very detailed and complex explanation of the mechanism of mind-body communication which goes beyond the scope of this study, but, for the purpose of this study, it suffices to say that Rossi draws a clear distinction between the placebo response and hypnosis. Hypnosis, by its very nature, also emphasises the centrality of the person's responsibility for her or his own health and well-being.

Probably the most well-known application of hypnosis in pregnancy is that of pain control during childbirth. Whilst the purpose of this study and the hypnotic intervention is not pain control during childbirth *per se*, it must be acknowledged that the fear of pain is commonly experienced by many women during pregnancy. In fact, childbirth is described as one of the most intense forms of pain (Abbasi et al., 2009). This fear of the birth experience and negative expectations represent one of the psychosocial factors cited by Mehl-Madrona (2002) as a predictor of complicated birth. White (2007) refers to the Fear-Tension-Pain Syndrome as the mind-body connection which allows a woman to alter her experiences and reduce or eliminate pain from childbirth, a central concept in the HypnoBirthing® approach (this concept is further discussion in Section 2.4). If hypnosis can offer pregnant women a

more positive expectation of the childbirth experience and confidence in managing any accompanying discomfort, the reduction in fear may contribute to an uncomplicated or less complicated birth. In fact, Abbasi et al. (2009) found that women reported a sense of relief and consolation, self-confidence, satisfaction, decrease in fear of natural birth and lack of anxiety after undergoing hypnosis and training in self-hypnosis. August (2009) stated in a report on the use of hypnosis in private practice with 361 patients that 94% of women required no additional anaesthesia during childbirth and that, in only 6% of cases, hypnosis was not completely adequate to provide the desired degree of pain control.

Yapko (2003) described pain management as one of the more sophisticated uses of hypnosis, applicable for both chronic and acute pain. More specifically, hypnosis can be used after surgery, to facilitate easier childbirth and to help manage physical trauma of some kind. Jensen & Patterson (2014) report on significant findings from clinical trials on hypnotic approaches for pain management, and state that hypnosis is effective over and above placebo treatments. While there remains a high variability in response to hypnotic treatment, the benefits of hypnosis treatment extend beyond pain management, and the overhwelming majority of research participants in these trials have continued to practice self-hypnosis skills during follow-up studies.

In the treatment of anxiety and stress, hypnosis is considered to be very effective (Yapko, 2003). Hypnosis has been used successfully to teach medical patients techniques to prevent negative stress, to identify stress before it reaches levels causing debilitating symptoms, and to relax and manage stress positively.

In the treatment of serious medical illness, hypnosis has demonstrated its use as an adjunct to medical treatment (Yapko, 2003). The important factor is addressing the patient's emotional needs, while other medical treatment still takes place. Whilst hypnosis has been shown to be effective in addressing even illness thought to be purely physiological, the precise mechanism by which it operates remains open to speculation. It is known, however, that hypnosis can be very effective in strengthening the patient's immune system, something that is more precisely explained in the field of psychoneuroimmunology.

Yapko (2003) points out two important factors when using hypnosis in the mind-body domain, namely:

1. Whilst the responsibility for self is located with the patient, this is not meant to translate into blaming the person for causing the illness or condition.
2. Hypnotherapists working in the medical field – who are not also medically qualified to work with these conditions – must operate under the supervision of an appropriately qualified medical practitioner. This aspect is also further addressed in Section 3.6, which deals with *Ethical Considerations.*

Another application of hypnosis in pregnancy is the treatment of morning sickness. According to Madrid, Giovannoli and Wolfe (2011), hypnosis is an effective means to treat persistent nausea and vomiting during pregnancy. Distinguished from common pregnancy morning-sickness, *hyperemesis gravidarum* is considered the severe end of the spectrum of nausea and may result in weight loss exceeding 5% of the pre-pregnancy weight. Their view is supported by the American Society of Clinical Hypnosis (The American Society of Clinical Hypnosis, n.d., http://www.asch.net) which lists *hyperemesis gravidarum* and pregnancy as areas for the legitimate use of hypnosis.

In a study conducted by Alexander, Turnbull and Cyna (2009), it was found that women are more hypnotisable when they are pregnant, which has implications for hypnosis as an alternative or adjunct to pharmacological analgesic during childbirth.

Most existing research on the use of hypnosis with pregnancy focused on its applications in normal pregnancy, such as treating morning sickness and pain relief during childbirth. However, some research has been conducted on hypnosis in the treatment of hypertension. In a single case study, Borckardt (2002) discussed the flexibility of hypnosis as a therapeutic tool. He examined the effectiveness of hypnosis within a multimodal approach in the treatment of hypertension and found that the interventions significantly reduced diastolic blood pressure over and above traditional pharmacological treatment. Borckhardt states that, whilst psychological interventions aimed at modifying blood pressure have been disappointing in the past, a more systematic and integrative approach combined with hypnosis yields hopeful results. Results from a randomised study support Borckardt's findings. The randomised study found that hypnosis is effective in reducing blood pressure not only in the short term, but also in the middle and long terms (Gay, 2007).

For the purpose of this study, however, the researcher did not need an in-depth understanding of the medical complexities of hypertensive or other medical disorders. Rather, the focus of the researcher was on the psychological support required by each of the participants, how hypnosis can be applied in offering such support, and the research participants' experiences of HypnoBirthing® in providing such psychological support.

2.4 The approach adopted for the purposes of this study

There are various theoretical explanations for hypnosis, and in order to clarify where HypnoBirthing® fits into these categories, a brief background will be explored. Most approaches to hypnosis can be classified as either dissociated control (state) or sociocognitive (non-state) approaches, while Cosser (2001) also suggests an ecosystemic approach to the understanding of the hypnotic phenomena. The dissociated control approaches assume that hypnosis is fundamentally a trance state in which the subject is in an altered state of consciousness (Baker, 1990). This hypnotic state is induced by the hypnotist and renders the person more open to accepting suggestions. This approach accepts that there are different levels of trance, and that a person can therefore enter a light or deeper trance. And the end of such a session the person is emerged from the trance state and returns to a normal everyday waking state of functioning (Woody & Saddler, 2008). Milton Erickson (Erikson, 1985) considered hypnosis to be dissociation between the conscious and unconscious mind whereby the unconscious potential of the client can be unlocked and released. Sociocognitive approaches reject the notion of a trance state, rather referring to the phenomenon of hypnosis as a social role adopted by the person (Barker, 1972). This approach explains hypnotic phenomena as a result of sociopsychological factors such as social expectation and an attitude of the person in hypnosis towards the process, rather than that of an actual trance (Lynn, Kirsch & Hallquist, 2008). Cosser (2001) also described an ecosystemic explanation of hypnosis whereby the linear and causal thinking of the state and non-state approaches are discarded in favour of an approach that locates hypnosis not in the psyche of the individual, but in the context within which it occurs. From this perspective hypnosis is not approached as an entity, but as a concept that exists purely because it is mutually defined and accepted as such by those involved in it.

From this brief description of the various approaches to understanding hypnosis, it becomes clear that the HypnoBirthing® approach is developed from a trance state perspective, as it makes use of trance induction and deepening as some of its core techniques (White, 2007). It must be clarified however, that while the HypnoBirthing® approach itself adopts a trance state position for the techniques used, the research is conducted from an ecosystemic perspective.

Both participants (focus of each case study) in the research were trained in the HypnoBirthing® approach, specifically the Mongan method. This approach is cited by Madden, Middleton, Cyna, Matthewson and Jones (2012) as a community-based preparation programme of hypnosis for childbirth. HypnoBirthing® is the trademark of a comprehensive hypnotherapeutic approach to childbirth in which participants are taught the skills of self-hypnosis (White, 2007). The approach is based on the principle that, when fear is not present, pain is not present (Mongan, 2005). The theory, developed by Dr Dick-Read, is that fear causes the arteries leading to the uterus to constrict and become tense, thereby creating pain (Dick-Read, 1947). In the absence of fear, the muscles are able to relax and become much more pliable as a result, and the cervix is able to thin naturally and open as the body pulsates rhythmically and expels the baby with ease. He termed this the Fear-Tension-Pain Syndrome. HypnoBirthing® is said to be able to help participants have a birth experience without pain because it enables the body to make use of its own natural analgesic response, which can be far more effective than medical or pharmacological painkillers. It appears that the profound calming effect of hypnosis enables the release of endorphins, which in return produce a tranquil amnesiac condition – one that occurs naturally in the birth of mammals.

HypnoBirthing® is a standardised childbirth education programme taught by practitioners trained and certified by the HypnoBirthing® Institute (Mongan, 2005). The programme consists of four basic hypnosis techniques that are taught to attendees over a number of sessions as self-hypnosis, and include a combination of breathing techniques, relaxation techniques, visualisation techniques and ultra-deepening techniques. Following this approach, participants aim for a birth experience free from medical intervention, unless it is necessary. According to Jackson (2003), the HypnoBirthing® programme explores the wonders of the human body while teaching mothers and couples skills in relaxation and self-hypnosis. The self-hypnosis skills enable the mother reframe previous negative programming and conditioning about labour and birth, to work with the birthing process rather than resist it. In this manner HypnoBirthing® frees the mother from unwanted fears about childbirth, replacing them with calmness and confidence in her her ability to birth her baby naturally. Cyna, McAuliffe & Andrew (2004) note that there are two main methods for providing hypnosis interventions for childbirth, namely hypnotherapy delivered in-person by a practitioner and self-hypnosis, where the practitioner teaches the mother how to use self-hypnosis skills. The HypnoBirthing® approach makes use of both these methods.

HypnoBirthing® does not preclude medical intervention, but it precludes medical interventions that are arbitrary, routine or unnecessary, or which are introduced for the sake of expediency and in order to get things over with (Mongan, 2005). There are still many attitudes and myths that pervade the medical profession regarding childbirth, which work together to produce fear and tension and, therefore, pain. It will, however, not serve the purpose of this study to explore this debate in detail, and this brief introduction to HypnoBirthing® is only intended to provide some context to the approach that was used in this study to teach and prepare the participants for childbirth. The term HypnoBirthing® will

be used to refer specifically to the training and preparation that the participants received, while hypnosis and hypnotherapy will be used to refer to all other hypnotherapeutic applications, but do not exclude HypnoBirthing® and can, therefore, be used interchangeably at times.

2.5 Hypnotherapy today

According to the South African Society for Clinical Hypnosis (The South African society for clinical hypnosis, n.d., http://www.sasch.co.za), modern clinical hypnosis can be utilised for a wide range of therapeutic applications, ranging from the augmentation and facilitation of "normal" psychology to the facilitation of the growth-orientated approaches of positive psychology. It can even be used for the relief and resolution of psychosomatic aspects of what are normally considered to be medical conditions. This sets the stage for the exploration of the application and potential benefit of hypnotherapy for women with high-risk pregnancies.

2.6 Theoretical paradigm: Ecological systems perspective

According to Durrheim (2006), a paradigm is a system of interrelated ontological, epistemological and methodological assumptions, which provides a rationale for the research and commits the researcher to particular methods of data collection and analysis. Rule and John (2011) refer to it simply as the researcher's broad orientation to knowledge and reality. In an attempt to understand human functioning and behaviour, the researcher is bound by the limits of a chosen frame of reference (Vorster, 2003). It is, therefore, inevitable that the world view of the researcher will influence the perspective and decisions made regarding the

research, and it should, therefore, be described clearly. Becvar and Becvar (2009) and Corey (2009) differentiate between two different psychological world views, namely individual psychology and systems theory.

2.6.1 Individual psychology

An individual-psychology paradigm is based on the principle of linear causality, that is, the assumption that every effect has a direct cause (Becvar & Becvar, 2009). From this perspective, every problem is viewed as solvable if we can find an answer to the question *why?* Therefore, A causes B in a linear fashion (A → B), and we can hold A responsible for causing B. Reality is then considered to be separate from the individual and exists outside of our minds. By reducing the sequences of an external reality to its smallest possible component, we can uncover the laws according to which the world operates, and individuals are, therefore, seen as reacting to and being determined by reality rather than creating it (Becvar & Becvar, 2009). The world is understood in a deterministic way as operating on law-like principles, which, if we can discover them, will reveal some absolute truth about reality.

When beliefs such as these are translated from the physical sciences into behavioural sciences, human behaviour comes to be described as either determined by internal events or external environmental sequences to which we react (Becvar & Becvar, 2009). Behavioural scientists embrace the notion of body-mind dualism, meaning that mind and reality exist independently of each other. We can thus only view reality independently and from a distance, leading us to believe that objective measurement and value-free science is possible and desirable, leaving the subjective dimension to be distrusted and unscientific.

This scientific tradition is still very well respected in Western societies, and psychologists have embraced the notion of the importance of objectivity and the value of measurable, quantifiable data. When the goal is to reduce human behaviour to the lowest common denominator, we must focus either on the individual and individual behaviour or on the internal events of the mind (Becvar & Becvar, 2009). Whilst I do not completely reject this perspective, I favour an approach that values the subjective experience of individuals.

2.6.2 Ecological systems perspective

The ecological systems perspective is a metatheory that consists of a combination of principles of general systems theory and ecological theory (Forte, 2007). General systems theory was defined by its founder, Ludwig von Bertalanffy, as a field of study that is concerned with the formulation and derivation of principles which hold for systems in general. Considered to be quite a complex perspective, it was considered a way to integrate knowledge from different perspectives as well as a theory explaining the way systems function. From a general systems perspective, the environment as a whole is often compared to a machine with the individual person considered to be a part of the whole. The person is not considered to be freestanding and is defined by his or her interaction with other parts of a larger system, much like one organ forms part of a larger body. The value of this approach is that it provides a holistic perspective of people rather than only dealing with the parts of human or social behaviour as other theories do (Payne, 2005).

Ecology as a discipline studies the relationships between organisms and their environments, and ecological theorists incorporate ideas from various disciplines such as biology, sociology, psychology and geography. The concept of the ecological environment was development by Urie Bronfenbrenner, who struggled with the concept of a single dimension of cause-and-

effect relationships as implied in Von Bertalanffy's theory. Instead, Bronfenbrenner believed that there are a number of additional environmental factors present in human social systems, which he collectively referred to as the ecological environment (Bronfenbrenner, 1979). According to Bronfenbrenner (1979), human development cannot be studied in isolation, but must be understood within the context of the individual's relationship with the environment. The environment was also not limited by Bronfenbrenner to the here-and-now; he also included aspects of the person's history as well as social and cultural aspects. Applied ecological theory is, therefore, concerned with the nature of transactions between people and their physical and social environments (Forte, 2007).

The ecosystems approach (ecological systems approach) blends assumptions and concepts from both general systems and ecological theory into a metatheory – or paradigm – about the nature of reality and about helping work suited to this reality. Added to the concepts of ecological theory and general systems theory are those of cybernetics, the science of information processing and system self-regulation developed by Norbert Weiner (Forte, 2007). Cybernetics as a field is, however, traditionally concerned with mechanistic control systems and, although it contributes valuable concepts to our understanding of the way in which systems operate, as a mechanistic science it is not sufficient or appropriate to deal with the issues of human systems. Becvar and Becvar (2009) propose that a postmodernist, social-constructionist stance is logically consistent with a cybernetic paradigm since both have a strong focus on communication and context. This focus is relational in that all behaviour is considered to have communication value, and communication and information processing are considered to be basic systemic processes. A postmodern perspective challenges the modernist, positivist perspective (of individual psychology) which holds that answers to society's problems are to be found in hard science and that reality is objective and can be

revealed through expert knowledge and reliable research. Instead, a postmodern perspective holds that truth is not only subjective, but is in fact constructed through the act of observation. Clients are considered to be experts on their own reality, and the focus shifts to how they construct their world through the use of language and discourse. Within the postmodern perspective two important distinctions are made, namely constructivism and social constructionism.

A constructivist perspective holds that we construct both our personal knowledge about reality, and reality itself (Becvar & Becvar, 2009). We cannot observe or know the truth about people in any objective way – all we can know are our constructions of people and the world around us. Social constructionism considers language and its context to be central to not only understanding reality, but creating it. This departs from constructivism in that the focus shifts away from the mind and the constructions of individuals towards inter-subjective and shared meaning making. Reality is considered to be understood within the narrative, the lived and storied experiences of individuals. Language is thought to express the conventions, symbols and metaphors of groups of people and is, therefore, always tied to the social context. Corey (2009) states that language and the use of language create meaning and that each story is true for the person telling it. Knowledge is, therefore, constructed through social processes, and these negotiated understandings are practices that affect social life rather than just being abstractions from it. In other words, truth does not exist objectively, but it is created through the narrative process in which the research participants share their stories. Fact and reality become subjective and pliable from this perspective, and the researcher's own subjectivity is also recognised in the process.

Whilst I primarily identify my theoretical orientation as an ecological systems perspective, I consider the principles of cybernetics and social constructionism to be compatible with this approach and intricately tied to my own frame of reference.

2.6.3 Principles of an ecological systems perspective

From an ecological systems perspective, reality is understood to be something created by people rather than being an external reality. The subjective experience of an individual is, therefore, never denied, even though the focus may be on the interaction between individuals and groups of individuals (Vorster, 2003). In fact, the subjective experiences of individuals are regarded as important and often utilised in therapy. These subjective experiences are not directly available or observable for study, but are accessed through the individual's own reporting.

Based on the principle of reciprocal causality, the researcher is not interested in uncovering the cause of a particular situation, but rather in understanding the context of mutual interaction and influence between the research participants and their environment (Becvar & Becvar, 2009). Meaning is derived from the relationship between these individuals and their environment, as each defines and shapes the other, and no linear causality can be determined. Behaviour is, therefore, purposeful and as such constitutes the way in which members of a system relate to one another so as to coexist optimally (Vorster, 2003). Whilst each individual can be regarded as goal-directed and self-actualising, it is also essential for individuals to negotiate with the physical and social environment by acting in a manner that elicit responses that will allow them to meet their own needs. This is a process of mutual interaction between individuals as social systems, where each is both acting and reacting in order to meet their own needs. Members of a system, therefore, interact with and impact on one another in a

circular fashion where cause and effect becomes difficult to determine, and the concept of circular causality is adopted instead. From the subjective perspective of an individual, behaviour and patterns of interaction can be experienced as either effective or ineffective in meeting the needs or goals of the individual, but from a systemic point of view, all behaviour is simply part of a larger system in which each operates in response to the other.

Responsibility or power is understood to be a bilateral process, and anything that influences the system becomes part of that system. Every system is, therefore, influencing and being influenced by every other system with patterns of connection existing at every level of the system. This forms the basis of the world view – or paradigm – of the researcher.

Systems are considered to be open, as opposed to closed (Vorster, 2003). A closed system would be considered a self-contained system in which no input from "outside" of the system is allowed, whilst an open system allows for the input of new information. Rather than considering systems as either open or closed, Becvar and Becvar (2009) refer to the openness or closedness of systems, thereby considering it a matter of degree rather than a quality of a system. An appropriate balance of openness and closedness is desirable for the healthy functioning of any system, and the most suitable degree of openness or closedness can in each circumstance be considered to be relative to the context. When systems become too open or closed – either allowing too little or too much input – they will probably become dysfunctional as they enter into a state of entropy, tending towards disorder and disintegration. In the ideal state of balance between openness and closedness, the system is said to be in a state of negentropy, tending toward maximum order and maintenance.

As systems interact with other systems in an effort to survive, feedback from those past interactions is fed back into the system in a circular manner that results in self-correction (Becvar & Becvar, 2009). Feedback may result in the system either accepting the feedback, resulting in a change in the system, or rejecting the feedback. The relevance of feedback to a system can only be judged relative to its context as both change and stability are considered to be critical aspects of each system's survival. As self-corrective mechanisms, feedback may indicate fluctuations that serve to increase (or decrease) the probability of the survival of a system. Thus, the maintenance behaviour of systems is said to occur in reaction to change, and new behaviour within a system, therefore, calls for change within the system in order to remain stable in a functional way. A system may also reject or oppose disturbances in order to remain stable, but it is not an either-or situation: Well-functioning systems have both the ability to remain stable in the face of change and to change in the face of stability. These two functions are like the two sides of a coin – they cannot be separated. Either extreme on the continuum of change and stability would cause a system to become chaotic and disintegrate, whilst an appropriate balance will allow the system to grow and change as needed.

From an ecological systems perspective, the relationships between individuals, rather than the intrapersonal experiences of the individual, become the operational area of focus (Vorster, 2003). The individual is often seen as somewhat of a mystery that can be understood only in terms of the inputs and outputs, the relational interactions between the individual and the social environment. These actions and reactions are often the focus of attention for the therapist operating from a systemic orientation, and these characteristic relationship patterns within a system can be regarded as the rules according to which the system operates (Becvar & Becvar, 2009). They express the values of the system and help define the roles of various members within the system. The rules, or characteristic interaction patterns of the system, can

also be explained as boundaries which are not visible to outside observation, but have to be inferred from the patterns of interaction.

During a process of therapy, the therapist joins the system that was assisted therapeutically (the same can be said for a researcher). This happens irrespective of whether the client was being assisted individually or whether the whole family was present physically (Becvar & Becvar, 2009). The therapist becomes a temporary member of the system as he or she becomes part of the system of interaction and feedback. System theory holds that change in any one part of the system will result in change in the whole system and, therefore, even when working with an individual, the system as a whole should be borne in mind and therapeutic interventions should be in accordance with this (Vorster, 2003). The therapist, however, does not become an ordinary part of the system, but his or her role is defined as that of a helper, and the established family roles do not apply to the therapist. Whilst the therapist interacts with family members (or different members of the system) and in doing so becomes part of the system, he or she at the same time keeps a metaperspective of the system, observing interaction and communication. Through deliberate input and feedback, the therapist works to bring about changes in the behaviour and subjective experiences of the members of the system. Whilst the emphasis of the hypnotherapist (within the context of hypnosis for childbirth) may initially appear to be the subjective experiences of the pregnant client, the systemic interaction becomes evident when the woman's partner is also encouraged to learn the skills of hypnosis in order to assist the woman during labour and childbirth. The temporary nature of the therapist's interaction is, therefore, defined from the outset, and the woman and her partner (the couple, or the system) have limited time at their disposal to accommodate the input of the therapist and adjust accordingly. The degree of openness or closedness of the couple as a system will impact on how well they accommodate

the new way of interacting and being in relation to one another. However, since hypnotherapy is regarded – in this context – as an intervention with a specific focus and time limit, the hypnotic skills taught (behaviours and interactions) will probably be assimilated by the couple or system for as long as needed.

Although, as part of the system, the therapist can no longer observe the system objectively, this does not mean that the therapist cannot operate as an expert or helper (Vorster, 2003). The therapist, although subjective in his or her perception, had been educated to act from within a trained frame of reference from a systemic perspective. In fact, the very subjective and involved interaction and participation of the therapist in the system becomes the vehicle through which the therapist effects change. Therefore, it is not a handicap that the therapist becomes part of the system, but a necessary and beneficial action.

2.6.4 Bronfenbrenner's model

Bronfenbrenner's ecological systems model is amongst the most widely cited and frequently taught in human development (Weisner, 2008). The model was found by the researcher to be a useful tool in contextualising the experiences of the participants of this study. In this model, various systems – microsystem, mesosystem, exosystem and macrosystem – are considered to be in mutual interaction with each other. A system is not tangible or visible, which makes direct observation of it impossible, but we can observe systems by paying attention to the hierarchy, tasks, roles and positions of authority that people occupy in relation to one another.

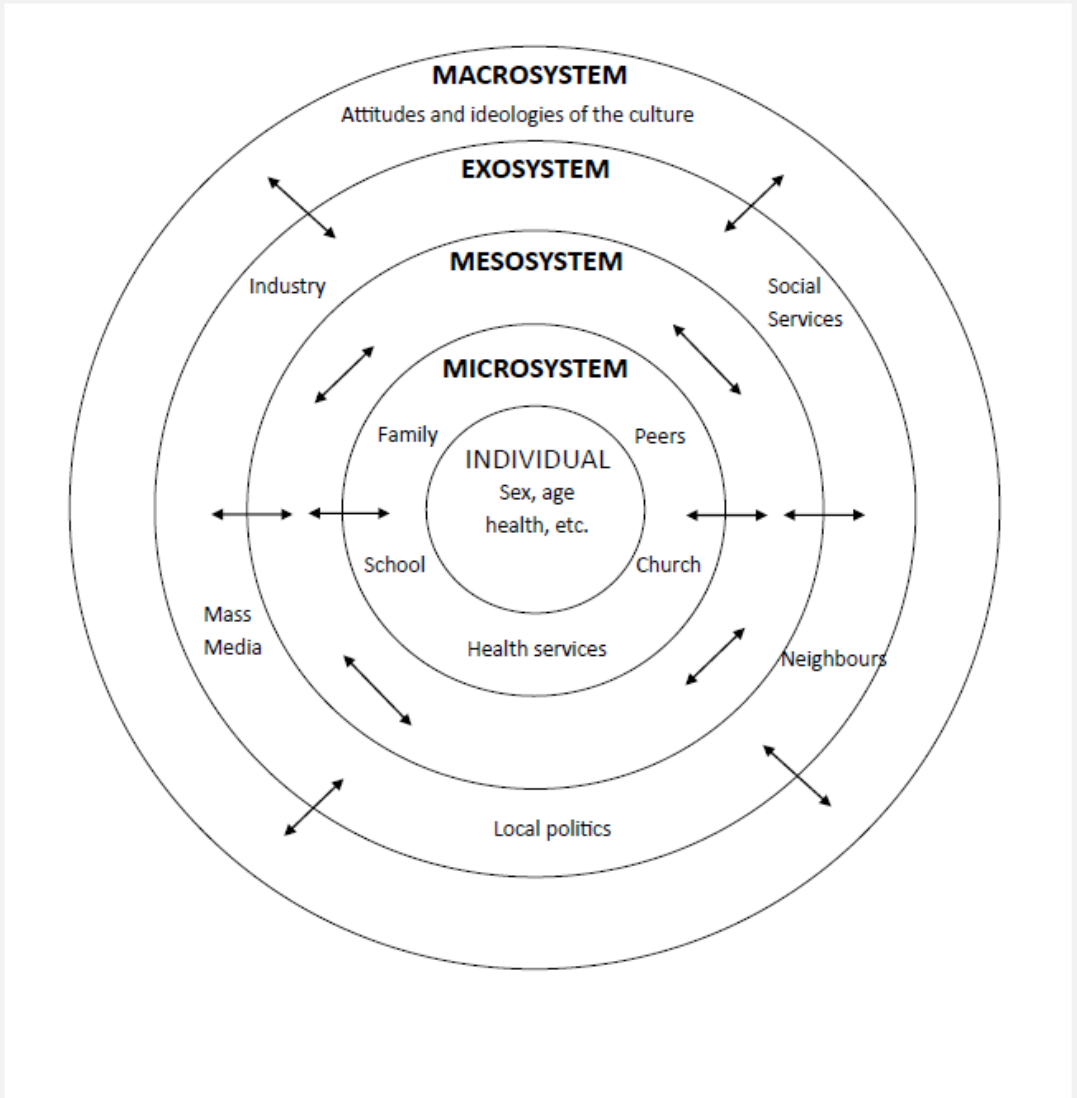
Whilst the research study had as its primary interest the pregnant woman's experience of a high-risk pregnancy, it is obvious from a systems perspective that this phenomenon cannot be studied or observed without considering the other systems that form part of this ecosystem.

An individual forms part of a number of larger systems, such as a marital system, a family system and other larger social systems, such as the medical service-provider system. At the same time, the individual is a system that is the environment of a number of smaller subsystems such as biological, emotional, cognitive and spiritual systems. According to this hierarchy of systems, each system, therefore, forms part of a larger system (suprasystem) whilst at the same time consisting of smaller systems (subsystems). I, therefore, accept that, whilst I may initially have conceptualised the primary interest of the study as women's experience of high-risk pregnancy, I cannot explore only one part of the system. Inevitably, I am exploring both larger and smaller systems in interaction with one another. This is necessary because, as Bronfenbrenner (1994) argues, in order to understand human development, one must consider the entire ecological system in which growth and change occurs. This ranges from the microsystem, which refers to the relationships between a person and her immediate environment, to the macrosystem, which includes institutions and culture such as the medical health system. Bronfenbrenner's model of ecosystems theory can be illustrated as below in Figure 1.

In Bronfenbrenner's ecological theory, the body forms part of the microsystem and consists of smaller systems of its own such as the circulatory system, respiratory system and nervous system. For example, in Felicity's case (Case Study 1), the biological microsystem is central in impacting on her experiences when she undergoes a Caesarean birth. The microsystem is the layer closest to the individual and contains the structures with which the individual has direct contact. It also encompasses the relationships and interactions that individuals have with their immediate surroundings, and structures in this level include family, work or neighbourhood (Berk, 2007). In the microsystem, individuals constantly interact with and influence other individuals and structures, and vice versa, especially in face-to-face settings

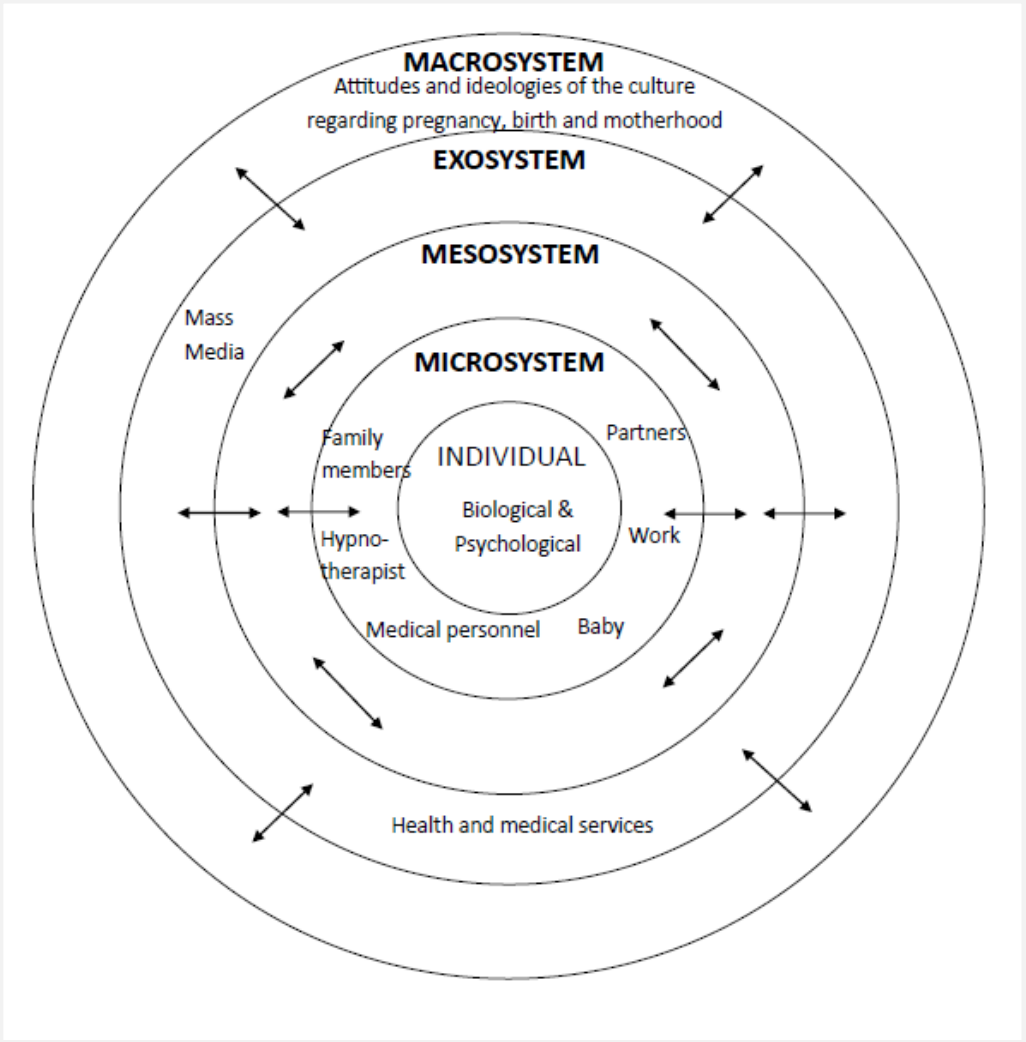
such as family, the peer group and work (Bronfenbrenner, 1994). In both case studies that formed part of this research, it became clear that relationships in the microsystem were critical as they form part of the experiences of the women who participated in the study. This includes relationships with partners, family members, the hypnotherapists and even medical personnel. Each of the persons in the microsystem of the women played a central part in shaping their experiences. At the same time, the experiences of the two women clearly impacted on the experiences of each of these people.

Figure 1: Bronfenbrenner's ecological systems model (Bronfenbrenner, 1994)



When Bronfenbrenner's model is adapted to depict the specific systems and subsystems of interest in this study, it can be illustrated as follows (Figure 2).

Figure 2: Bronfenbrenner's model adapted to illustrate systems of specific interest to the study (Bronfenbrenner, 1994)



According to Berk (2007), the mesosystem provides the connection between the structures of the individual's microsystem and exosystem. It comprises of the links and processes taking place between two or more settings containing the individual (Bronfenbrenner, 1994). Of specific interest in the mesosystem is how these links may conflict with or complement each

other (Forte, 2007). Connections between the home, work, and other social settings where the individual or family interacts are important, especially support systems.

The exosystem defines the larger social system in which the individual does not function directly. In this case, the exosystem would, in particular, include the medical service provider systems. The exosystem consists of the links and processes taking place between two or more settings, at least one of which does not contain the individual person, but in which events occur that influence the processes within the immediate setting in which the individual lives (Bronfenbrenner, 1994). For example, health and medical services exist within the exosystem and influence the immediate setting of the individual through the involvement of medical personnel who, during the pregnancy and birth, temporarily become part of the individual's microsystem.

The macrosystem is depicted as the outer layer of the system and is comprised of cultural values, customs and laws (Berk, 2007). Structures or influences in the macrosystem that are of particular interest to the researcher include the influence of societal expectations with regard to pregnancy and birthing. They may also include perceptions or beliefs held within the medical community about pregnancy, birth and hypnosis. For example, in Danelle's case (Case Study 2), the cultural significance of transition to motherhood played an important part in her experiences.

2.6.5 An ecological systems perspective and the research paradigm

With an understanding of the therapist as part of the system, rather than an outside objective force acting upon the system, the researcher has to accept that it is not possible to observe the system objectively. By using a systemic perspective as point of departure for understanding

people within their environment, it therefore became a logical choice to operate from an interpretivist paradigm. Terre Blanche, Kelly and Durrheim (2006) state that interpretive research is based on two key principles: First, it involves understanding in context and, second, the researcher is the primary instrument by which information is collected and analysed. Understanding a phenomenon within context requires that human interactions and experiences can only be ascertained in relation to the contexts within which they occur. According to Fouche and Schurink (2011), this is based on an assumption that reality should be interpreted through the meaning that the research participants give to their experiences. Furthermore, I (the researcher) as the primary instrument of data collection and analysis am required to consider and interpret my own presence appropriately within the research project, accepting subjectivity to be the very thing that makes it possible for me to understand personal and social situations empathically. For me, an interpretive paradigm fits hand in glove with a systems perspective.

From a systems perspective and interpretive paradigm, I adopt an ontological view of reality as internal and subjective (Terre Blanche & Durrheim, 2006). The nature of reality and the phenomenon being studied cannot be separated from the personal subjective experiences of the research participants, and it is their lived reality that is my interest. It follows, therefore, that my epistemology is empathetic and subjective as I can only understand the experiences of the research participants by engaging empathetically with them. The most appropriate methodology for the research, given an interpretive paradigm, was, therefore, a case-study approach, which made use of mainly qualitative methods, but also incorporated some quantitative methods in order to add to the understanding of the phenomenon.

2.7 Research findings

Several studies have been found to be relevant to the subject of risk in pregnancy, specifically relating to the experiences of the main participants of this study. Whilst these were reviewed in general in Section 2.3.5, they are also discussed further in Section 6.2 in order to understand better the experiences of the research participants in light of these findings.

CHAPTER 3

METHODOLOGY

3.1 Overview of the research questions

Main research question:

- What are women's experiences of HypnoBirthing® as psychological support offered during high-risk pregnancy?

Sub-questions:

- What are the expectations of women experiencing high-risk pregnancy about their pregnancy, birth and parenthood?
    - What are their fears and anxieties?
    - What are their hopes and wishes?
- What are the expectations of women experiencing high-risk pregnancy about what would be helpful to them in terms of psychological support and HypnoBirthing® during their pregnancy?
- What are the experiences of women with high-risk pregnancy of themselves throughout the pregnancy, in terms of their ability to cope with stress, anxiety and other fears?
- What are the experiences of women with high-risk pregnancy concerning HypnoBirthing® as a means of psychological support?

- What did the women experiencing high-risk pregnancy find particularly helpful during pregnancy, birth and postnatal?
- What did the women experiencing high-risk pregnancy find not helpful during pregnancy, birth and postnatal?
- How effective is HypnoBirthing® in cases of women experiencing high-risk pregnancy in treating the actual physical complications?
- How does the data inform the HynoBirthing® process and results?

3.2 Research design

The research design consisted of a clinical case study with a complex data set of mostly qualitative data, supported by quantitative data and information on medical conditions under consideration.

Case-study research can be done using various methods, including qualitative, quantitative or mixed-methods approaches (Denzin & Lincoln, 2005). Three types of case study are mentioned by Denzin & Lincoln (2005), namely intrinsic, instrumental and multiple case studies. Multiple case studies are appropriate when the researcher wants to investigative a phenomenon or condition – it is an instrumental study extended to several cases. These cases may be similar or dissimilar and are chosen because it is believed that understanding them will lead to better understanding and perhaps better theorising about a large collection of cases. This view is supported by May (2011) who states that, although theory development may not be the primary aim, generalisation remains possible. Descriptive singular cases may be a natural basis for generalisation given their epistemological resonance with the reader's

experience. There is a growing trend to find a middle ground between generalisation and particularisation in case studies, which is sometimes referred to as fuzzy generalisations or even moderatum generalisations (May, 2011). For the reasons above, a clinical case study approach seems especially appropriate to the study being undertaken, as this design fits with the problem identified and research questions formulated.

According to Swanborn (2010), case-study research applies an intensive (as opposed to extensive) approach by focusing on one specific instance (or a handful) of a phenomenon to be studied. Each instance is studied in its own specific context and in great detail, and data collection methods consisting of a mix of both qualitative and quantitative data, as in this case, are typically combined.

Denzin & Lincoln (2005) stated that qualitative clinical research is increasingly finding its way into primary health and medical care as patients and clinicians engage in research conversations, thereby generating new hybrids in the clinical-research space. Clinical research may aim at deepening and contextualising practical and ethical questions and seeking change within the clinical world itself (Denzin & Lincoln, 2005). Clinical researchers have various research styles available to them, including qualitative field research, which fits particularly well with the purpose of this study.

Schurink, Fouche and De Vos (2011) emphasise that research in a qualitative paradigm does not proceed in a linear fashion and that there is no one way to do interpretive, qualitative enquiry. In fact, the researcher is positioned as the primary instrument in the research process that seeks to gain understanding of a phenomenon in its own context (Terre Blanche, Kelly &

Durrheim, 2006). The research design was, therefore, chosen for its pragmatic value in seeking to gain a rich understanding of the experiences of the participants.

3.3 Sampling

Babbie and Mouton (2011) describe sampling as the process of selecting observations. Whilst probability sampling is typically used in quantitative studies, non-probability sampling was more appropriate in this study given the methods of data collection, such as interviewing. Strydom and Delport (2011) explain that, in order to collect the richest possible data, one often has to make use of an unstructured approach in the process of selecting participants. This unstructured approach does not always fit with probability sampling. For this reason, I made use of purposive non-probability sampling in selecting participants who could potentially provide information-rich accounts of their experiences; in other words, convenience sampling. Purposive sampling involves selecting cases in order to generate a wealth of detail from a few cases (Teddlie & Tashakkori, 2009). This is also known as case sampling.

The selection of the cases also relied on my expert judgement. It was I who had to decide whether each identified potential participant could provide the depth of information sought through the study. According to Rule and John (2011), case-study research may consist of singular or multiple case studies. Whilst single cases can be studied in greater depth, the findings of single cases cannot be generalised to other cases, and there is no comparative dimension with the study. In this study, the two cases allow for both breadth and depth of focus of the two individuals' experiences, as well as for a comparative analysis between their experiences. Whilst the use of two cases only allows tentative generalisations that might be

tested in future studies, they contribute to a deeper understanding of the experiences of the participants.

Teddlie and Yu (2008) asserted that the sampling strategy should generate sufficient data to answer the research questions by achieving saturated information. Data saturation is considered the gold standard of qualitative research and is the point where sampling additional participants would not yield any new information, and information thus becomes redundant (Tashakkori & Teddlie, 2010). Data saturation can be a complex issue and is affected by the quality of the data collected insofar as its degree of complexity, sample heterogeneity, the researcher's resources and the number of individuals analysing and interpreting the data is concerned. Data saturation in the sense of adding additional cases did not apply to this study as the number of cases was selected for a specific purpose. Data saturation in collecting information from different sources for each case was important and guided the completeness of each case. Due to the nature of the research, namely a case study approach, each case was explored individually.

The quality of data collected is also highly dependent on how the researcher and the research study itself are viewed by participants and others in the research context (Teddlie & Tashakkori, 2009). Researchers are often considered outsiders who intrude into the lives of others, and they may need special permission to conduct research in a certain context or at least gain the cooperation of participants. For this reason, it may serve a researcher well to become acquainted with the gatekeepers in a community and ensure that they are well informed about the study and, furthermore, support the study. In this instance, I did not form an active part of the medical community, considered to be the primary gatekeepers in working with pregnancy and high-risk pregnancy. It was, therefore, critically important that

those individual gatekeepers were identified and approached for support, in order to refer their patients to participate in the study. This was done in such a way that not only the fears or concerns the gatekeepers might have had for the welfare of their patients were allayed, but I also convincingly demonstrated to them the benefits of participating in the study. Potential gatekeepers included medical practitioners, specialists and professional midwives, and due to the sample size required, I did not anticipate difficulty in reaching an adequate sample size. However, in reality, this proved the greatest challenge for the research. Even though most practitioners who were approached to refer clients for the study were quite willing to do so, very few referrals were forthcoming. At the same time, of the number of potential participants who were referred and agreed to an initial interview, only two were willing to participate in the study, correlating to the suggested number of cases for the study. The first participant was referred by a midwife and the second by a hypnotherapist, both of them HypnoBirthing® practitioners.

According to Babbie and Mouton (2011), setting criteria for inclusion in the study is important in order to narrow down the research, until faced with a smaller number of potential participants; from which point on, decisions are usually made on a pragmatic level. The criteria for inclusion in this study were women:

- Who were pregnant
- Whose pregnancy was considered high-risk by a medical practitioner or midwife
- Who were prepared to undergo hypnosis as a means of psychological support.

Teddlie and Tashakkori (2009) also refer to the expert judgement of the researcher in purposive sampling. It is possible that the researcher could be faced with more potential participants than needed or practically possible to study; although this did not prove to be the

case. How would the researcher know which cases would provide the richest information for the purpose of the study? How would the researcher use expert judgement? Whilst only two participants agreed to participate in the study, it was equally important that they fit the criteria for inclusion and that they were eager to participate.

The criteria for exclusion included any case in which the medical practitioner cautioned against the use of hypnosis, or cases where the participants had recently undergone – or were still undergoing – psychological treatment. This was in order to ensure that the participants' safety (physical and emotional) remained a high priority. The rationale for excluding participants who had recently undergone psychotherapy was that the research would explore sensitive issues around their experiences of a high-risk pregnancy, and I needed to avoid a situation where participants had to recount recent distressing experiences of such a nature that the experience caused them to seek therapy.

The sampling strategy must also be ethical (Teddie & Yu, 2008). Participants had to provide full informed consent prior to participation and were, therefore, made aware of any potential risks and benefits from participating in the study. Furthermore, any promised confidentially had to be maintained, and participants retained the right to withdraw from the study at any time. These ethical considerations are discussed in more detail in Section 3.6.

For the study, two cases were selected. Comparing two cases added understanding beyond what one case study would have yielded on its own. It was felt that additional cases (beyond two) would not significantly aid in an in-depth understanding of an exploratory study of pregnancy. Recruiting additional cases would have been challenging and would not necessarily have contributed to the scope of this study.

3.4 Data collection

In this study, I employed a case study approach that involved the collection mainly qualitative data, but also some quantitative data that allowed for triangulation of data when the quantitative and qualitative data were analysed (Teddlie & Tashakkori, 2009). The researcher conducted semi-structured, in-depth interviews with each of the research participants; the interviews were recorded to be transcribed later. The quantitative data collected by reviewing the medical records of the research participants were analysed qualitatively in support of the data collected from the in-depth interviews, since there was not sufficient quantitative data to allow for a quantitative comparison or analysis.

In-depth interviewing is a research strategy that basically involves the researcher interviewing and questioning each participant (Taddlie & Tashakkori, 2009). The interviews were semi-structured in that they followed a general interview guide that was open-ended enough to allow participants the opportunity to describe their experiences in their own words. Interviews were conducted with each participant after the birth of her baby and, therefore, after the HypnoBirthing® training was completed. This retrospective approach allowed for capturing of the complete experience through a time perspective. Pregnancy is a time-bound event that needs an approach that can capture experiences of all stages, without continuous intrusion in the experience. The data collection in this study was challenging because I initially struggled to identify suitable research participants and, for this reason, the data were collected retrospectively from the participants. The main data collection interviews with the two case participants were conducted in the presence of their hypnotherapist and midwife, who referred them and set up the interviews. While it can be argued that their presence could

have influenced the participants in some way, it was clear to the researcher that the content under discussion was very sensitive, and that they presence of the hypnotherapist and midwife provided Felicity and Danelle with comfort, allowing them to be very forthcoming about their experiences.

3.5 Data analysis

3.5.1 Coding

According to Harding (2013), codes are usually notes made in the margin of transcripts and can take many forms, from complex abbreviations to numbers or even simple phrases and words. Saldana (2013) states that, in qualitative research, a code is often simply a word or a short phrase that describes a piece of data that is of particular interest to the researcher. Further types of coding strategies include Neuman's distinction between open, axial and selective coding, and Richards' descriptive, topic and analytical coding. One of the most useful distinctions highlighted by Harding (2013) is that of Gibson and Brown who distinguish between a priori and empirical codes. A priori codes consist of categories already identified by the researcher whilst empirical codes are derived directly from the data. This distinction resonates well with me, since it fits with the study, which has already been described as inductive. This means that categories and themes emerged directly from the data. It is inevitable in this kind of study that some degree of a priori consciousness will exist and emanate from the research questions, but the coding was conducted in such a manner that categories and themes emerged directly from the data.

Coding also involves the process of categorising the data (Saldana, 2013). When codes are applied and reapplied to the data, the data is grouped en regrouped in order to elicit meaning.

Thus, the process of coding and categorising data is an analytical act in itself as it involves the search for patterns in data – and explanations for those patterns. The coding process remains a subjective and intuitive process, which results in the emergence of analytic reflections – also known as themes. Harding (2013) states that selecting strategies or techniques for coding is not an objective task and relies on the researcher's ability to identify the broad subject areas under which the data can be grouped.

The process of coding suggested by Harding (2013) was chosen as a general framework to guide the coding process of this study because it is a comprehensive process; it is also simple. Its simplicity was seen as a desirable characteristic by the researcher because data analysis is likely to be a messy process, and a system that provides easy reference and a way for organising data in a complex data set is useful. Harding (2013) suggests a four-step process for data coding:

1. Identifying initial categories based on reading the transcripts
2. Writing codes alongside the transcripts
3. Reviewing the list of codes, revising the categories and deciding which codes should appear in which category
4. Looking for themes and findings in each category.

Within the process identified by Harding (2013), which I used as a metaframe, specific techniques for coding, as explained by Saldana (2013), were used.

Saldana (2013) reminds us that coding itself is an interpretive act and part and parcel of the process of data analysis. It is not an exact science, and the researcher's background, academic discipline, ontological and epistemological orientations, and choice of methods and

techniques become intricately tied to the data and the meaning that emerges from the data. Even the choice of coding and the methods used – since coding itself is an interpretive act – influence and shape the meaning as it is formed.

3.5.2 Process of coding and data analysis

The process of coding that I used is a combination of that suggested by Harding (2013) and input from various other sources. Furthermore, my own intuition shaped the process, which can be summarised as follows:

- **Stage 1: Immersion in the data collected**
    - Conducting the in-depth interviews
    - Transcribing the interviews
    - Reading the transcripts
- **Stage 2: Coding and initial data analysis for Case Study 1: Felicity**
    - Coding for Felicity
    - Identification of initial codes and data reduction
    - Reviewing the codes and identifying categories
    - Identifying themes (from the codes, categories and transcripts)
    - Coding for Sr Melanie
    - Identification of initial codes and data reduction
    - Reviewing the codes and identifying categories
    - Identifying themes (from the codes, categories and transcripts)
    - Coding for Sr Monique
    - Identification of initial codes and data reduction
    - Reviewing the codes and identifying categories
    - Identifying themes (from the codes, categories and transcripts)

    - Data analysis for Case Study 1
- **Stage 3: Coding and initial data analysis for Case Study 2: Danelle**
    - Coding for Danelle
    - Identification of initial codes and data reduction
    - Reviewing the codes and identifying categories
    - Identifying themes (from the codes, categories and transcripts)
    - Coding for Ms Stabler
    - Identification of initial codes and data reduction
    - Reviewing the codes and identifying categories
    - Identifying themes (from the codes, categories and transcripts)
    - Coding for Dr Olivier
    - Identification of initial codes and data reduction
    - Reviewing the codes and identifying categories
    - Identifying themes (from the codes, categories and transcripts)
    - Data analysis for Case Study 2
- **Stage 4: Comparative data analysis of Case Study 1 and 2**
    - Analysis and discussion of the similarities between the case studies
    - Analysis and discussion of the differences between the case studies
    - Final discussion and relating the findings to the research questions

The above summary provides an overview of the process that was followed for data analysis, and the repetitive nature of the process of coding, categorising and identifying themes for each participant becomes very clear.

3.5.3 Immersion

According to Terre Blanche, Durrheim and Kelly (2006), immersion is the process by which the researcher familiarises her or himself with the data throughout the process of conducting the study. Through the process of gathering information, contact with the gatekeepers and interviews with the research participants, the researcher starts to develop ideas and theories about the phenomenon being studied. Then, during the process of data analysis the researcher becomes further immersed in the data by working through the field notes and interview transcripts.

3.5.4 Conducting and transcribing the in-depth interviews

Conducting the in-depth interviews allowed me the first opportunity to be exposed to the information collected. As each participant told their own story, in their own way, I already started to develop questions and ideas to be followed up. Some of the questions could be answered in the same interview, while it was being conducted, but others had to be followed up afterwards.

Transcribing the interviews provided me with another opportunity to become more familiar with the material. As Schurink et al. (2006) point out, the researcher should read through the interview transcripts many times over, even re-playing audio recordings. Whilst this allowed me the opportunity to check for mistakes and ensure that the audio recordings were accurately transcribed, it also allowed for ideas for possible coding and themes to emerge, and I started to make rough notes of these. The process of coding each interview required me to read repeatedly through each transcript in order to code the data. Rule and John (2011) state that many researchers prefer to do their own coding, despite the labour-intensive nature of this process, because it provides them with a further opportunity to be immersed in the

data. This was found to be very useful in this study, since the back-and-forth process of listening to the audio recordings while transcribing them verbatim allowed me to code and re-code the data repeatedly, ensuring an intimate familiarity with the data. At the same time my supervisor fulfilled the role of co-researcher by acting as a second coder and thus improving inter-coder reliability.

3.5.5 Member checking

Member checking involves the process of taking the transcripts and analysed texts back to the research participants to check with them whether the analysis and interpretation accurately represents their views (Babbie & Mouton, 2011). It also contributes to ethical practice within the research, because it provides an opportunity for the participants to correct or remove data which is inaccurate or with which they are uncomfortable (Rule & John, 2011). As such, it forms part of the data-analysis process, but it is also a strategy for strengthening the credibility of the research and the trustworthiness of the data.

In this study, I conducted member-checking interviews with research participants from both case studies, in the presence of their HypnoBirthing® practitioners. This provided each of them with the opportunity to comment on and add to my analysis, thereby strengthening the credibility of the data analysis. The reasons why the member-checking interviews were conducted in the presence of the HypnoBirthing® practitioners include the sensitivity of the subject matter and the fact that both the HypnoBirthing® practitioners acted as gatekeepers in identifying Felicity and Danelle for participation in the research. Given the existing trust relationship between the HypnoBirthing® practitioners and their clients, the member-checking interviews in the presence of HypnoBirthing® practitioners provided for a more comfortable setting. Furthermore, this particular way of conducting the member-checking

interviews allowed for additional interpretive insight from these participants. For example, during Felicity's member-checking interview, she not only had the opportunity to comment on the data collected from her experience, but she was also able to view the data collected from the other participants in her case study and then to discuss these with the HypnoBirthing® practitioner during the member-checking interview. The same process was followed for Danelle. I believe that this allowed for more cross-checking of the perspectives between the participants, something which would not have occurred had each of them been interviewed individually. The details of these interviews are discussed in the data-analysis section of the report.

3.6 Ensuring quality in the research

Onwuegbuzie and Leech (as cited in Clark & Creswell, 2008) suggest the use of the term *legitimation* as an inclusive term for discussing the overall criteria for assessment of quality in mixed-method research, instead of the traditional *validity* for quantitative research and *trustworthiness* for qualitative research. Whilst this section will focus on legitimation specifically, it may also be discussed in other sections of the study (for example, under *Sampling*) where legitimation may be relevant to that particular part of the research process. Trustworthiness of qualitative data, in particular, is described in the next section.

Clark and Creswell (2008) present a typology for types of mixed-methods legitimation, consisting of nine types. *Inside-outside legitimation* refers to the degree to which the researcher accurately presents and utilises the insider's (participant's) view as well as the observer's (researcher's) view. One strategy for gaining inside-outside legitimation, which

this study utilised, is member checking where participants assess the researcher's interpretations (already discussed in more detail in Section 3.4.5).

3.6.1 Trustworthiness

Whilst some texts focus on establishing quality through providing rigour in data collection and analysis, Rule and John (2011) take the view that quality is rather about on-going rigorous, professional and ethical practice. They prefer the concept of *trustworthiness* as an alternative to reliability and validity, and I also adopted their approach in this study. The traditional constructs for determining quality in research are internal and external validity, reliability and objectivity (Schurink et al., 2011). However, these are often rejected by qualitative researchers as inappropriate to establishing quality in qualitative research and, instead, the following concepts proposed by Lincoln and Guba (1985) are often used:

- Credibility/authenticity
- Transferability
- Dependability
- Confirmability.

Credibility entails demonstrating that the research was conducted in such a way that the subject of the study has been accurately identified and described, and it is the alternative to internal validity in quantitative research (Schurink et al., 2011). There are various strategies for increasing the credibility of a study, which include member checking. Member checking involves getting research participants to verify the accuracy of the analysis of the researcher. It contributes to ethical practice within the research because it provides space for the participants to correct or remove data which are inaccurate or with which they are uncomfortable (Rule & John, 2011). In order to ensure the credibility of the study, I

conducted follow-up member-checking interviews with the main participants in each case study and their hypnotherapist. During the interview, the participant was able to comment on and add to my analysis, thereby strengthening the credibility of the data analysis. The details of these interviews are discussed in the data-analysis section of the report.

A further strategy for strengthening the credibility of a study is to provide a thick description of the case study, in order to portray the fullness and essence of the case study (Rule & John, 2011).

Transferability, known in quantitative research as external validity, refers to the degree to which the findings of the research can be transferred from a specific situation to another (Schurink et al., 2011). A qualitative study's transferability to other settings may be problematic and is often pointed out as a weakness by traditionalists. However, as the researcher is able to demonstrate that data collection and analysis were guided by concepts and models which defined the theoretical parameters of the study, it is possible for other researchers employing those same parameters to determine the degree of transferability to other settings.

Choices about methodology in qualitative case studies must also be guided by the principle of *fit for purpose* (Rule & John, 2011). Case-study research is not fit for the purpose of statistical generalisation – it is fit for the purpose of generating in-depth, holistic and situated understanding of a phenomenon. The purpose of case-study research is to gain understanding of the particularity of the singular case and, thereby, penetrate situations in ways that are not always susceptible to numerical analysis. Therefore, generalisability is not the purpose of case-study research, and other measures of quality must, therefore, be employed. Yin (2003)

also suggests that the goal of case-study research is to expand and generalise theories rather than to enumerate frequencies. Therefore, the mode of generalisation is analytical generalisation.

When collecting data for Felicity's case, I conducted interviews with the participant (Felicity), the midwife who attended to her in hospital, as well as her HypnoBirthing® practitioner. In addition, some hospital records were obtained to further elaborate on her experiences, and a final interview was conducted with the participant as a member checking strategy. For Danelle's case, interviews were conducted with Danelle, her HypnoBirthing® practitioner and the medical doctor who attended to her during the birth. A member checking interview was also conducted with Danelle, with her HypnoBirthing® practitioner present during the interview.

In each case study, the interviews with the HypnoBirthing® practitioners and the medical practitioners provided a different perspective on the experiences of the participants, adding alternative views to further expand the description of their experiences.

The degree to which the research process follows a logical format is well documented and can be audited determines the dependability of the research (Schurink et al., 2011). I ensured that an audit trail of the research process is available by keeping exact records and a case file of each case study, including copies of all correspondence, audio-recordings of interviews and notes made by the researcher. Furthermore, my supervisor acted as a second coder during the data analysis process, adding to the dependability of the research by confirming the results of the data analysis process.

Confirmability is the qualitative counterpart of objectivity in quantitative research and refers to whether the findings of the study could be confirmed by others (Schurink et al., 2011). This can be achieved when the researcher provides evidence that corroborates the findings and interpretations and is why the researcher integrates literature into the data analysis process.

3.6.2 The limitations of the study

According to Rule and John (2011), it is important to declare the limitations of a study so that the reader can engage with the study, fully aware of its limits, thereby increasing the dependability and confirmability of the study. The limitations of the study can stem from many sources, including:

- The methodology
- Data-collection methods
- Sampling
- Practical and logistical circumstances
- The researcher's personal attributes.

Rule and John (2011) propose that, in dealing with these potential limitations, researchers answer the following four questions about the limitations of the research, and these are discussed below:

- What are the limitations?
- What is their likely impact?
- What measures were taken to minimise their impact?
- What would the research recommend to other researchers to deal with such limitations?

One of the basic limitations of the research study conducted is inherent in the approach chosen, namely the case study approach. The research results cannot be generalised to the entire population of cases. Generalisation is not the purpose of this study, however. Rather, it aims to provide a rich description of the experiences of the research participants, which may yield information valuable for a practice setting. I was also compelled, through the circumstances under which participants were identified, to shift from a parallel mixed-methods design to a mostly qualitative design, which included some descriptive medical quantitative data. This is, however, not necessarily a limitation because, whilst it excluded the strength of a mixed design, it allowed for a more rich description of data through the inclusion of the perspectives of other practitioners in each of the cases.

The data-collection method used was primarily semi-structured, in-depth interviews. I limited the structure of the interview to the basic questions of the research and followed the direction provided by the participants. This allowed for as much non-directed collection of data as possible, whilst still ensuring that the data collected is relevant to the questions posed in the study. Two of the participants (the hypnotherapists) were not available for a personal interview, and I had to rely on electronic mail as a medium to conduct the interviews. The participants were posed certain questions and asked to respond by electronic mail. Whilst this still allowed the collection of valuable information, a limitation is the loss of dialogue in the exchange. The researcher was also unable to pick up on non-verbal cues and follow these up through probing, as was possible in the personal interviews. A further limitation is the inability of the researcher to probe and follow up on ideas presented in the conversation. This limitation did however not prevent the collection of the data and does not invalidate the data that was collected, but it might have diluted some of the richness of it. During the

member checking interviews both these participants were present, which provided a second opportunity for adding further information or clarifying any issues.

Sampling of participants posed a definite limitation to the research and caused several practical and logistical challenges. Whilst this was discussed in more detail in the *Sampling* section of the research report, it is worth mentioning here that I experienced significant difficulties in obtaining participants for research, more so than was anticipated. Whilst several participants were initially identified, most of them declined further participation, the reasons for which are discussed under *Sampling*. The result was that I had to deviate from the initial plan of identifying participants and conducting the interventions myself whilst collecting the data. Instead, the research participants who were willing to participate had already undergone the intervention (HypnoBirthing® training). The result was both a limitation and strength of the research. The limitation was that I was unable to set up quantitative measurements for the intervention, such as measuring blood pressure throughout the intervention. Therefore, I had to revert from the original plan of a mixed-methods design to a more qualitative design and develop significantly more in-depth case studies. The unanticipated strength was that, because the interventions were conducted by different practitioners and people other than myself, it provided for triangulation of data and eliminated the subjective perspective of the researcher in both the cases studied. Instead, I could collect data from different practitioners for each of the cases, providing for a richer description and more in-depth study of each case.

3.7 Ethical considerations

Ethics are defined by Reber, Allen & Reber (2009) as the branch of philosophy concerned with what is acceptable in human behaviour, what is good or bad, right or wrong. Until recently, professional ethics have largely been ignored in the social sciences, but caring professions have increasingly realised that the recognition and handling of ethical issues are imperative if successful practice and research are the goal (De Vos, Strydom, Fouche & Delport, 2011). Whilst researchers may not always agree precisely on what is right, wrong or acceptable in research, the stage is set for discussion, and guidelines are continuously being developed and improved.

There are a number of ethical principles which formed the basis of the decisions I made throughout the study. These principles are:

- Voluntary participation and the right to withdraw at any stage of the research
- No harm to the research participants
- Obtaining informed consent, including an understanding of the risks and benefits of participation
- Ensuring confidentiality, privacy and anonymity where relevant and practically possible.

These principles are further elaborated in the section below.

Participation in the study was voluntary, and research participants were not be pressurised in any way to participate in the study. Since research is often an intrusion into the lives of participants, disrupting their routines and signalling the start of an interaction they did not

request, I approached the participants with sensitivity for their privacy. For this reason, the HypnoBirthing® practitioners first approached their clients in order to suggest their participation in the study, and only after they provided permission where initial contact made between the researcher and the participants. Babbie and Mouton (2011) state it is important that participation must be voluntary and participants should not, in any way, be pressurised to participate. Whilst it may seem inconceivable to imagine that participants could be forced to participate in research in a time when people are so aware of their rights, one must keep in mind that this may refer not only to physical force, but also to psychological or social factors which may exert psychological pressure on someone to participate. There is a significant power discrepancy between researcher and participant, which influences the relationship. Even though I may have been sensitive to these potential issues and ensured that all participation was voluntary, I may not have been able to fully address all aspects of this ethical imperative. It becomes even more important then, according to Babbie and Mouton (2011) that the principle of "no harm" is adhered to. Participants, therefore, had the right to withdraw from the study at any time if they felt uncomfortable for any reason.

Hypnosis also presents some unique considerations with regards to the influence, and possible deception, of the researcher or hypnotherapist. According to Yapko (2003), the hypnotist's influence is inevitable simply by being there. The presence of a hypnotist inevitably alters the participant's behaviour and expectations of the process, and it is not a matter of whether the researcher influences the participant, but merely *how* the researcher influences the participant. HypnoBirthing® – and in fact any therapy – is essentially a process of influence. Although I did not conduct the intervention myself, it remains important to understand the nature of hypnosis and special ethical considerations involved. Whilst I realised that, by interviewing the participants, I was becoming part of their experience, I also

wanted to avoid influencing their experience as much as possible. Normally in therapeutic hypnosis, a practitioner will work hard to create with clients a positive sense of expectancy of the change that is about to happen (Hammond, 1990). These are essentially suggestions, one of the primary tools of the hypnosis practitioner. Care should be taken that the phrasing of suggestions and positive expectations of the practitioner do not translate into expectations which the participants hold literally, which if not realised could result in the participant feeling deceived. This challenge was alleviated by the fact that the HypnoBirthing® practitioners did not collect data or act as the researcher.

The duty to protect participants from harm goes beyond just avoiding harm, or even attempting to repair damages afterwards (De Vos et al., 2011). The researcher is responsible for identifying potentially vulnerable participants to eliminate them from the study if needed. I allowed participants to decide whether to continue with the study or withdraw, having been informed of the risks of participation and possible unintended consequences. It is in the nature of many psychotherapeutic processes that participants may suffer some discomfort at some stage of the therapy in order to better their circumstances (Strydom, 2011). It is difficult to determine exactly how much discomfort is acceptable before harm is done. However, any risk to the physical health of the mother or the pregnancy is an unacceptable risk, and participants should, therefore, not be subjected to any discomfort that in any way exceeds what any person might normally experience during the course of a pregnancy. The risks associated with hypnosis did not feature in the ethics of the research study per se. However, participants were made aware that participating in the in-depth interviews and sharing information on their HypnoBirthing® process and birth experiences could result in psychological discomfort when recalling any unpleasant memories or events. While the conduct of the hypnotist or research is a critical consideration in ensuring that no harm befalls

a participant, it can be notes that hypnosis as such is generally considered to be free of adverse effects (Cyna, 2004).

It must be added, in light of the discussion above, that the expected response of the participants to HypnoBirthing® is one of relaxation and comfort. However, it is also the nature of hypnosis that, sometimes, repressed psychological content may emerge unexpectedly as an *unanticipated consequence* of hypnosis. This may then require therapeutic intervention. Such experience may be psychologically distressing to the participant, and this is a risk that participants were carefully informed of beforehand. According to Yapko (2003), one of the most common hazards in doing hypnosis is spontaneous regression and abreaction. When doing hypnosis, clients interpret what the therapist says from their own frame of reference and can associate meanings to the practitioner's words that the practitioner never intended. These associations that may be formed are often idiosyncratic and can, therefore, not be predicted. Memories may simply arise spontaneously during an imagery exercise, and they may be pleasant or unpleasant and be accompanied with some emotional intensity. When these feelings are painful, involving hurt, grief, fear, rage or any other intense negative emotion, this has to be carefully and skilfully managed in the hypnosis session. Abreactions can manifest in a variety of ways, including hyperventilation, trembling of the body, premature disengagement from hypnosis, hallucinations, delusions and even autistic-like rocking motions. Although I did not conduct the HypnoBirthing® sessions, it is still considered relevant to the study that the researcher understands and takes note of such special circumstances.

According to Babbie & Mouton (2011), one of the most important ways to protect the interests of the research participants is the protection of their identity. Two techniques are

often used to protect the identity of participants, namely anonymity and confidentiality. Anonymity refers to a situation where data is collected in such a manner that the researcher cannot identify a particular participant; this is particularly used in survey research. Since I personally conducted face-to-face sessions with each participant, their details were not anonymous, but were kept confidential. In confidential research, the researcher can identify the responses of a given participant, but agrees not to do so publically. One way to ensure that participants remain confidential is to remove all identifying information as soon as it is no longer needed and, for this reason, pseudonyms are used throughout the study to refer to the participants when their responses are discussed.

Since the research explores the experiences of the participants in response to the HypnoBirthing® approach, a psychological intervention, the research should not only comply with ethical requirements generally expected in research, but also with ethical considerations of psychological practice. Corey (2009) makes the distinction between mandatory and positive ethics, where mandatory ethics refer to the minimum level of professional practice required; in other words, complying only with the technical requirements of a standard. Positive and aspiration ethics, by contrast, is an approach where a practitioner strives to do what is best for the client, rather than simply meeting minimum standards to stay out of trouble. Corey (2009) further states that establishing confidentiality is a central component to the development of trust and a productive client-therapist relationship. It is also important that the practitioner define the degree to which confidentiality can be promised, since it is not an absolute protection, and there are always circumstances that may warrant the practitioner breaching the confidentiality contract. Although I did not conduct the HypnoBirthing® sessions, it seemed appropriate to apply the principles of positive ethics and the best interest of the participants. An agreement of confidentiality that defined the scope and limitations of

confidentiality was, therefore, offered to each participant and formed part of the informed-consent agreement.

According to Strydom (2011), respect for persons requires that participants be given the opportunity to choose what will or will not happen to them. This implies that participants receive adequate information about the goal of the investigation, the expected duration of their involvement, the procedures that will be followed during the research, possible advantages and disadvantages, and the credibility of the researcher, to name a few. Written consent forms were used to ensure that the consent was properly recorded, that each participant received the same information, and that critical components were not overlooked. All participants gave written informed consent (see Appendix C for an example of the consent form).

In some research studies, it may be difficult to determine exactly how much information must be provided to research participants in order to be considered adequate. It may also be difficult to disclose everything to the research participants because it may cause them to act unnaturally, which may invalidate the findings of the research. This may cause a conflict between the researcher's task and the responsibility to protect the interests of the participants. In this study, however, no information was withheld from the research participants. In fact, I operated on the principle that the more the research participants knew, the better the trust relationship was likely to be and, therefore, the better the conditions for research participants to openly share their experiences.

I had to consider whether I am adequately and appropriately trained to research and understand hypnosis, and to deal with any problematic issues that may arise. Even though I

did not conduct the HypnoBirthing® sessions with the participants, I explored very sensitive and personal experiences that were dealt with through this hypnosis intervention. I hold a master's degree in clinical social work and have 18 years of working experience, most of this in therapeutic settings. As a mental-health professional, I am adequately trained to deal with most mental-health issues. Furthermore, I am a master practitioner of neuro-linguistic programming, an approach with a strong training component of Ericksonian hypnosis. I also completed elementary and intermediate training in Ericksonian hypnosis with the South African Society for Clinical Hypnosis. I, therefore, felt adequately trained and prepared to research hypnosis and to provide psychological support during the interviews should this be required.

CHAPTER 4

REPORTING THE RESULTS

CASE STUDY 1: FELICITY'S STORY: ENDOMETRIOSIS AND HIGH-RISK CAESAREAN BIRTH

4.1 Introduction to Felicity and relevance to the research

Felicity was identified as a potential candidate for the research by her midwife and HypnoBirthing® practitioner. When she agreed to participate in the research, it was two weeks after the birth of her baby. Felicity's pregnancy was considered a high-risk pregnancy due to her existing medical condition of endometriosis. The birth, in particular, was also considered high-risk due to the position of the foetus (transverse), which resulted in her having to give birth by caesarean section. During the caesarean birth, medical complications increased the risk of potential life-threatening complications for Felicity and her baby, due to excessive bleeding and an extended time of surgery.

Prior to the birth of her baby, Felicity attended a HypnoBirthing® course in anticipation of natural childbirth. She made use of the self-hypnosis skills taught during this course in preparation for birth as well as for the birth itself and the period after the birth. This made her

an ideal candidate for a case study, since her experience of a high-risk pregnancy coupled with hypnosis as support was a good match with my interests as a researcher.

The only caveat was that Felicity was identified as a candidate for the research after the birth of her baby. I, therefore, had to make use of information that was recorded during the birth without having had the opportunity to set up any quantitative measurement specifically for the purposes of measuring the effectiveness of the hypnotherapy. However, since the primary interest was the experiences of the participant, this did not disqualify her from being an excellent research candidate. A retrospective study allowed for an understanding of the temporal development of the case.

4.2 Intervention

Felicity attended antenatal classes with a registered midwife. This entailed eight sessions focusing on various areas of preparation for birth and early parenthood, including topics such as nutrition, preparing for birth, natural birth and caesarean section, caring for the new-born baby and breastfeeding. In addition to the antenatal classes, she attended the HypnoBirthing® programme, which involved five sessions of training in the techniques of HypnoBirthing®. The programme was presented by Sr Monique, a midwife and registered HypnoBirthing® practitioner. The HypnoBirthing® programme emphasises a natural approach to birthing that precludes medical intervention unless it is necessary.

4.3 Interviews conducted

To investigate all the factors of her lived experience, the following interviews were conducted:

- Felicity and Sr Monique: the main data-collection interview
- Sr Monique: obtaining the perspective of the HypnoBirthing® Practitioner
- Sr Melanie: obtaining the perspective of the midwife who attended to Felicity during her stay in hospital and during the caesarean section
- Felicity and Sr Monique: member-checking interview.

Due to the fact that Sr Monique set up the interview between the researcher and Felicity, she was present at the time of the interview. Felicity requested that Sr Monique remain present during the interview due to the sensitive nature of the content being discussed, and the fact the Sr Monique was also her HypnoBirthing® practitioner.

4.4 Medically relevant information

Felicity has endometriosis, a condition that consists of the presence and growth of endometrial glands and stroma outside of the uterus (Perry, Cashion & Lowdermilk, 2007). Several theories exist about the aetiology of endometriosis, but a familial tendency is observed. Some of the signs and symptoms of endometriosis include:

- Pelvic pain
- Dysmenorrhea
- Dyspareunia

- Abnormal menstrual bleeding
- Infertility
- Diarrhoea or pain with defecation.

Treatment is based on the severity of the symptoms and may include medical and surgical treatment. Medical treatment may include management of pain and hormonal menopause to avoid bleeding. Surgical treatment may include a total abdominal hysterectomy and the removal of all endometrial tissue. Whilst the precise details of Felicity's condition remained private, she disclosed that she had previously undergone an operation as a result of this condition and was, therefore, very apprehensive about undergoing a caesarean section.

A caesarean birth is the birth of a foetus through a transabdominal incision of the uterus (Perry et al., 2007) and, therefore, entails a medical operation. One of the indications for a caesarean birth is foetal malpresentation, such as the transverse presentation in the case of Felicity. Some of the risks of a caesarean birth to the mother include:

- Aspiration
- Pulmonary embolism
- Wound infection
- Haemorrhage
- Anaesthetic-related complications
- Longer recovery period.

In Felicity's case, she experienced significant blood loss, and her baby was premature, one of the foetal risks (Sr Monique, Table 13).

On the day she gave birth, Felicity experienced spontaneous rupture of membranes in the early evening and started preparations to go to hospital. She arrived at hospital around midnight, and observations by the medical staff and hospital records indicated the following vital statistics at 00h05:

- Blood pressure: 128/87
- Pulse rate: 77
- Temperature: 36°c
- Haemoglobin: 13.5

At this time, she experienced four contractions in 10 minutes, each 55 seconds in duration. These were sufficient in duration and intensity for medical staff to expect her to give birth at any time. Sr Melanie stated:

> And then I said to her: "I though we're gonna wait for the morning, but there's no way we're gonna wait for the morning. This child's gonna come, and this child's gonna come now."

Her labour progression was very fast and, therefore, the medical staff expected her to give birth fast. She progressed from five centimetres to six centimetres dilation within 20 minutes. Her cervix was 0.5 centimetres thick at five centimetres dilation, which is an indication of the later stages of labour. The baby was lying transverse left and could, therefore, not be born naturally.

> So I palpate, and I felt, and it felt like the baby was lying transverse, which is across, which means she wasn't gonna have a normal birth (Sr Melanie)

At 00h25, she was moved to theatre for a caesarean section, and her baby was born at 01h00. During the caesarean birth, she experienced blood loss of 1.2 litres, which is considered significant. A corrugated drain and colostomy bag was used to drain blood during the

caesarean section. This is not considered a standard procedure and was necessary due to the high level of blood loss. The blood loss was attributed to the uterus scarring, which was a result of endometriosis, and the endometriosis probably also caused the transverse foetal position (Sr Monique, personal communication, 2 September 2013).

A measurement during the caesarean section indicated:

- Blood pressure: 128/88
- Pulse rate: 88
- Respiration: 22
- SATS (oxygen saturation): 98.

The caesarean section was completed at 02h05, which is considered significantly longer than a typical caesarean section without complications. Towards the end of the caesarean section, a space blanket and bear hugger was also used because Felicity's temperature dropped due to the high level of blood loss, and she was going into shock.

Felicity's HypnoBirthing® practitioner, also a registered nurse and midwife, commented that it is significant that her blood pressure never dropped during the caesarean section because the level of blood loss should have caused her blood pressure to drop and her pulse rate to rise significantly (Sr Monique, personal communication, 2 September 2013). She referred to the HypnoBirthing® training that Felicity underwent, and how it may have played a role in this instance:

> It enable the mom to control her pulse and adrenaline, in other words to avoid the fight and flight response. This is of significance for her and the baby in a high risk situation and can make the difference between a life or death result for foetus and mother. Decreasing the pulse to a normal rate

> also contributes to both mother and baby not losing blood as quickly during a bleeding incident. (Sr Monique, personal communication, 2 September 2013)

Felicity was returned to the postnatal ward at 02h45 and, at this time, the following measurements were taken:

- Blood pressure: 130/80
- Haemoglobin: 10.7
- Temperature: 36.3.

While in the postnatal ward, the colostomy bag was emptied twice with a first measurement of 200ml of blood and a second measurement of 600ml of blood; in total 800ml of blood was drained.

The caesarean section was a complicated operation, and the amount of blood lost represented a significant risk to Felicity. Sr Monique commented on this:

> She had lost nearly 2 litres of blood [*during the caesarean birth*] and had a premature baby. She persevered and expressed the milk [*with a breast pump*] for a month before she gave up. She did not produce a lot [*of milk*] due to the blood loss. She remained very calm through all this. I think most women may have gotten depressed. When baby got to 6 weeks, her husband had to leave the country again. She had finally gotten to the point of realizing just how serious her experience had been; how much blood she lost and how the doctors had fought to save her life.

Perry (2007) states that medication for pain relief after the operation forms part of postoperative care and recovery, as the woman's physiological concerns for the first few days may be dominated by pain at the incision site. The pain medication that Felicity took was Pethidine (at 04h30), Prefalgan (at 07h30) and Panamor (at 13h00). All of this was given on the same day that the caesarean section was performed. She was also offered medication at

08h30, 10h00 and 14h00 – all of which she declined. On the following day, she took two MyPaid tablets (schedule 2 and not a strong analgesic) for pain relief at 12h00, and then again at 00h00 the following morning. Sr Melanie considers this very limited use of pharmacological pain relief unusual and commented:

> She had the minimum of anything, she was absolutely happy.

The drain was removed the day after the caesarean section, and the blood loss at that time was minimal and, therefore, not measurable.

4.5 Data analysis

The first stage of the data analysis involved extensive and repeated coding of each interview to reduce the information to workable data. Coding of the data for the case studies is captured in the appendices and was removed from the main text to ease reading of the results (See Appendix A for the coded interview transcripts: Tables 9, 11 and 13). The data were then further analysed by grouping the codes (Tables 1, 2 and 3) into more usable categories. This allowed me to deconstruct the data from the original transcript based on the coding and then reconstruct it based on the categories.

Table 1: Felicity: Codes revised to categories

List of codes	**Codes revised into categories**

• Use of medication
• Calm
• Risk
	• Coping
	  ○ Support from partner
	  ○ Attitude of medical staff

• Coping without partner • Caesar/fear • Psychological coping • HypnoBirthing® uses • Preparation • Attitude of medical staff • Time distortion • Stress • Managing baby • Other	○ Positive emotional impact of HB ○ Dealing with negative emotions ○ Preparation ○ Experience of pain • Risk • Managing baby • HypnoBirthing®

Table 2: Sr Melanie: Codes revised into categories

List of codes	**Codes revised into categories**
• Pain • Calm • Panic • In control • Risk • Labouring • Coping • Recovery	• Coping ○ Calm and relaxed ○ Psychological coping ○ Experience of pain ○ Use of medication ○ In control ○ Recovery ○ Family unit

• Breastfeeding
• Baby
• HypnoBirthing®
• Caesarean section
• Emergency
• Medication
• Family unit
	• Risk
	  ○ Caesarean section
	  ○ Emergency
	• Managing baby
	  ○ Breastfeeding
	• HypnoBirthing®
	  ○ Labouring

Table 3: Sr Monique: Codes revised to categories

List of codes	**Codes revised into categories**

• HypnoBirthing® uses
• Hopes and expectations
• Stresses and fears
• Helpful uses
• Psychological support
• Calm
• Birth
• Risk
• Preparation
• Medication use
• Pain
	• Coping
	  ○ Psychological coping
	  ○ Hopes and expectations
	  ○ Stresses and fears
	  ○ Calm and relaxed
	  ○ Experience of pain
	  ○ Birth experience
	  ○ Use of medication
	  ○ Preparation
	• Risk
	• HypnoBirthing® helpful uses

Even at this early stage of data analysis, when the codes were revised into categories, obvious similarities started to become apparent between the various codes and categories of the different participants. Once the codes were revised into categories, the text (transcript) was reconstructed in a table according to the categories (see Appendix A: Tables 10, 12 and 14), so that the parts of the text that referred to the same issues were now grouped together. From this reconstructed text, themes, which formed the basis for the discussion of the case, could start to emerge.

A note of clarity regarding the process and presentation: the researcher initially planned a separate discussion of themes and analysis for each participant, but then decided that combining this discussion for the three participants of each case study would aid integration of the material better. This decision was made because, during the discussion of the themes and analysis of the primary participant, there were several instances when the researcher wanted to refer to the data collected from the other two supporting participants. Discussing each of these separately would have provided a disconnected sense of the material, and so it was decided to combine the discussion of themes and analysis for all the participants in each case study. Due to the length of the tables, they are represented in Appendix A, but for the sake of demonstrating the relevance and interrelatedness of the themes that emerged from the different interviews, they are represented below in Table 4, from which the discussion follows.

Table 4: Comparison of themes

Felicity	**Sr Melanie**	**Sr Monique**
HypnoBirthing® techniques enabled her to cope emotionally in the absence of a critical social support system. The ability to remain physically calm and relaxed enabled her to have a positive mental mind set.	Felicity displayed remarkable calmness and relaxation, and this ability also allowed her to cope psychologically during the emergency situation. The ability to remain calm and relaxed was beneficial to the health of the baby during the delivery. The position of the baby presented a rare complication for birth, which necessitated an emergency caesarean section. At the same time, the mother had a medical condition which increased risk during a medical operation. The risks were,	The ability to be calm is beneficial to the mother during pregnancy and birth.

Felicity	Sr Melanie	Sr Monique
	therefore, significant. Felicity's physical relaxation and calmness prevented the use of medication to calm her down during the emergency. If she had not been calm and relaxed, this could have complicated the delivery, necessitated the use of medication, and also impacted negatively on the baby's health. The ability to remain calm and relaxed, therefore, greatly reduced risk during the emergency.	
Sensitivity to Felicity's vulnerability and an empathic response was experienced as supportive and important to her ability to cope in the absence of her partner.	A birth experience that is too overwhelming may result in psychological trauma, which could manifest as postnatal depression. Felicity's ability to cope with the situation	Felicity wanted and prepared for a natural, uncomplicated birth.

Felicity	**Sr Melanie**	**Sr Monique**
The ability of the medical staff to communicate calmly and display empathy in the midst of a busy hospital environment is important to Felicity's ability to remain calm and relaxed and cope with the emotional distress of not having her partner present.	exceptionally well reduced the chances that she would suffer psychological trauma, and no indication was observed that the experience was traumatic for her.	
The use of HypnoBirthing® techniques resulted in physical relaxation and mental calmness. Felicity experienced complete physical relaxation and mental calmness. The relaxation and calmness enabled Felicity to easily	Felicity's ability to eliminate pain through the use of HypnoBirthing® techniques was surprising and exceptional to the medical staff, to the point creating some fear for them that something could be wrong. Felicity's degree of relaxation, calmness and	

Felicity	Sr Melanie	Sr Monique
accept that she would not give birth naturally and would undergo a caesarean section [which was particularly risky for her given her medical history]. The use of HypnoBirthing® techniques created, for the participant, an awareness of positive and negative thoughts, enabling her to take control, experience herself as in control, and subsequently make positive choices. The use of HypnoBirthing® techniques created a sense of time distortion. Focusing on the HypnoBirthing® techniques	absence of pain was exceptional and not representative of a typical case of labour. The medical staff was completely surprised by her ability to eliminate pain, and they even offered her pain medication, which she mostly declined.	

Felicity	**Sr Melanie**	**Sr Monique**
allowed Felicity not to be distracted by the medical environment and equipment.		
HypnoBirthing® enabled Felicity to accept easily having to undergo a risky medical procedure of which she was previously fearful.	Often medical staff has to administer medication to patients in order to reduce pain to allow them to cope with labour and birth. Felicity, however, experienced hardly any pain, and declined most medication offered, only accepting some medication after the caesarean section, but still less than what was offered to her.	The use of HypnoBirthing® techniques enabled Felicity to remain calm and relaxed, even when facing the risks of a complicated delivery. HypnoBirthing® enabled Felicity to use only minimal medication for dealing with discomfort. HypnoBirthing® enabled Felicity to bond with her baby after a traumatic birth.
The regular practice of HypnoBirthing® techniques in preparation for the birth experience was a significant factor in the degree of	Feeling in control reduces panic and stress and allows for an overall better experience.	The ability to remain calm and relaxed reduced or eliminated pain, allowing her to accept minimal medication.

Felicity	**Sr Melanie**	**Sr Monique**
success experienced by Felicity.		
The idea of not using medication appealed to the participant and was a motivating factor in her decision to use HypnoBirthing®. The use of HypnoBirthing® for Felicity resulted in virtually eliminating pain and discomfort usually experienced during birth or a medical operation. Instrumental to this was the ability to dissociate from her surroundings and keep her attention focused through visualisation and relaxation exercises.	Felicity declined most medication offered to her, accepting only the minimum amount needed after the caesarean section. Her recovery was remarkably quick, faster than most patients undergoing a caesarean section.	HypnoBirthing® clients general give birth more quickly.
The use of the	Felicity's ability to remain	The use of medication was

Felicity	**Sr Melanie**	**Sr Monique**
HypnoBirthing® techniques was successful for Felicity, even though she went into labour unexpectedly and medical complications caused her to undergo a caesarean section, which posed additional risks to her. HypnoBirthing® is effective even when labour is unexpected, and Felicity had little time to "get into the mind-set" – HypnoBirthing® was immediately available to her.	calm and relaxed also allowed the rest of the family to remain calm.	greatly reduced.
The techniques helped Felicity with the physical exertion immediately after undergoing a caesarean section and allowed her to care for her baby.	The risk to the patient was significant. The operation was described by medical staff as more complicated (and, therefore, risky) than usual, and the patient had a	Preparation and practice is critical to ensure effective use of HypnoBirthing® techniques.

Felicity	Sr Melanie	Sr Monique
	medical condition which further complicated matters. If Felicity was not so calm and relaxed, it could have made it difficult for the doctor to deliver the baby. Her ability to remain calm and relaxed, therefore, aided in the delivery of the baby through a caesarean section.	
Felicity generalised the techniques learnt for labour and birth to apply them when dealing with a phobia and for relaxation at the office to relieve stress and cope with anger. Felicity would not have chosen to use HypnoBirthing® if she did	Whilst HypnoBirthing® would have greatly aided in a natural delivery, it also helped significantly in this case with the caesarean section.	The effective use of HypnoBirthing® techniques can save the life of the mother and baby during a complicated delivery. HypnoBirthing® allows the mother to remain calm and relaxed even when facing an emergency.

Felicity	**Sr Melanie**	**Sr Monique**
not anticipate having a natural birth – her initial perception was that it was only useful for natural birth.		
	Felicity remained calm and relaxed even though it was an emergency.	HypnoBirthing® enables the participant to cope more effectively with unexpected crisis situations. Felicity effectively used HypnoBirthing® to remain calm and relaxed and increase bonding with her baby. Apart from improved psychological coping, HypnoBirthing® provides control over physiological functions such as the fight-flight response, heart rate and blood pressure; all of which

Felicity	Sr Melanie	Sr Monique
		are factors that influence the outcome of an emergency delivery.
	Felicity's ability to remain calm and relaxed had both physical and psychological benefits for the baby.	
	Felicity's ability to remain calm and relaxed allowed her to breastfeed well.	
	The medical staff would prefer that more women do HypnoBirthing® because of the benefits of reduced blood pressure, relaxation, helping with labour progress and fewer epidurals and less medication.	

4.6 Discussion

Felicity was initially attracted to the use of HypnoBirthing® because she wanted to give birth naturally and because she wanted to avoid medical interventions which might pose additional risk to her and her baby.

> And I quite liked the idea that one won't use any medication if one should then have a natural birth, and one would use techniques – breathing techniques, visualise, that type of thing. Just to calm yourself and to relax, and so that you don't necessarily have to use medication for the baby that is coming. (Felicity)

Felicity's husband was out of town when she went into labour during the night, and she felt especially vulnerable emotionally, knowing that she would have to give birth without him present or being there to support her. Despite this, she experienced the use of HypnoBirthing® techniques as providing her with a sense of control and, therefore, the ability to make positive decisions, rather than being a passive recipient of a medical service or a victim of circumstances.

> If I had been stressed, I would have wanted my husband with me, and at that stage I couldn't because he was [*out of town*], and he was on his way home, but it takes about a day or two to get here. So I think I would have handled the situation very differently if I had not been so relaxed, definitely. (Felicity)

> It just makes it easier because you can use those techniques to choose the positive instead of the negative and to turn it around, just like that, into something which may not be the way you wanted it, but you make it better. That you [*aren't*] negative about something, that you can change your mind-set. You are in control of your life, basically. (Felicity)

This was an important aspect for her, and she confirmed this during the member-checking interview. The midwife also commented that Felicity seemed in control of herself and that a sense of control reduces panic and stress and allows for an overall better experience.

> She was calm, relaxed during the Caesar; totally, totally happy. You never saw, I never saw an inch of any indication that she was in labour, any indication that she was in pain. (Sr Melanie)

> Because she was just so well in control – you really and truly didn't expect that she was in labour. (Sr Melanie)

> But with HypnoBirth, she was so calm and she knew, "This is what I gotta do" and she wasn't an out of control patient. (Sr Melanie)

> Also, being so in control with the situation, not the panicking, not the stressing, that all helps the situation. (Sr Melanie)

Felicity also reported that the attitude of the medical staff who attended to her had a significant impact on her ability to cope in the absence of her partner. It appears that the medical ward was especially busy on the night when she was admitted to the hospital, but in the midst of all the activity, the medical personnel were able to respond to her empathically. The midwife who attended to Felicity was able to make the time to sit and talk with her and reassure her. The midwife was sensitive enough to make special arrangements for Felicity to keep her wedding ring on during the caesarean section – something that is normally not allowed. The empathy from the medical staff was experienced by the participant as a significant support factor.

> The nurse who helped me at the labour ward, I [*spoke*] to her…she was very, very friendly and she was just…I could see she was a little…they were very, very busy at the labour ward that night. But she moved quickly and everything and she was just so calm as she spoke to me. And one thing that I can also say about her is that, because my husband, it was as if she knew what I was feeling, because since

> I could not have my husband there, I really wanted to keep my wedding ring on, and…and [*crying softly*] she allowed me to wear it. So I asked, "May I keep my ring on in theatre?" And then she said – even before I could ask her – that we'd keep my ring on; we'd just cover it with masking tape. And um…yes, that also helped me. (Felicity)

> She just had such a calming effect on me. Even though I could see that she was busy. (Felicity)

> One of the sisters also came and sat with me and chatted with me quite a bit. (Felicity)

By making use of the HypnoBirthing® techniques, Felicity was able to experience total physical relaxation and an accompanying sense of mental calmness and a positive attitude. It appears that the ability to remain physically relaxed is an important factor in order to remain mentally calm and to cope with the situation psychologically. This sentiment is echoed by both the midwife who attended to Felicity during her stay in hospital and the HypnoBirthing® practitioner who visited her while in hospital. It was also observed that the ability to remain calm and relaxed was observed not only with Felicity, but with her whole family.

> I was so relaxed – my husband wasn't even there, only my mom was with me. I was just so calm; there was just such a calmness over me, and I just did the visualisation all the time and [*noise*], especially the "slow breathing" where I visualise how I breathe in and break my breath up into parts…from one's head to one's shoulders…I used that a lot in that time. So my whole body was relaxed. I wasn't stressed at all. (Felicity)

> I thought the HypnoBirthing® would help me be relaxed, but I did not think I would be that relaxed. (Felicity)

> I used the relaxation techniques and especially the breathing again, in that situation. Just so I could be calm for the rest of the Saturday and the Sunday. (Felicity)

> The whole little family unit was so calm. (Sr Melanie)

This ability to remain completely physically relaxed also seems to have had a significant impact on Felicity's experience of pain – or the absence thereof. She repeatedly referred to the fact that she experienced no pain, except on two occasions. These were when one of the clips came loose and after the caesarean birth, as a result of the operation. This ability came as a surprise and shock to the medical staff, who commented that it was "scary to see the patient's talking to you so calmly, relaxed, and you don't even realise she's actually in labour" (Sr Melanie). This was certainly not a typical case as far as the medical personnel were concerned. It seems that a central element of the reduction or elimination of pain in Felicity's case was the ability to dissociate from her surroundings through visualisation and physical relaxation. She also made further mention of the fact that time seemed to be a "blur". The distortion of a sense of time is a common hypnotic phenomenon (Garver, 1990), which in this case also seems to have contributed to her ability to cope with a stressful situation. There can also be little doubt that the absence of pain contributed greatly to Felicity's ability to cope well with the situation, as fear of pain during birth is commonly one of the major factors that causes physical tension, which creates a cycle of pain and distress. She also reported that the use of HypnoBirthing® distracted her from the medical environment and equipment around her and allowed her to keep her focus on herself.

> I had no pain, so [*laughing*].... (Felicity)

> I was very calm, and I did the HypnoBirthing®, and I didn't even really think of pain. (Felicity)

> The only pain I had was when they put that thing on my tummy, with one of the contractions, the clip came loose...I really had no pain at all. (Felicity)

> Perhaps also during the contractions because the sister told me I was five centimetres dilated already, and I had no pain. (Felicity)

> I was very aware then that I was doing the visualisation – I was in another place, I wasn't really there. I certainly had no pain. (Felicity)

> I had NO pain. (Felicity)

> Yes, definitely no pain, no discomfort. (Felicity)

The midwife also commented on the absence of pain in Facility's case, making mention of the fact that this was an unusual case for her. In her opinion, the degree of relaxation that Felicity was able to attain was not only beneficial to her in terms of her level of comfort, but also aided in the actual caesarean birth.

> I asked whether she had any pain, and she said there was no pain, there was nothing wrong. And really, she didn't look like she had pain. (Sr Melanie)

> It's actually scary to see the patient talking to you so calmly, relaxed, and you don't even realise she's actually in labour. It's actually a bit freaky. (Sr Melanie)

> I never saw an inch of any indication that she was in labour, any indication that she was in pain, and then out comes the baby, and then everything's fantastic. And she just look so calm and relaxed (Sr Melanie)

> She walked into the ward; she said she wanted to go to the bathroom first. She was totally comfortable, calm and relaxed. (Sr Melanie)

> And then, and she handled it so well. The patient will still complain about the pushing and tugging and pulling, and then she never even complained about that, and then, the most calm, relaxed, happy, patient that there was. (Sr Melanie)

> Because she was calm, the muscles were fine, everything was relaxed, and the doctor could successfully turn the baby. (Sr Melanie)

> And with her being so relaxed, we didn't have to give Dormicum. So the baby, we could turn it easily and deliver the baby easily. (Sr Melanie)

Felicity's HypnoBirthing® practitioner also referred to her ability to remain relaxed, pointing out that her ability to produce a hypnotic analgesic phenomenon allowed her to reduce the amount of pain medication she took after the caesarean section.

> She was so confident and calm and very ready for birth. Going into labour, she experienced no pain whatsoever. (Sr Monique)

> She was calm, almost euphoric. She had used the deepening techniques. Even the night staff commented on how calm she was, that she never complained of pain, took very little analgesics and managed well. (Sr Monique)

The elimination of pain during the labour and delivery process allowed Felicity to take only minimal medication, in fact declining pain medication on occasions when it was offered. This also indicates that the medical staff found almost incredible her ability to reduce pain to the extent of not needing medication, and so they continued to offer it to her.

> Also the nursing staff, when I went afterwards, when I checked up on her, they said she hardly ever asked for pain relief. They kind of had to force her and say, "Look, you gotta have something". But she didn't seem to want pain relief or anything; she just handled everything beautifully. (Sr Melanie)

> It's a very stressful situation, and yet she didn't need it. (Sr Melanie)

Felicity knew that she might have to undergo a caesarean birth but was hoping to give birth naturally. Her endometriosis was an additional risk factor, and she had already previously had a bad experience during a medical operation, which she was hoping to avoid this time. Whilst one would expect the knowledge of undergoing a risky medical operation to contribute significantly to mental distress or discomfort, Felicity was able to keep a positive mind set through the use of HypnoBirthing® techniques. Whilst previously she was fearful of undergoing any medical operation, this fear was reduced to the point of being insignificant to her in the situation.

> I think I would probably have been quite stressed – as I said, it [*was*] my first baby, I didn't really know what to expect, especially with a caesar, because I had not wanted a caesar at all. (Felicity)

> My fear was that I would have a caesarean section because I really did not want another operation. Well, I did make peace with it. And the HypnoBirthing® definitely helped me with that. (Felicity)

The midwife considered the caesarean birth under these particular circumstances to be rare and high risk, and she commented that Felicity's calm attitude and relaxed response actually significantly reduced the risk to both herself and her baby during the caesarean birth. It allowed the medical doctor to perform the delivery without the complications that usually accompany a stressed and panicky mother.

> The baby was laying transverse, which is across, which means she wasn't gonna have a normal birth. (Sr Melanie)

> And then we got it out with a caesar because it was in a transverse position, you gotta deliver by a caesarean. (Sr Melanie)

Because the baby was lying in the transverse position, it's one of your more difficult caesarean sections. (Sr Melanie)

Really so much could have gone wrong. I mean, with lying in a transverse position, a transverse position we don't see often. With the baby lying in a transverse position, the cord could have slipped through, which means you could have had a cord presentation, which means we could have lost the baby – because the cord slides through. But with 'HypnoBirth', she was so calm and she knew, "This is what I gotta do" and she wasn't an out-of-control patient. And you could do an internal properly on her. (Sr Melanie)

...that it actually puts the body into spasm. (Sr Melanie)

That's another risk because if your mom stresses out and all your muscles contract, then it can actually tighten around the baby and then it's difficult for the doctor to turn it. (Sr Melanie)

Even to the extent that their blood glucose can go into a stress level, because it's a difficult delivery; the baby's blood glucose was fine. (Sr Melanie)

We don't like to give much Dormicum because it passes on to the baby; then your baby's also lazy. So we only use it if we really have to – that's with the really stressed-out patients (Sr Melanie)

The minute you're stressed at labour, you can forget about it. The cervix tightens up, and we actually end up giving the labouring patients medication to try and calm them, so we can get the labour going. Because it like gets to a halt. Because they're so stressed. (Sr Melanie)

The HypnoBirthing® practitioner also added that, although clients normally attend the HypnoBirthing® training with the intention of having a natural birth, Felicity was able to generalise the use of the HypnoBirthing® skills to her situation and make use of them just as effectively.

She was able to adjust what she was taught to keep her calm when she lost a great deal of blood during her c-section due to endometriosis scars. (Sr Monique)

This is of significance for her and the baby in a high-risk situation and can make the difference between a life or death result for foetus and mother. Decreasing the pulse to a normal rate also contributes to both mother and baby not losing blood as quickly during a bleeding incident. (Sr Monique)

She realised that the baby was in transverse lie. And when the doctor arrived and realised that she was dilating very quickly with a transverse lie (with risks of cord prolapse, etc. looming) she remained perfectly calm. (Sr Monique)

She remained very calm through all this. I think most women may have gotten depressed. (Sr Monique)

A birth experience with this particular set of risks and complications can be traumatic for the mother and baby, and according to the midwife, the medical staff will observe indications of such a traumatic experience. However, there were no such indicators after the caesarean section and, in fact, Felicity's physical recovery and psychological coping was exceptional.

She was disappointed that her husband couldn't be there for the birth. (Sr Melanie)

They usually get to that stage where, "This is too much for me, I can't cope; I need you to slow down or something." (Sr Melanie)

She just took everything as it came, and that was fine. (Sr Melanie)

She didn't show any indication of someone who's gonna struggle with. (Sr Melanie)

She was so calm and, even afterwards, she was just perfect. (Sr Melanie)

There was nothing that would give us an indication that she would need extra counselling. (Sr Melanie)

> She tries to calm herself if she gets upset, and you don't even realise that she's getting upset, or you don't even realise, anything…she's just this picture of calmness. (Sr Melanie)

> She had the minimum of anything, she was absolutely happy. (Sr Melanie)

The regular practice of HypnoBirthing® techniques seemed to be a critical factor in the degree of success experienced. Felicity diligently practiced the use of the exercises and techniques at home. This seems to have been especially useful, given the timing of events – going into labour unexpectedly and having to go to hospital in the middle of night. One can assume that, if the techniques and exercises had not been second nature to her by that time, she might have had difficulty in eliciting the physical and mental responses taught through HypnoBirthing® classes.

> I listened to the HypnoBirthing® CD probably three times every evening. So I switched it on when I went to bed. When I woke up at midnight, I switched it on; when I woke up again at 3 a.m., I switched it on. So I was just so relaxed. (Felicity)

> Even if you don't always hear what the woman [*on the CD*] is saying, you become so calm, quickly, that you do hear it, and it does go in. Yes…listening to the CD definitely helped. (Felicity)

Furthermore, Felicity found the techniques helpful after the caesarean section, when caring for her baby in hospital. The operation results in significant physical discomfort and pain and, whilst she reported that she did experience pain after the operation, she also noted that she made use of the techniques to alleviate the physical discomfort of moving around after the operation to care for her baby.

> And also in the middle of the night, with a screaming baby, one has to do like sit-ups to get to her in the crib next to your bed – so I think it helped me with that as well. (Felicity)

The baby just attached beautifully and everything was just perfect. (Sr Melanie)

She's just so calm and just so natural with the baby. (Sr Melanie)

According to the midwife, Felicity's ability to remain so calm and relaxed also had direct benefits for the baby.

A huge advantage that she was able to remain calm, being relaxed. And with being so calm and relaxed, it gives so much extra boost to the baby, because it gives them extra oxygen; it's less adrenaline, and it helps that baby so much more. (Sr Melanie)

If you have a stressed-out mommy, you have a stressed-out baby. (Sr Melanie)

With her being so relaxed, there was extra oxygen going to baby. There's no adrenaline going to baby; baby's heart wasn't tachycardiac. So everything was just the ideal situation. (Sr Melanie)

She was just a very happy baby. (Sr Melanie)

Usually when you have a 'ruk en pluk' baby, you've got to move fast and get that baby out fast; they become very irritable. Like the very first few hours, we say to the mom, "don't stress, they'll get over it; it's a bit of a shock for them". But that baby was the just the calmest happiest thing ever. (Sr Melanie)

The baby was calm. It was fine, it drank fine; there was nothing that said we need to watch this child. (Sr Melanie)

Even to the extent that their blood glucose can go into a stress level, because it's a difficult delivery. The baby's blood glucose was fine. (Sr Melanie)

We don't like to give much Dormicum, because it passes on to the baby; then your baby's also lazy. So we only use it if we really have to – that's with the really stressed out patients. (Sr Melanie)

These techniques also facilitated bonding between Felicity and the baby after the caesarean section and made it easier for her to initiate breastfeeding.

> They said she handled the breastfeeding quite well. (Sr Melanie)

It is the observation of the midwife that, when mothers are anxious, the tension tends to manifest in their babies as well. Felicity's ability to remain physically and psychological relaxed thus enabled her baby to bond more easily and start breastfeeding without difficulty.

> If you have a stressed-out mommy, you have a stressed-out baby. (Sr Melanie)

Furthermore, the fact that Felicity was able to take minimal medication allowed her to be alert and responsive to the baby, which likely also impacted on the initial bonding experience. The midwife described Felicity's recovery as exceptional, pointing out that she recovered much faster than typical patients, experienced much less pain, was more mobile after the caesarean section than usual, and was "absolutely happy". The use of HypnoBirthing® can, therefore, be beneficial during natural delivery or with a caesarean section by lowering blood pressure, providing relaxation, helping with labour progress and probably resulting in fewer epidurals and medication.

> ...hardly ever asked for pain relief. (Sr Melanie)

> She didn't seem to want pain relief or anything, she just handled everything beautifully. (Sr Melanie)

> She had the minimum of anything; she was absolutely happy. (Sr Melanie)

> You could almost discharge her the next day, she was so well. (Sr Melanie)

> She was more mobile. She was up and about. You know, usually you have to convince the patients to get out of the bed. (Sr Melanie)

> She didn't really show that she has pain. (Sr Melanie)

Whilst the term "HypnoBirthing®" seems to suggest that the techniques and exercises are for use during birth only, it is clear that Felicity has found many additional uses for it. She had already started to use the techniques to relax at work when dealing with stressful situations, and it appears that this approach even found favour with her colleagues at work who joined her in these exercises. She also planned to use the self-hypnosis techniques to cope with her phobia for riding in an elevator. This apparent "misnomer" of HypnoBirthing® could prevent others from making use of it. Felicity noted that had she not planned to give birth naturally, she would probably not have chosen to enter HypnoBirthing® training. In the end, she found it extremely useful before and after the caesarean section. She also stated that more women could benefit greatly from this approach, but that the marketing of the techniques can be better in order to create more awareness of its uses (Table 9). It seems that there is a perception that HypnoBirthing® is appropriate for natural birth only, but the midwife believes that, in fact, even patients who plan, for some reason, to undergo a caesarean section can benefit greatly from this approach.

> Well, my midwife also taught us about Lavender, and Lavender – I always told the girls in the office, if there's a difficult situation in the office, we just do a quick Lavender. I taught them about the Lavender as well [*laughing*]. So, I used it in other places as well; so I would say doing that also definitely helped me. Before the time already, even though I planned to have a natural birth, I learnt that I could use it in other situations as well; so I am going to go on using it. And I suffer from claustrophobia, so I don't like taking the lift. So now I have to…you know…especially when I have to go to the hospital alone with the baby, I'm going to have to take the lift. So I'm going to Lavender then. So I'm going to…it's

something you can use more than once, you can use it multiple times and apply it to other situations as well. (Felicity)

[*laughing*] It's for anything, yes...if someone makes you angry, you do a quick Lavender.... (Felicity)

4.7 Member checking

A member-checking interview was conducted with Felicity and her HypnoBirthing® practitioner in order to verify the findings and analysis of the data. During the interview, Felicity did not contradict any of the findings in the discussion, but confirmed and emphasised the following aspects:

- The HypnoBirthing® techniques provided her with a sense of control, which was an important aspect for her.
- The medical staff who attended to her during her stay in hospital were very calm, and this also played a positive role in her own ability to remain calm and relaxed. Since it was her first baby, and she had no basis for comparison, she believes that her experience was how it is supposed to be.
- The midwife's empathic response to the participant "meant a lot" to her, and she considers this a very important aspect.
- Felicity emphasised the importance of being able to relax physically in order to have a mental sense of calmness, and she feels that this aspect was most important in her experience to eliminate pain. She added that she would not have been able to enter a state in which she did not experience pain, were she not able to relax completely physically.

- Felicity found it interesting and humorous to hear that the medical staff were initially shocked by her absence of pain and discomfort and were actually checking their equipment to make sure that it was functioning correctly.
- She also confirmed the importance of the ability to dissociate from her immediate surroundings – she stated that the birthing experience felt "far away". In addition to the experience of time distortion, which added to her ability to use the techniques successfully, she mentioned that the birthing experience "felt like a blur".
- Felicity stated that she was not concerned about the risks of her endometriosis and that "this was not an issue" for her at the time.
- When looking back on her entire experience, she feels that the first seven weeks of motherhood were particularly challenging for her, but for reasons unrelated to the risk of the pregnancy and birth experience.
- Commenting on the use of the HypnoBirthing® techniques, she further mentioned that she developed a few "favourite" techniques, which she practiced more often and mastered as a result, particularly the visualisation and deepening exercises.
- Whilst she planned to make more use of the techniques after the birth, and she confirmed that this remains the plan, but she has not overcome her fear of riding in elevators yet. However, she did report that she does not feel claustrophobic as quickly as before.
- Felicity confirmed that the HypnoBirthing® techniques were useful in allowing her to bond with her baby after the caesarean section.
- She found it interesting that her recovery was considered by the medical staff to be particularly good.

CHAPTER 5

REPORTING THE RESULTS

CASE STUDY 2: DANELLE'S STORY – PRETERM LABOUR

5.1 Introduction to Danelle and relevance to the research

Danelle was initially identified as a candidate for the research by her hypnotherapist, who was aware of the study being conducted. When Danelle agreed to participate in the study, it was approximately two weeks after the birth of her baby. She suffered preterm labour during her pregnancy, which posed a high risk to the pregnancy at the time, and hypnotherapy was one of the interventions utilised at the time to successfully prevent the premature birth of her baby. This was Danelle's first pregnancy.

Danelle had an otherwise normal pregnancy and delivered the baby through a vaginal birth without complications. The high risk, therefore, refers specifically to the preterm labour.

Although the participant had a normal pregnancy and birth, apart from the preterm labour, her experiences of the hypnotherapeutic techniques as support during the pregnancy and birth provide a rich set of information. In particular, when contrasted with the other case study, it provides valuable comparative information.

The fact that the participant was identified after the birth of her baby meant that I did not have the opportunity to set up any quantitative measurement for during the pregnancy and birth. The only data that could be collected, retrospectively, was of the experiences of the participant herself, as well as of her hypnotherapist and medical doctor.

A detailed background and medical history of the participant was not taken because she preferred for the information to remain private. This, however, did not impact on the quality of the information that was collected.

5.2 Intervention

Danelle was encouraged to enter the HypnoBirthing® programme after talking to a friend and, when her medical doctor also recommended it, she decided to enrol. She attended HypnoBirthing® instruction with Ms Stabler, a hypnotherapist and HypnoBirthing® practitioner. Before she could complete the course, she went into preterm labour and was hospitalised for medical treatment. She also underwent hypnotherapy when she returned home and continued with the HypnoBirthing® instruction.

5.3 Interviews conducted

To investigate all the factors of her lived experience, the following interviews were conducted:

- Danelle and Ms Stabler: the main data collection interview
- Ms Stabler: obtaining the perspective of the HypnoBirthing® practitioner
- Dr Olivier: obtaining the perspective of the gynaecologist

- Danelle and Ms Stabler: member-checking interview.

Since Ms Stabler accompanied the researcher to the home Danelle for the interview, she was present during the interview. This proved helpful as she was able to assist with the care of Danelle's baby during the interview, without which the interview would not have been possible to proceed. Her presence also provided Danelle with comfort, and it was the researcher's perception that Danelle was very forthcoming as a result of this.

5.4 Medically relevant information

Preterm labour is defined by Perry, Cashion and Lowdermilk (2007) as cervical changes and contractions between 20 and 37 weeks of pregnancy. Preterm labour and birth lead to about 90% of all neonatal deaths and can, therefore, be considered to be a significant risk.

The cause of preterm labour is unknown and assumed to multifactorial, but at least 50% of all women who ultimately give birth prematurely have no identifiable risk factors. In Danelle's case, there was no known reason for her preterm labour, but 29 weeks into her pregnancy; it posed a significant risk to the health and survival of the foetus.

5.5 Data analysis

The same data analysis process followed for Felicity's case study was followed here. The first stage of the data analysis involved extensive and repeated coding of each interview to reduce the information to workable data (See Appendix B: Tables 15, 17 and 19). The data were then further analysed by grouping the codes into more usable categories (Tables 5, 6

and 7). This allowed the researcher to deconstruct the data from the original transcript based on the coding, and then reconstruct it based on the categories.

Table 5: Danelle: Codes revised to categories

List of codes	**Codes revised into categories**

• Attitude medical staff
• HypnoBirthing® uses
• Effectiveness
• Risk
• Calm and relaxed
• Failure to do it on her own
• Trust in the practitioner
• Pain
• Partner
• Anxiety and fear
• Stress
• Baby
• Preparation and practice
• Breastfeeding
• Presence of practitioner during labour and birth
	• Coping
	  ○ Attitude of medical staff
	  ○ Positive emotional impact of HB
	  ○ Calmness
	  ○ Trust in the practitioner
	  ○ Dealing with negative emotions
	  ○ Feelings of failure
	  ○ Stress
	  ○ Anxiety and fear
	• Preparation and practice
	• Experience of pain
	• Risk
	• Husband as partner in HypnoBirthing
	• Managing baby
	• Breastfeeding
	• HypnoBirthing®
	• Use of HypnoBirthing®
	• Effectiveness
	• Presence of the practitioner during labour

	and birth

Table 6: Ms Stabler: Codes revised to categories

List of codes	**Codes revised into categories**

• Empowerment and knowledge
• Medical persuasion/interference/ interruption
• Partners
• Preparation
• Confidence
• Anxiety
• Comfort
• Fear
• Pain
• Positive anticipation
• Risk
• Caesarean section
• Postnatal depression
• Hopes and wishes
• Calm and relaxed
• Augment medical treatment
• Control
	• Coping
	  ○ Attitude of medical staff
	  ○ Psychological support
	  ○ Positive emotional impact of HypnoBirthing®
	  ○ Positive anticipation
	  ○ Knowledge and empowerment
	  ○ Calmness
	  ○ Confidence
	  ○ Comfort
	  ○ Control
	  ○ Dealing with negative emotions
	  ○ Anxiety and fear
	  ○ Postnatal depression
	• Risk
	• Partners
	• HypnoBirthing® uses
	• Augment medical treatment

• Psychological support	• Preparation and practice • Experience of pain

Table 7: Dr Olivier: Codes revised to categories

List of codes	**Codes revised into categories**
• Pain • HypnoBirthing® benefits caesarean sections • Calm and relaxed • Cooperation • Risk • Natural and alternative healing • Preparation • HypnoBirthing® uses • HypnoBirthing® practitioner present during labour • Fragmented process	• Coping o Calmness o Natural health o Cooperation o Psychological support fragmentation • Preparation and practice • Experience of pain • Risk • HypnoBirthing® uses • HypnoBirthing® practitioner present during labour

Even at this early stage of data analysis, when the codes were revised into categories, similarities started to become apparent between the various codes and categories of the different participants. However, the process was followed, and the categories for each participant were represented in a table, together with the accompanying text, to allow themes

to emerge, which formed the basis for the discussion of the case (See Appendix B: Tables 16, 18 and 20). Due to the length of the tables, they are represented in Appendix B, but for the sake of demonstrating the relevance and interrelatedness of the themes that emerged from the difference interviews, the themes are represented below in Table 8, from which the discussion follows.

Table 8: Comparison of themes

Danelle	**Ms Stabler**	**Dr Olivier**
Danelle was encouraged by the positive attitude of her doctor to attend the HypnoBirthing programme.	Information about birth empowers women to be proactive in making decisions about birth instead of allowing the medical profession to make decisions on their behalf. When there is a discrepancy between what the woman in labour wants and what the medical staff want, staff often pressure women into decisions that leave them with regrets afterwards.	HypnoBirthing patients are substantially more in control and calmer than patients who did not undergo the training. HypnoBirthing can benefit mothers in dealing with a crying and upset infant.
HypnoBirthing effectively	HypnoBirthing allows	People with a natural or

Danelle	**Ms Stabler**	**Dr Olivier**
reduced fear and anxiety experienced during early labour and promoted feelings of calmness and control. Danelle experienced feelings of tremendous calmness and relaxation during HypnoBirthing® sessions and training.	women to be proactive in making decisions about birth.	alternative approach to healing (as opposed to a medical approach) take more responsibility to control the labour and birth process.
Danelle had complete faith in her therapist, but experienced failure when attempting to use the techniques herself. Danelle decided to give it a "try", which implied a negative expectation of failure.	HypnoBirthing® provides an opportunity to correct misconceptions and deal with negative emotions.	Medical practitioners experience HypnoBirthing® patients as calm, and in control and more cooperative with the medical staff during labour.
Danelle experienced failure	HypnoBirthing® empowers	There is fragmentation in the

Danelle	**Ms Stabler**	**Dr Olivier**
when attempting the techniques on her own and desired to have the therapist present during labour and birth to assist her. Danelle did not believe that HypnoBirthing® would actually be effective. Danelle feels that she did not practice enough for the techniques to be effective. Danelle developed feelings of self-doubt. She failed to use the techniques successfully, but the hypnotherapist obtained excellent results with her.	women to be proactive in making decisions and taking control of the birth, as opposed to being passive recipients of medical service.	process of support, i.e. the HypnoBirthing® training takes place before labour. During labour, the medical staff take over; and, after birth, the mother deals with the infant alone, unless she needs help. There is not enough continuity in this process that is intended to support the mother.
Danelle experiences herself	The ability to attain calmness	HypnoBirthing® clients tend

Danelle	**Ms Stabler**	**Dr Olivier**
as more stressed and anxious in general.	and relaxation is experienced as empowering.	to take more responsibility for the planning and the process of labour and birth, because they are more informed.
HypnoBirthing® effectively reduced fear and anxiety associated with early labour.	Women are more confident to make decisions and take control of the birth.	Danelle was managing the pain much better than she realised. Danelle's preterm labour and the pain experience created an expectation that later labour would be excruciating. During the hypnotherapeutic preparation, attention could be paid to underlying beliefs, or critical incidents, which may create fear and thus interfere with the ability to

Danelle	**Ms Stabler**	**Dr Olivier**
		obtain hypnotic phenomena such as analgesia or anaesthesia.
Danelle did not practice enough in her own estimation. Did the infrequent practicing impact on the feelings of failure, or did the feelings of failure cause the infrequent practicing?	Especially with subsequent pregnancies, HypnoBirthing® provides the possibility of comfort during birth.	A potential risk from a medical perspective is that complete calmness may interfere with the urge to "push" and, at this stage, monitoring of the infant is difficult.
Danelle experienced her labour and giving birth as very painful and did not feel that the HypnoBirthing® was working for her at the time. Danelle doubts herself and wonders whether more practice would have improved her experience.	The ability to remain calm provides women with a feeling of being in control of the birth.	The calmness associated with HypnoBirthing® allows for a calmer birth even when doing a caesarean section. The calm and relaxed response of HypnoBirthing® facilitates bonding and breastfeeding.

Danelle	**Ms Stabler**	**Dr Olivier**
Danelle went into preterm labour, which caused her anxiety and fear. This was relieved by HypnoBirthing® techniques in a session with the therapist.	Physical relaxation and calmness also reduces anxiety. Negative expectations, fear and anxiety can be replaced with positive expectations.	It would be beneficial for the HypnoBirthing® practitioner to be present during labour and birth, or at least for some time period during these processes.
Danelle could not get a good hypnotic response on her own compared to that of the hypnotherapist. Danelle's husband was sceptical about HypnoBirthing® – what was the impact of this on her belief in the process? It was awkward for Danelle and her husband when he tried the techniques with her.	HypnoBirthing® may reduce the incidence of postnatal depression.	

Danelle	**Ms Stabler**	**Dr Olivier**
Danelle feels that her ability to respond in a calm and relaxed manner to the preterm labour may have allowed her to prolong her pregnancy.	Women feel more prepared for birthing.	
The HypnoBirthing® techniques were effective with breastfeeding some of the time.	Fear of pain and harm to their baby is a common emotional experience in women.	
Danelle's motivation for doing HypnoBirthing® included the prospect of being able to manage stress in general. Danelle was also encouraged by the doctor's opinion that HypnoBirthing® could be	The confidence and calmness allows women to be content with birth, even if it does not progress as planned. HypnoBirthing® techniques reduce anxiety about unexpected complications with the pregnancy.	

Danelle	**Ms Stabler**	**Dr Olivier**
useful even in the case of a caesarean section.	HypnoBirthing® alleviates fear and anxiety and promotes calmness.	
Whilst Danelle was very uncertain about the effectiveness of HypnoBirthing®, her doctor was convinced that it was very effective. The language difference might have impacted on the level of comfort in using the HypnoBirthing® scripts. The couple's home language is Afrikaans, but the hypnotherapy scripts are in English.	Women and their partners are more proactive and in control during labour.	
Danelle had complete	HypnoBirthing® can be used	

Danelle	Ms Stabler	Dr Olivier
confidence in her hypnotherapist and wanted her present during the labour and birth to assist her with the HypnoBirthing® techniques. She is convinced that her presence would have made a big difference.	with caesarean births as well as with natural births.	
	HypnoBirthing® reduces stress and is an effective adjunct to medical treatment.	

5.6 Discussion

Danelle was 29 weeks pregnant when she went into preterm labour, which posed a risk to her and her baby. She immediately went to the hospital where she received medical treatment. When she returned home, she contacted the hypnotherapist, who conducted a home session for her in addition to the HypnoBirthing® programme in which she was enrolled.

The preterm labour was an emotionally upsetting and traumatic experience for Danelle, and she reported that the hypnotherapeutic sessions provided her with a tremendous experience of calmness and relaxation. The fear for her unborn baby and her anxiety was completely eliminated in the home session and, afterwards, she felt at peace in the knowledge that whatever happened would be for the best. This was also her experience with most of the training sessions, namely that they allowed her to relax completely.

> I was scared, and she came, and it was just the most calming session of everything we did. (Danelle)

> She could just feel this peace and calm over here. (Danelle)

> I really felt good afterwards, and I felt calm, and I felt, "Everything was going to be OK. It's not this big crisis and all is well with the world again". [*laughing*] (Danelle)

Danelle did, however, experience some difficulty in obtaining the same results when practicing the HypnoBirthing® techniques on her own. Especially during labour and birth, she reported experiencing extreme pain, even though Dr Olivier believes that she handled it very well and that the HypnoBirthing® techniques did, in fact, work very well.

> [*A*]nd she said to me, "By that stage, women are so out of control, in pain, screaming the roof off, so it must have worked". I didn't expect it to be that painful. (Danelle)

> There was just more pain involved than I thought there was going to be. (Danelle)

According to Dr Olivier, Danelle was more calm and in control than most women who did not undergo the training.

> [*My doctor*] thinks I did brilliantly...the doctor...she just says the whole thing was so calm and, "You were so calm, you didn't scream. And you were so calm, and you told me in a normal voice to do this and to do that." (Danelle)

> From my point of view, I think she handled the pain fantastically well, but she still feels it was too much. (Dr Olivier)

> You know, she was still communicating, whereas often people are completely overwhelmed by pain at that stage, by the moment. (Dr Olivier)

Danelle also doubted herself throughout the training process. She could not obtain the same level of calmness and relaxation as during training with the hypnotherapist and experienced frustration and self-doubt. She felt like she was "talking nonsense" to herself.

> [*A*]nd I couldn't really get it right on my own, as good as you [*directed at hypnotherapist*] did it with me. And my husband couldn't get me to that state either. Really, I wanted you [*directed at hypnotherapist*] there, at a labour actually. (Danelle)

Even before she enrolled in the programme, Danelle never really believed that hypnosis works, and even her husband was very sceptical of the process. She feels that he supported her because he wanted her to have the birth that she wanted, but he was fearful that she would experience a lot of pain and would have preferred her to have an epidural during the labour. It remains unclear to what extent his doubts and fears were communicated to her. Danelle was further motivated to enter the programme after she met the hypnotherapist. She stated that she immediately liked and trusted the hypnotherapist and decided to "give it a try". Both Danelle and her husband were sceptical of whether hypnosis would actually work, but decided to go ahead because it came recommended by a friend and the medical practitioner. When Danelle met the hypnotherapist, she immediately felt comfortable with her. It is possible, however,

that the seeds of disbelief were already sown, and each time that Danelle ”tried” practicing the techniques on her own, she met with frustration and failure, which further reinforced her belief that it would not actually work for her.

> I told her when I first started, I’ve got this weird thing with hypnotherapy, I don’t really think it works. (Danelle)

> When I try to do it, go into your happy place, go into your subconscious, it feels like I’m sort of...talking nonsense to myself. (Danelle)

> And I don’t have the faith in myself to do it. (Danelle)

> When I try to talk myself into that calm space, then I don’t “believe myself”. (Danelle)

When Danelle went into preterm labour, she experienced tremendous pain, and the medical practitioner noted that she could hardly walk into the hospital. The experience of preterm labour provided her wither her first “big scare” of what labour could be like – “horrible pain”. She said to her doctor that, if early labour was so extremely painful, how painful would the actual birth be? It appears that this traumatic experience served the purpose of further reinforcing the already existing belief that the techniques would not work and that the process of labour and birth would be extremely painful. This idea was supported by the medical doctor.

> She came in at 34 weeks in the night with pain…we didn’t know why…but it was so bad, she could barely walk into the hospital. And her words on that Saturday – it was her stork tea; she missed her own stork tea. She said to me, “If this is not labour yet, and it hurts so much, what will THAT be like?” (Dr Olivier)

> Yes, whether it had a negative impact. And those were her exact words “If it’s so damn sore now already....” (Dr Olivier)

> You see, I did try to make that mind switch at that stage, and Ms Stabler worked with her, and then she stayed in the house for a week, and Ms Stabler … she went on with the sessions. So one hopes that if there had been something, one could have caught it, but perhaps deep down there is still this perception. (Dr Olivier)

Regardless of this, however, she continued with the HypnoBirthing® training. And, even though she expressed doubt as to whether the techniques had worked for her, in the opinion of her medical doctor it did, in fact, work very well. Her experience of the labour and birth was, however, very painful and in her own words "a traumatic experience – life changing".

It seems that Danelle's doubt about the effectiveness of HypnoBirthing® was not a general belief because, while she continued to experience feelings of failure at her own attempts to make use of the techniques, she experienced the session with her hypnotherapist as very successful, to the extent that she wanted her hypnotherapist present during the labour and birth.

> [*A*]nd I couldn't really get it right on my own, as good as you [*directed at hypnotherapist*] did it with me. And [*my husband*] couldn't get me to that state either. Really, I wanted you [*directed at hypnotherapist*] there, at a labour actually. (Danelle)

> I thought "you [*directed at Ms Stabler*] would be helpful now". (Danelle)

Dr Olivier also commented on the possibility that it would, in fact, be beneficial if the hypnotherapist was present when some of their clients give birth. Whilst not every individual client may need or want the hypnotherapist present during this private moment, the doctor feels that the experience of a few births would allow the hypnotherapist to make certain adjustments in the programme that could be beneficial. She is of the opinion that the

HypnoBirthing® programme does well in preparing women for childbirth, but that many patients would benefit from support through the prenatal and perinatal period. She specifically mentioned the potential benefits of HypnoBirthing® in relation to easier bonding and breastfeeding, as well as when the mother deals with an upset infant. She (Dr Olivier) believes that the HypnoBirthing® approach should provide continued support throughout this process. The emphasis of the programme is on preparing clients through a training programme, but once they have completed the programme, the hypnotherapist is no longer involved during the labour, birth or postnatal period.

> ...yes, the process is fragmented. (Dr Olivier)

> When the classes are done, the therapist's work is done, but then the birth is still to come. It would be good if there could be on-going support. (Dr Olivier)

> But I also think it would be a good thing is the therapist could be present at least at one or two births, to see what the circumstances are. (Dr Olivier)

Danelle did not experience the techniques as successful when she practiced them on her own, and so she did not practice as much as she should have – in her own estimation. Hypnosis is, however, a skill that requires practice. Neglecting regular practice of the techniques only contributed further to Danelle's feelings of failure whenever she attempted to use the techniques. It became a vicious cycle – the fewer good results she experienced, the more frustrated and doubtful she became and the less she practiced, resulting only in further frustration and failure. The sessions with the hypnotherapist were very successful, however, and probably served to keep her hopes up and keep her motivated, despite the underlying feelings of fear of pain, self-doubt and lack of confidence in herself. She continued with the

training in the hope that it would work, but deep down, she kept on fearing that it would not work.

> Most times when I did practice I just felt, em, and then I got to Ms Stabler again and then it just felt so perfect. And I thought, "How could this not work?" She could do it; I couldn't do it myself. (Danelle)

> I feel it's her profession; she knows how to do it. And I don't. (Danelle)

> Whereas when she does it, she knows what she's doing. (Danelle)

> I knew I would get along with her. I liked her, and I liked the content of the course. When I met her, I thought if she's doing it, I'm going to give it a try. (Danelle)

> Because like I said, when she [*HypnoBirth instructor*] did it with me, it was all easy and good. (Danelle)

According to Dr Olivier, most of her HypnoBirthing® patients are significantly more calm, relaxed, cooperative and in control than patients who did not undergo the training. They take more responsibility for planning the labour and birth, which she attributes to the community being very conscious of alternative or natural healing approaches.

> Much more peaceful, much calmer, much more in control, much more there – present – the co-operation is fantastic. (Dr Olivier)

> I think our people here are more focussed on the natural. You know…and on alternative treatment. (Dr Olivier)

> They arrive here with the birth plan and everything....Look, they've done their homework, and they really want to…I think there is much more awareness of what the delivery and the pregnancy and the baby can do. (Dr Olivier)

One of the concerns of the medical practitioner with regard to the use of HypnoBirthing is that, in her experience, patients are so relaxed that they do not feel the urge to push, which prolongs the birth. For her, this becomes a risk factor when she is unable to monitor the baby once it has descended into the birth canal.

> ...and I have had patients who were so calm at that stage, they are flying somewhere, that they don't get the sensation to push. (Dr Olivier)

> ...you're struggling at that stage to monitor the baby with its head so low. (Dr Olivier)

5.7 Member checking

The member checking interview was conducted with both Danelle and her hypnotherapist, Ms Stabler.

- Danelle confirmed the importance of practicing the techniques and mentioned that it is important to schedule enough time for practice sessions.
- Part of the discussion focused on Danelle's experience of pain and the possible role that her initial scepticism, amount of practicing and preterm labour experience played in the amount of pain she experienced. She confirmed her early scepticism, adding that it "sounded too good to be true" – the idea of a natural birth without pain. It seems that she remained sceptical about this possibility throughout the process. However, she clarified that she never intended or hoped to have a pain-free birth experience and that she accepted the possibility that the experience would include a fair amount of pain. Furthermore, she considers natural childbirth and the entire experience as a "kind of initiation" that a woman must go through, and pain forms part of this process. A question then arose about the role of pain in this process and

her expectation of the importance of having to experience pain. It relates to her view that a birth experience without pain would not be a complete experience and that she would, therefore, fall short of her goal. She clarified that she did not consider pain to be a central component of the process, but only an inevitable accompaniment. Relating to women who experience birth without pain, she mentioned that she "can't imagine if it's possible". Danelle plans to have a second child and stated that she expects that the birth will involve some pain.

- Danelle confirmed that she experienced feelings of failure in the practice sessions, due to not achieving the result she hoped for.
- A discussion on preparing to give birth to her baby explored the role of fear. She clarified that she was not fearful in the sense that she experienced panic, and that she experienced herself as calm throughout the process (something that her medical doctor also confirmed).
- Further discussion brought about the topic of an epidural. Danelle wanted to give birth to her baby without an epidural, and it became clear that this was, by far, the more important goal for her – not the elimination of pain as the researcher initially assumed. Considering this aspect, together with the importance she placed on giving birth to her baby naturally as an important "initiation", Danelle completely reached her goal – which was to have a natural birth experience without an epidural. She added that the pain was unexpected and more than she anticipated, but certainly not the central aspect of the experience for her. In describing the birth experience as overwhelming, she also clarified that she felt that the entire experience was overwhelming, not only the pain she experienced – that was only a part of the experience.

- The presence or absence of a hypnotherapist during the birth was discussed, and Danelle clarified that, whilst it would have been useful for the therapist to be present to help her anchor her relaxed state, she would not want the therapist to be present during the entire birth process. She related her vulnerability during the birth experience and that she would certainly not have wanted her therapist to have been present at that time.

CHAPTER 6

REPORTING THE RESULTS

COMPARATIVE DATA ANALYSIS OF CASE STUDIES

6.1 Discussion and comparison of the cases with reference to existing studies and theoretical paradigm

In terms of the themes that emerged for each participant, the following aspects of their experiences will be discussed and contrasted:

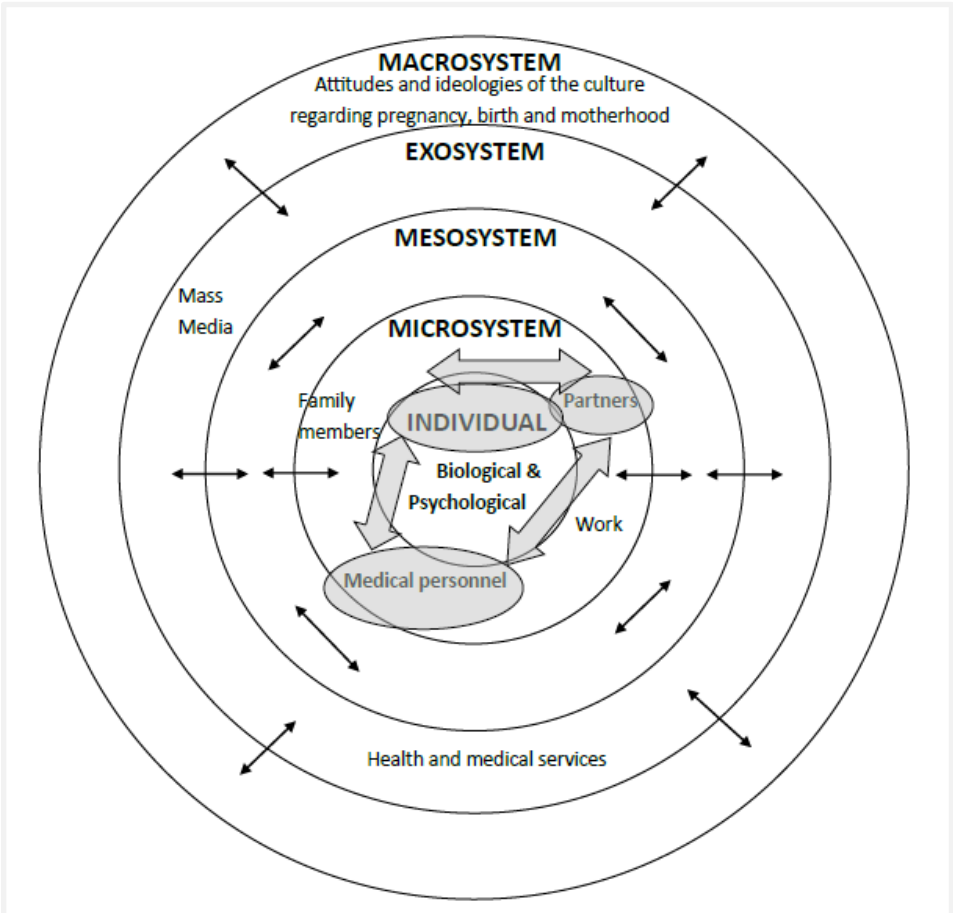
- Sense of control
- Attitude of medical staff
- Physical relaxation
- Mental calmness and psychological coping
- Experience of pain
- Practice and preparation
- Caring for the infant
- Recovery after birth
- Uses and applications of HypnoBirthing®.

It is noted that both participants experienced a strong sense of control during the prenatal and perinatal experience. It does seem that Felicity had a much greater experience of control than Danelle. Felicity reported that she felt in control and able to make decisions, choosing her responses to her circumstances, whilst Danelle reported feeling overwhelmed, especially during the birth itself. However, it must be noted that Danelle's medical doctor reported that she was, in fact, very much in control and calm and able to make normal conversation, and respond to the instructions of the medical doctor. However, Danelle did not experience this at all.

In both cases, the attitudes of the medical staff were reported as very supportive, and this appears to have been significant in shaping the experiences of the participants. In Felicity's case, she experienced the attending nursing staff and, in particular the midwife, as very supportive. She spent time with her and was very empathic with regard to the absence of her partner. This is significant, because her experience corresponds with the findings of Da Motta, Rinne and Naziri (2006) that emotional support by a midwife has a direct impact on childbirth and enhancing emotional support should be a key element of assistance during childbirth. The absence of Felicity's partner during the birth could have been experienced as traumatic if this psychosocial stressor was not remediated by the midwife supporting her. Mehl-Madrona (2002) found that the woman's partner is one of the most significant psychological factors which discriminates between complicated and uncomplicated birth; fear of birth being the other factor. Mehl-Madrona (2002) concluded that psychological factors greatly influence birth complications, and attention to reducing their impact could potentially improve birth outcomes. Danelle reported her medical doctor being very supportive of the hypnotherapeutic approach, encouraging her to practice the techniques and being patient with her wish to have the birth that she wanted. In this way, the doctor provided a similar positive

experience of medical support as that experienced by Felicity. Danelle also reported that her partner's supportive attitude during the birth was an important part of her experience. This is supported by White (2007) who stated that the presence and on-going emotional support of a partner is vital to both the mother and the baby, potentially impacting positively on the couple's relationship. If the mother is supported, she is more able to bond with the infant. In terms of an ecological systems perspective, there is an interrelationship between the microsystems of the individual psychological and social experience of coping. The interrelationship between the medical personnel and the partner also plays a role here. At the same time, the medical personnel as a microsystem form part of medical services on an exosystem level, again highlighting the interrelatedness and interdependence of various systems, as can be observed in Figure 3.

Figure 3: Ecological subsystems theory: Interaction between the individual, medical personnel and partners



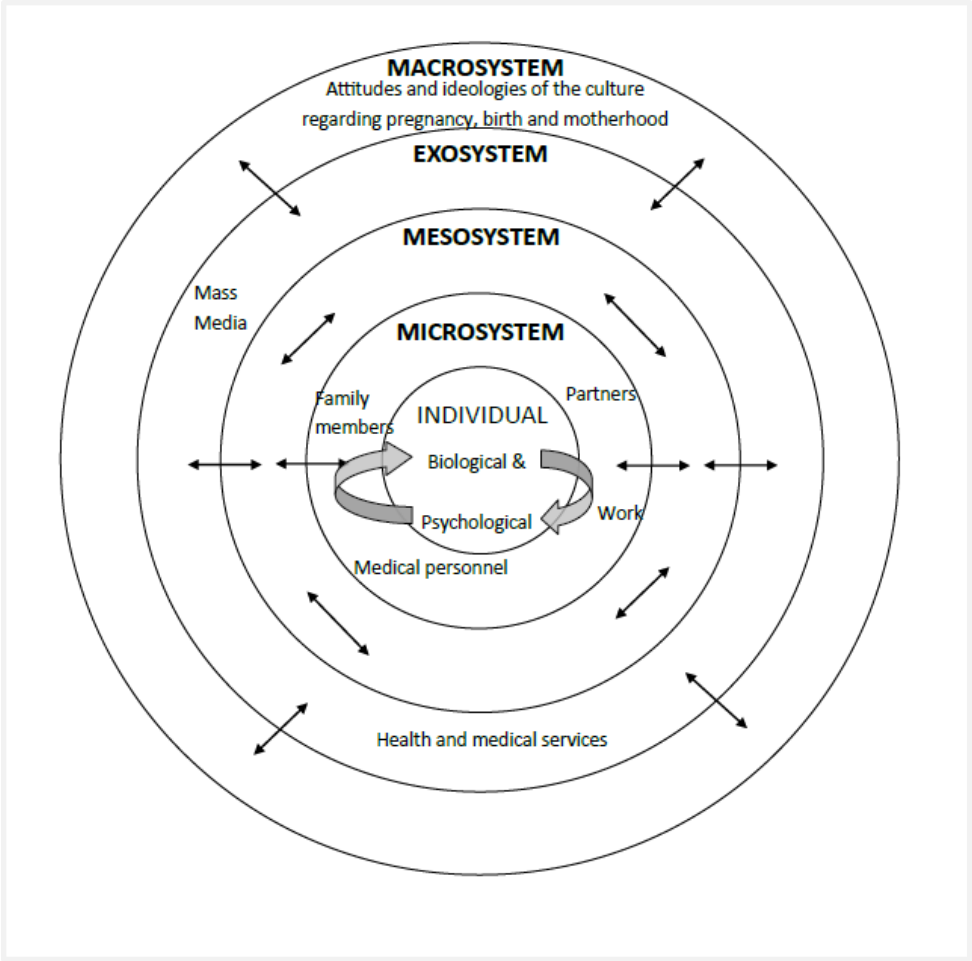
The role and importance of physical relaxation was very clear in both case studies. According to White (2007), relaxation techniques form a central part of the HypnoBirthing® training programme for women to achieve a calm, gentle labour and birth. It is important that the mother becomes accomplished in reaching a deep level of relaxation. Both participants reported that practicing the hypnotherapeutic techniques allowed them to experience profound physical relaxation. The major difference was that, whilst Felicity could produce the hypnotic phenomena of analgesia or anaesthesia herself, Danelle was unable to – or less successful – produce these effects without the help of her therapist. Similarly, Benham and Younger (2008) reported that, in certain instances, hypnosis has been found to be effective in the reduction of pain and anxiety only when therapist-administered hypnosis was used, not with self-hypnosis. This is echoed in Danelle's experience. She was able to experience profound relaxation with hypnosis when guided by her hypnotherapist, but not by herself (self-hypnosis). Whilst the reason for this is unknown, it is still significant to note that her experience is not unique and that this may be a dynamic that hypnotherapy practitioners should be mindful of.

Felicity was able to have an experience in which pain was an insignificant part of her total experience, whilst Danelle's experience appeared to be overshadowed by her experience of pain. Danelle clarified her experience during the member-checking interview by stating that the experience of pain did not detract from her experience of the birth and that she experienced the entire labour and childbirth as overwhelming. Danelle reported specifically that her experience of hypnotherapy when she went into preterm labour was one of complete physical and mental relaxation, calmness and peace. So it is clear that she was able to produce these hypnotic effects, but not herself. Whilst it is not possible to draw a causal link between the use of hypnosis and the effective stopping of preterm labour with Danelle, it is

significant to note that Brown and Hammond (2007) reported a study in which hypnosis was successfully used to stop six cases of preterm labour. Whilst Danelle also received medical treatment at the time, she valued the hypnotherapeutic session highly and suggested that it may have contributed to stopping the preterm labour.

It seems that the experience of physical relaxation is closely tied to the experience of pain, as well as to psychological coping, and so these are discussed together. Felicity did not have any pain during labour, so much so that the medical personnel were initially dumbstruck. She did not resemble the typical patient in labour at all, and presented as completely relaxed, calm and without pain and discomfort during labour. Her experience corresponds with the outcomes of a study described by Abbasi et al. (2009), where women who underwent hypnotherapy for pain control during childbirth reported a sense of relief, self-confidence and satisfaction, and a decrease of fear and absence of pain during labour. The relationship between physical relaxation and psychological coping can be understood in terms of ecological systems theory as the dynamic interaction between biological and psychological subsystems - a mind-body connection. The more Felicity was able to relax physically and reduce the pain experience, the better she felt and the more she was able to cope psychologically. At the same time, the more she was able to feel confident and in control, the more she was able to relax. The principle of reciprocal causality is illustrated in her experience, where physical and psychological factors continuously and mutually influenced each other, without either being identified as a cause or effect. Once this feedback loop was established, it became self-maintaining and self-reinforcing with each experience feeding into and reinforcing the next experience in a circular fashion. This interaction is illustrated below (Figure 4).

Figure 4: Ecological subsystems theory: Biological and psychological interaction



Brown and Hammond (2007 stated that hypnosis demonstrates a significant reduction in pain levels and adds to the enjoyment of labour. This, however, contrasts with the experience of Danelle, who experienced, in her own words, “extreme pain”. Even though Danelle’s doctor is of the opinion that she remained in control and relaxed, the doctor’s version is not consistent with Danelle’s reported experience. Danelle felt overwhelmed by pain, to the extent that she described her experience as “traumatic” and life changing. The same principle of ecological systems theory can be applied to Danelle’s experience, where a dynamic interaction between physical and psychological subsystems created and maintained her experience of failure and pain: The more failure she experienced in practicing self-hypnosis,

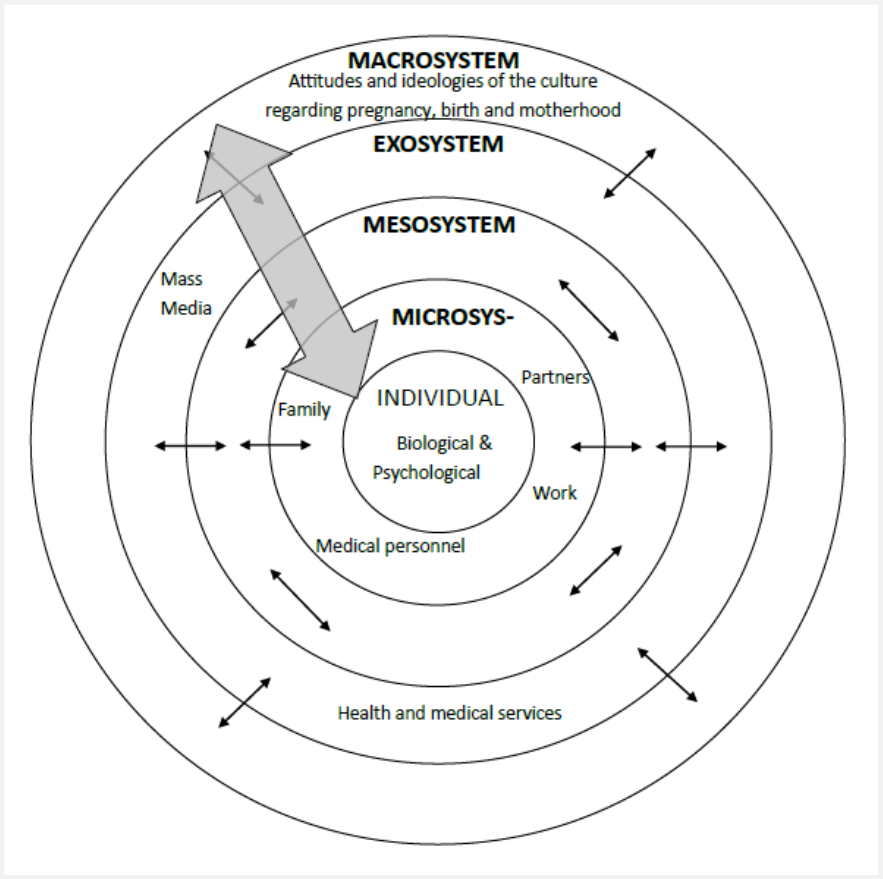
the more anxious she became; and the more anxious she become, the less she was able to attain success in self-hypnosis. The painful experience of preterm labour added to this anxiety and this, in turn, made it difficult for her to relax, further contributing to her experience of pain (also explained by the Fear-Pain-Tension Syndrome). Danelle did, however, provide further clarification during the member-checking interview, when she explained her expectations of childbirth being an initiation into motherhood in which she never expected pain to be absent. Rather, her goal was to give birth to her baby naturally and without an epidural and, therefore, she fully accomplished her goal. Guse, Wissing and Hartman (2006) also pointed to the childbirth experience as an important life transition, and this is how Danelle experienced the birth of her baby. When she eventually went into labour, one can certainly postulate that a degree of fear and apprehension must have been present, as she knew that she was not able, during the hypnosis practice sessions, to obtain the success that she desired. Added to this, her experience of preterm labour and the accompanying "horrible pain" provided sufficient mental impact to confirm her fears that her birth experience would be excruciating. When going into labour, the self-fulfilling prophesy was realised. According to Lear (2006), childbirth is a rite of passage into motherhood which can be an empowering event for the pregnant woman. However, if this anticipated triumph turns into a nightmare, the woman may experience an event so frightening that post-traumatic stress disorder may result. There also appeared to be some discrepancy between Danelle's initial report of her experience and her later recollection during the member checking interview. Whilst it is possible that the researcher misunderstood her during the initial interview with regard to the overwhelming nature of the pain and her experience, it is also possible that she re-evaluated her experience after having talked about her experiences. According to Lear (2006), narrative debriefing may be a source of validation for the woman. Through the telling of, and listening to, birth narratives, the woman re-evaluates her own experiences, and her perceptions change

as a result. I accept that this is not an *either-or* possibility, but rather a *both-and* situation. It is possible that the researcher misunderstood some of Danelle's narrative during the first interview and also that, through the telling, she re-evaluated her experiences and her perceptions may have changed. Either way, I had to remind myself of the danger of making assumptions about the experiences of participants. Whilst the experiences of Felicity and Danelle can be contrasted for the sake of broadening our understanding of their experiences, their experiences can really only be compared in relation to their own expectations and not to that of a researcher or anyone else. In Danelle's case, the birth carried a very significant meaning in terms of a transition to motherhood. In terms of an ecological systems understanding, the impact of societal expectations and values (macrosystem) on her experience of the birth was a remedial factor for what could otherwise have been overshadowed as a painful experience. The meaning that she attributed to her experience reframed a painful experience into a meaningful transition to motherhood, something that she considered to be important and which she accomplished successfully, as illustrated below in Figure 5.

According to Felicity, she practiced the HypnoBirthing® skills whenever she had the opportunity, whilst Danelle did not, in her own estimation, practice as much as she should have. It must be noted that Danelle's motivation to practice appears to have been impacted negatively by her feelings of failure when she did practice. According to White (2007), home practice of the HypnoBirthing® techniques are strongly recommended and encouraged as it is a conditioned response that needs to develop in order to remain free of tension. It seems that, for Danelle, each unsuccessful attempt may have compounded the previous one, creating a strong sense of failure or inability to produce the desired response herself (refer to Figure 4). This is not to say that her experience was only negative, or that using the skills was

ineffective. Her medical doctor reported that she performed excellently - that she was able to enter a relaxed state when needed and that she responded very well during the birth.

Figure 5: Ecological subsystems theory: Individual and macrosystem interaction

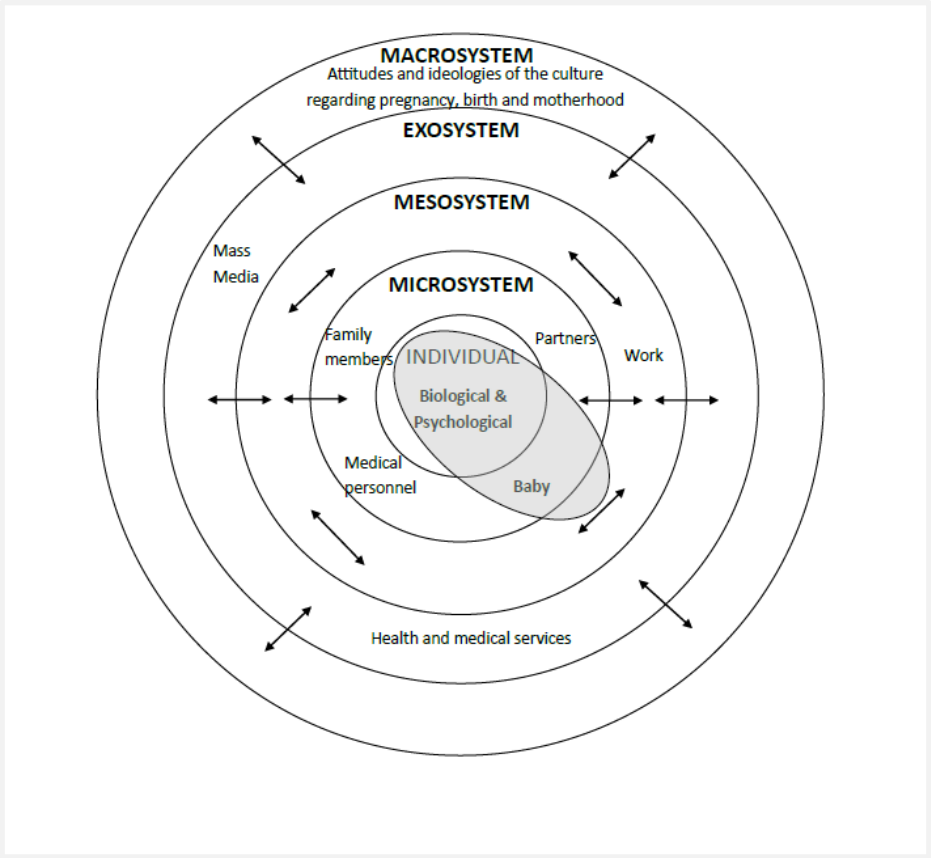


After the caesarean section, Felicity had a more difficult physical recovery to face than Danelle. Felicity reported some significant pain after the caesarean section and stated this made it difficult for her to care for her baby. However, she also reported that continuing to practice the HypnoBirthing® skills allowed her to manage the pain. Medical staff reported that she declined most of the pain medication she was offered. According to Moore and Tasso (2008) as well as Brown and Hammond (2007), women who made use of hypnosis for pain control used less pharmacological pain relief compared to those who did not make use of hypnosis. After feeling that the birth by caesarean section deprived her of the ideal birth

experience that she wanted, and interfered somewhat with bonding with her baby, Felicity once again experienced the techniques as useful in allowing her to bond through being calm and relaxed. On a microsystems level, her ability to manage physical discomfort and mental relaxation, therefore, impacted greatly on her ability to initiate a new relationship with her new born. Danelle did not report any specific use of HypnoBirthing® techniques in the care of her infant.

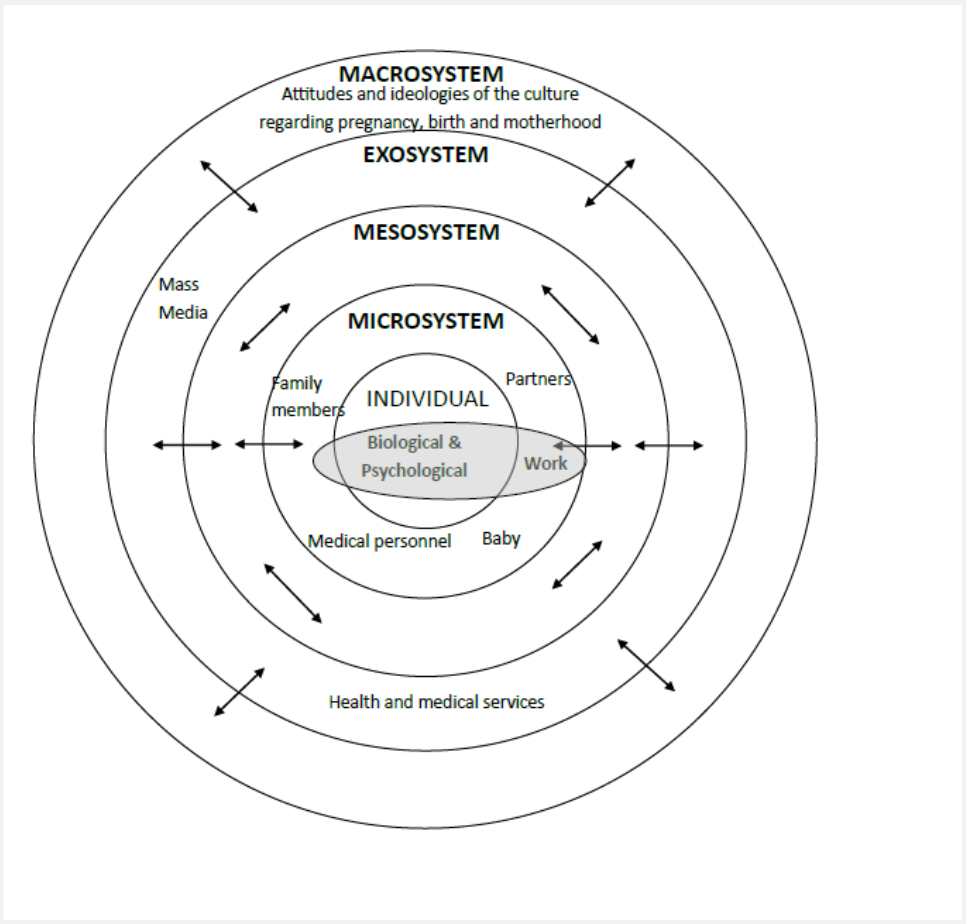
Danelle had a natural birth and reported her recovery as normal and without further complications. Felicity had to recover from a caesarean birth, and medical staff reported that she recovered remarkably quickly and well. Benham and Younger (2008) reported that some studies have shown hypnosis to be effective in reducing surgical recovery time or the length of hospitalisation following medical procedures. Due to the limited number of studies on this topic, these findings should be considered preliminary, but they certainly seem to be supported by Felicity's experience. Felicity stated that she continued to make use of the HypnoBirthing® skills during her recovery, to manage pain and to allow her to bond with her baby. The interrelated nature of her physical and psychological coping through the use of self-hypnosis and her bonding with her baby can be explained in terms of the ecological systems perspective as the mutual interaction between micro-subsystems. Physical relaxation and healing are interrelated with psychological coping. At the same time, physical and psychological coping is interrelated with bonding with her baby – the more she is relaxed and able to cope psychologically, the better she is able to bond with her baby (as shown below in Figure 6).

Figure 6: Ecological subsystems theory: Bonding with the baby



Both research participants underwent the same HypnoBirthing® programme – albeit with different HypnoBirthing® practitioners – and it seems that the programme left them with the expectation that the skills taught could be used for and generalised to further application in their lives, especially for physical and mental relaxation. Felicity reported that she planned to make use of the skills to overcome a phobia for riding in elevators, whilst Danelle planned to make use of the skills to reduce her levels of anxiety and stress in her workplace. Whilst it was probably not anticipated that a hypnosis programme designed for pregnancy and birth would find an application in work life, both Felicity and Danelle described how they naturally found the skills to be generalisable to other areas of their lives. The interrelated nature of the micro-subsystems is confirmed by their experiences and is illustrated below in Figure 7.

Figure 7: Ecological subsystems theory: Physical and psychological subsystems interaction with work life



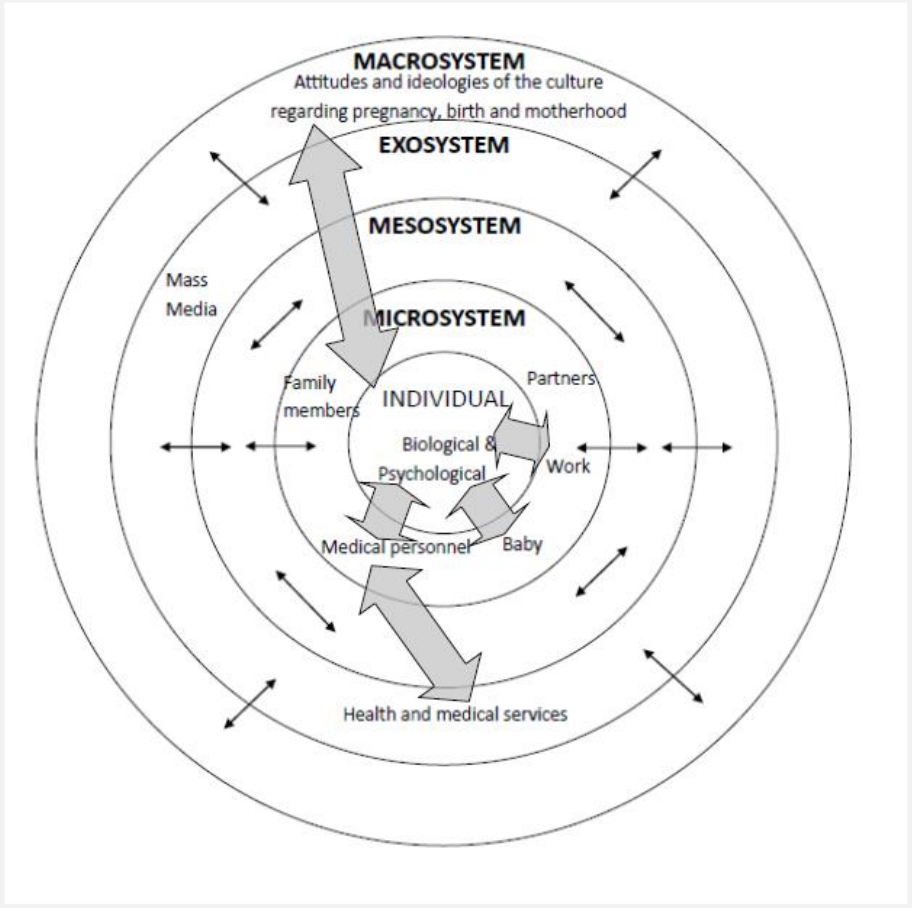
It is evident that the various systems that affect women's experiences of hypnosis, pregnancy and birth are complex and interrelated. Hypnosis as a psychological intervention in the context of pregnancy and birth cannot be viewed from a linear perspective, simply as a cause that has an effect. Hypnosis as an intervention is intricately interwoven into the dynamic relationships between the various systems affected, such as:

- Microsystems on an intrapersonal level, such as biological or physical systems that are affected by the pregnancy and birthing
- Microsystems on an interpersonal level, such as the individual person, the partner, medical personnel, hypnotherapist and the work environment
- Exosystem of the health-care and medical system

- Macrosystem, consisting of societal expectations, values and norms relating to pregnancy, birth and parenthood.

Whilst it would not be possible to depict accurately the complexity of the interrelatedness of the systems, the figure below (Figure 8) illustrates the principle that the systems are in constant dynamic interaction and that psychological interventions (such as hypnosis) operate on multiple levels of the individual's existence.

Figure 8: Ecological subsystems theory: Complex interrelated system



CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

In the final analysis of the data, the researcher is compelled to return to the research question posed at the outset of the study. To what extent do the results of the research answer the research question?

- What are women's experiences of hypnotherapy as psychological support offered during high-risk pregnancy?

The research question has been addressed in full through the study. The experiences of Felicity and Danelle have been described in detail, with reference to the risk factors present in their pregnancies. Their fears, anxieties, hopes and wishes were explored, as well as their experiences of coping or struggling with stress, anxiety and pain. The role of hypnosis as a psychological intervention was explored, and both Felicity and Danelle reported, in considerable detail, their experiences of hypnosis and its effectiveness before, during and after the birth of their babies. Both reported on aspects of the process they found helpful, as well as areas where possible improvements could be made. The information collected from their experiences certainly provides some clear directions for the future uses of hypnosis and hypnotherapy with high-risk pregnancy. Their experiences were also discussed in light of the theoretical orientation of the researcher, as well as existing studies.

7.2 Recommendations

7.2.1 Recommendations regarding the use of hypnotherapy in high-risk pregnancy

From the investigations, results and conclusions of this study, the following recommendations can be made regarding the use of hypnosis in high-risk pregnancy:

- Hypnosis can be a useful psychological intervention to prepare pregnant women for both natural and caesarean-section birth.
- A hypnosis programme should give consideration to the potential risk of a fragmented service and should be comprehensive in supporting the woman during pregnancy, during birth and after birth.
- The woman's partner as an aid in practicing hypnosis should not be underestimated, and the hypnosis programme should invest sufficient energy in ensuring that both the woman and her partner are comfortable in the use of hypnosis.
- Strong emphasis should be placed on the regular practice of self-hypnosis techniques in order to attain a satisfactory level of conditioned responses to the various techniques.
- Monitoring the degree of success attained through the practice of self-hypnosis should take place to identify and mitigate any factors that might interfere with the development of hypnotic skills.
- When scripts are used for self-hypnosis practice, the home language of participants should be considered, since idiosyncratic language differences may interfere with achieving self-hypnosis, which may rely on hypnotic language patterns.
- The decreased anaesthetic risk to mother and new-born baby, as well as greater rapport between the mother and medical personnel, merit the use of hypnosis in pregnancy and childbirth.

- It seems that the general perception of the use of hypnosis with pregnancy and childbirth is that this intervention is appropriate only for natural birth. Public awareness can be raised regarding the use of hypnosis and approaches such as HypnoBirting® with high-risk pregnancy; for example its usefulness with birth through caesarean section, so that more women may have the option of making use of this intervention.
- The use of hypnosis and HypnoBirthing® in pregnancy where no known risks or complications are present can also be recommended, due to the apparent faster recovery of the women, which then also allows for easier bonding with the new-born baby as well as the reduction of fear, which will potentially benefit any pregnant woman.
- Medical personnel can be trained and made aware of the impact of their actions on the woman in labour, since the empathic actions of medical personnel were experienced by the research participants as a significant support system during the pregnancy and birth.

7.2.2 Recommendations for research studies on hypnotherapy

This study provided a much-needed investigation of the experiences of women in high-risk pregnancies. The following recommendations are made for possible follow-up studies:

- Further studies can focus on a specific type of high risk pregnancy (keeping in mind the challenges of recruiting participants).
- A stronger quantitative approach, with a larger sample size of either high-risk or normal-risk pregnancies, can be included in future studies.
- Whilst several studies explored the use of hypnosis with various risk factors in pregnancy, no studies were identified in which hypnotherapy was used with birth through caesarean

section, and Felicity's experiences make it clear that this is an unexplored, but valid, area for further research.

- An unanticipated challenge with this study was identifying participants willing to take part in the study. The public perception of hypnosis remains a challenge and, in future studies, more attention should be paid during the planning phase to ensure that research participants are identified, in order to ensure an adequate sample size.
- Whilst, in this study, both of the main participants underwent the HypnoBirthing® programme, further studies can explore the impact of different hypnotherapeutic approaches.
- Further studies can explore, in more detail, the impact of home practice of the self-hypnosis skills, taught during the programme, to determine how success or failure experienced during practice sessions impacts on the birth experience. If women who struggle with the practice sessions at home are identified early, further interventions or services might be offered as an alternative.
- Further study into the practice sessions at home might also investigate the reasons why some people experience success or failure, so that this can be integrated into the hypnotherapeutic programme from the beginning, to increase the chances of success.

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APPENDIX A

FELICITY'S CASE: INTERVIEW TRANSCRIPTS AND DATA ANALYSIS

Table 9: Felicity: Verbatim transcript of interview and coding

PERSON	VERBATIM TRANSCRIPT	CODING
Researcher	Could you give me an overview of your experience, you did the HypnoBirthing® Programme …	
Felicity	… yes	
Researcher	… and your birth was a caesarean …	
Felicity	… yes	
Researcher	… if you could tell me in broad strokes, how you experienced it. Where did you begin, what did you do, and what did you experience?	
Felicity	I attended the antenatal classes with my midwife [Sr Monique], and from there, I heard of HypnoBirthing, and I was quite interested in what it was, and so I asked Sr Monique what exactly the HypnoBirthing® was. And I quite liked the idea that one won't use any medication if one should then have a natural birth (9:1), and one would use techniques – breathing techniques, visualise, that type of thing. Just to calm yourself and to relax, and so that you don't necessarily	Medication Calm

	have to use medication (9:2), for the baby that is coming. Unfortunately [for me], it turned out to be a caesar. The baby was lying in a bit of a diagonal position for three months … and yes… we had to [do] a caesar in the middle of the night (9:4). And I must say, it really helped me a huge lot to use those techniques. Especially the "slow breathing", I used it a lot, calming myself with only that; and the visualisation, where I thought of other things, didn't concentrate on the machines and the figures and so on (9:3). I did not [inaudible noise]… what the machine and the figures meant.	Risk Calm
	[Switching microphones to improve audio]	
Researcher	So you initially planned for a …	
Felicity	… natural [birth], yes …	
Researcher	But then it …	
Felicity	… due to circumstances, yes …	
Researcher	So the idea with the HypnoBirthing was that you would have a natural birth.	
Felicity	Yes.	
Researcher	If I may ask you again to tell me more – you just spoke of the "slow breathing". Can you remember when it was that this helped you?	
Felicity	When they admitted me to the labour ward when I was in the room, they hooked me up to the machine to take	

	a look. It was especially then that I did "slow breathing". I … as I said … I was so relaxed (9:5) – my husband wasn't even there, only my mom was with me. I was just so calm, there was just such a calmness over me (9:6), and I just did the visualisation all the time and [noise], especially the "slow breathing" where I visualise how I breathe in and break my breath up into parts … from one's head to one's shoulders … I used that a lot in that time. So my whole body was relaxed. I wasn't stressed at all (9:7).	Calm Calm Calm
Researcher	How did it [HypnoBirthing®] help you to be relaxed? What difference did it make?	
Felicity	It made a very big difference because if I had been stressed, I would have wanted my husband with me, and at that stage, I couldn't because he was [out of town] and he was on his way home, but it takes about a day or two to get here (9:8). So I think I would have handled the situation very differently if I had not been so relaxed, definitely (9:10).	Coping without partner Coping without partner
Researcher	It's not as if he could have just jumped into the car …	
Felicity	No, unfortunately not [laughing]	
Researcher	So apart from the physical relaxation, the situation… because your husband was not with you … so it [gave] you that …	
Felicity	… yes, emotionally as well. Definitely.	

Researcher	Tell me a bit more about that. How did it help you emotionally?	
Felicity	Well, I think if I hadn't been … ten to one I would have had post-natal depression at this point because it all builds up, and I did not allow it to do that because when you are in such a situation, you can choose, are you going to remain positive, are you going to make yourself relax, are you going to tense yourself up; that also influences the outcome of your situation. So emotionally it was definitely an advantage [in that situation] as well (9:11).	Calm Coping without partner
	[Inaudible noise]	
Felicity	Well, I suspected that things might happen a bit more quickly than we had thought, and I must say I had prepared myself for that, and I listened to the HypnoBirthing CD probably three times every evening. So I switched it on when I went to bed. When I woke up at midnight, I switched it on. When I woke up again at 3 a.m., I switched it on. So I was just so relaxed, and I just sort-of prepared myself that, things might happen that way, so, yes … (9:12).	Preparation
Felicity	I don't know whether that quite answers the question …	
Researcher	[Nodding "Yes"]	
Researcher	How important do you think it was – you say you	

	listened to the CD very regularly – in other words, you did [your] preparation well. How important do you think that preparation was?	
Felicity	I think it is very important because, even if you don't always hear what the woman [on the CD] is saying, you become so calm, quickly, that you do hear it, and it does go in, yes… listening to the CD definitely helped (9:13).	Preparation
Researcher	[inaudible noise] … do it regularly?	
Felicity	Definitely, yes.	
Felicity	Because it's all positive things that the woman says on the CD, so it… definitely… and she has a very calming voice. That helps.	
Researcher	So you think the preparation is important?	
Felicity	Definitely.	
Researcher	When you arrived … [noise]	
Felicity	Well, my water broke at home. It had probably begun at around 6 o'clock. And I only got to the hospital at about 11 o'clock … so I was relaxed at home, [so much so that] I first packed and unpacked my little hospital bags, so… and I chatted to my husband and told him, "Things are happening now." My mom-and-them came to fetch me, and then we went to the hospital. And there I ... the nurse [Sr Melanie] who helped me at the labour ward, I [spoke] to her … she	

	was very, very friendly and she was just … I could see she was a little … they were very, very busy at the labour ward that night. But she moved quickly and everything, and she was just so calm as she spoke to me, and one thing that I can also say about her is that, because my husband, it was as if she, knew what I was feeling, because since I could not have my husband there, I really wanted to keep my wedding ring on, and … and [crying softly] she allowed me to wear it, so I asked "May I keep my ring on in theatre?" And then she said – even before I could ask her – that we'd keep my ring on, we'd just cover it with masking tape. And um … yes, that also helped me (9:14).	Attitude of medical staff
Researcher	How important do you think the attitude of the staff was?	
Felicity	Very important. It would have made such a big difference if she had been different. She just had such a calming effect on me. Even though I could see that she was busy, and it was only after she had done the internal exam that I realised how quickly things were happening (9:15).	Attitude of medical staff
Researcher	…. And one of the big fears is always physical discomfort and pain. Tell us a bit about that.	
Felicity	I had no pain, so [laughing] ... (9:16).	Pain
Researcher	No [pain]?	

Felicity	None. [Laughing] Nothing. So yes, I can't say much about that, but ...	
Researcher	How do you explain that?	
Felicity	Well, I was very calm, and I did the HypnoBirthing®, and I didn't even really think of pain (9:17). I just knew, my baby is coming now, and I should just focus on that. I really had no pain (9:18). The only pain I had was when they put that thing on my tummy, with one of the contractions, the clip came loose ... I really had no pain at all (9:19).	No pain No pain No pain
	[inaudible]	
Felicity	Yes, I did visualisation in one of the classes where one has to choose a place, and for some or other reason, I thought of the Baviaans Kloof where we sometimes camp. It is a peaceful place, it was as if I was there, but I wasn't really, so it was ... yes.	
Researcher	And after the caesar … [inaudible]	
Felicity	I, as I said, with the caesar, I thought it was just procedure, I didn't even really realise ... someone told me I went into shock. I know I was extremely cold, and they gave me that warm blanket and warm air. And I knew I would have to go to recovery, but I did not realise ... time was just a blur. I did not realise how long I was there for (9:20). But, yes, I was just at peace there, I just relaxed. One of the sisters [Sr Melanie]	Time distortion Attitude of medical staff Calm

	also came and sat with me and chatted with me quite a bit ... (9:21).	
Researcher	What do you think – if you hadn't done the HypnoBirthing® – in what way would it have been different?	
Felicity	I think I would probably have been quite stressed (9:22) – as I said, it [was] my first baby. I didn't really know what to expect, especially with a caesar because I had not wanted a caesar at all (9:23), and on that 2nd of May, the doctor said, "It's going to be a caesar, and it's going to be on the 14th of May, and you just prepare yourself for it." And then, I think I also had peace in my heart that morning, because on the 2nd of May … I have been for an exam that morning, and I think if I had not done the HypnoBirthing®, I would not have accepted the fact that it was going to be a caesar quite so easily. And I think I would have been negative about it (9:24).	Stress Risk Psychological coping Calm
Researcher	[inaudible] ... physical relaxation, and then you also mentioned emotional relaxation. Were they both important to you?	
Felicity	Definitely. Especially the emotional part as well because, because my husband could not be there (9:25). And I think he was more scared than I was because he could not be there. So it was definitely an	Psychological coping

	advantage.	
Researcher	Initially you did the HypnoBirthing® because you were planning a natural birth, but it was nevertheless an advantage for you even though you had a caesar, so it was unplanned use of the HypnoBirthing®.	
Felicity	Well, my midwife [Sr Monique] also taught us about Lavender, and Lavender – I always told the girls in the office, if there's a difficult situation in the office, we just do a quick Lavender – I taught them about the Lavender as well [laughing], so I used it in other places as well, so I would say doing that also definitely helped me (9:26). Before the time already, even though I planned to have a natural birth, I learnt that I could use it in other situations as well, so I am going to go on using it. And I suffer from claustrophobia, so I don't like taking the lift, so now I have to … you know … especially when I have to go to the hospital alone with the baby, I'm going to have to take the lift, so I'm going to Lavender then. So I'm going to … it's something you can use more than once, you can use it multiple times and apply it to other situations as well (9:27).	HypnoBirthing uses HypnoBirthing uses
Researcher	So initially the idea was to use it for a natural birth – and in the end it helped you with the caesar, and you use it in the office ...	

Felicity	[laughing] it's for anything, yes ... if someone makes you angry, you do a quick Lavender ... (9:28).	HypnoBirthing uses
Researcher	So it's something you can [use] at any time ...	
Felicity	... any time, yes ... definitely.	
Researcher	So although it had a specific application initially, you could generalise its use to other situations ...	
Felicity	... definitely ...	
Researcher	... to different …	
Researcher	Is there anything else you can think of, in terms of your experience, that is important to you?	
Felicity	I would say, for yourself just to stay positive and just as with the HypnoBirthing® as well, that ... how can I put it ... you have to accept things as they happen, and it's your attitude towards how things are going to happen, you can choose how you handle it. With the HypnoBirthing® … it just makes it easier because you can use those techniques to choose the positive instead of the negative, and to turn it around just like that, into something which may not be the way you wanted it, but you make it better. That you [aren't] negative about something, that you can change your mind-set. You are in control of your life, basically (9:29).	Psychological coping
Researcher	[inaudible – question to Sr Monique] – Anything important?	

Sr Monique	Clients are also taught time distortion.	
Felicity	I still have no idea, all I know is I was there for a long time because the doctor said – her specific words were "You are always a challenge" [laughing]. So ...	
Sr Monique	You were not aware of the challenges at that moment.	
Felicity	No. I know they had trouble closing me up, and there was a lot of blood, but it …	
Sr Monique	[inaudible]	
Felicity	Yes, so it was just a caesar to me. I thought that was the way it was for everybody. So ...	
Sr Monique		
Felicity	Yes, I was cold and I ... I had operations before with the endometriosis, but then one is under anaesthetic, so ... I did not realise that ... you know ... I thought that was just the way things went. I was very calm then, too (9:30). I was more worried about my mom, that she would pass out in theatre [laughing]	Calm
Felicity	The mask was pressing against her specs all the time, she couldn't breathe properly … [laughing]	
Sr Monique	[Some talk between Felicity and Sr Monique … joking]	
Felicity	It was all a blur. It just felt like a very [long] time before I could hold [my baby] (9:31).	Time distortion
Sr Monique	The reason – the medical team had to do something with the baby.	

Felicity	They let me hold her just quickly ...	
Sr Monique	And of course you were so cold, they tried to warm you up first.	
Felicity	That's the thing yes, they could not put her on me because I had the blanket and the air pipe , so they couldn't put her on me …	
Researcher	Are there any physical complications you can think of where you specifically used the exercises?	
Felicity	Perhaps also during the contractions because the sister [Sr Melanie] told me I was 5 cm dilated already, and I had no pain (9:32).	No pain
Sr Monique	You had transition contractions already. They couldn't understand it. If you had given birth naturally, you'd have been there within an hour.	
Researcher	Is there anything you can think of that works particularly well, before or after the birth?	
Felicity	The breathing definitely and then the visualisation.	
Researcher	Are there times you specifically used them, that you can remember?	
Felicity	The best was when they had just admitted me and hooked up those machines, I was very aware then that I was doing the visualisation – I was in another place. I wasn't really there. I certainly had no pain (9:33).	No pain
Researcher	Is there anything else you can think of that one might do to make these programmes more effective?	

Felicity	Perhaps the marketing thereof. There are many antenatal classes, everyone knows about them, but if I hadn't done the antenatal classes, I would not have known about the HypnoBirthing®. And the numbers, it was just me and one other person who attended the classes. And both of us had caesars in the end, but if more of the women had done it, they would have been able to make things so much easier for themselves (9:34). Especially those who were fortunate enough to have natural births. If I had chosen to have a caesar, I might not have done the HypnoBirthing® (9:35).	HypnoBirthing uses HypnoBirthing uses
Researcher	And you were able to further generalise the exercises and skills to apply them not only to the caesar but even to your work situation ...	
Felicity	Yes ...	
Researcher	And you mentioned that you intend using it in future to overcome claustrophobia ...	
Felicity	Yes ...	
Researcher	What were some of your biggest fears, beforehand, during or afterwards?	
Felicity	Beforehand, I really wanted the baby to turn, and yes, she didn't, so ... My fear was that I would have a caesar because I really did not want another operation. Well, I did make peace with it. And the	

	HypnoBirthing® definitely helped me with that (9:36). And then that the baby should just be normal and will be OK when it gets into the world. And of course that my husband should get there in time. Those three things were most important to me.	caesar/Fear Risk
Researcher	Any good things that you didn't expect or for which you didn't plan?	
Felicity	I thought the HypnoBirthing® would help me be relaxed, but I did not think I would be *that* relaxed (9:37). I wasn't affected at all by the machines, which were next to me all the time. If I had not done the HypnoBirthing®, I would have wanted all the time to know what is this, what are the machines doing, what does this mean ... (9:38).	Calm Other
Researcher	And you say you had no pain?	
Felicity	I had NO pain (9:39).	No pain
Researcher	AND the nursing staff were running around and they thought there was something wrong ...	
	[laughing]	
Felicity	Yes, definitely no pain, no discomfort (9:40).	No pain
Researcher	And afterwards ...	
Felicity	I must say it was very sore, the cut. Not the first day, but afterwards. And the injection in the evening – that was so sore, I could not even roll over for the injections, the sister had to help me roll over ... and	

	also in the middle of the night, with a screaming baby, one has to do like sit-ups to get to her in the crib next to your bed – so I think it [HypnoBirthing®] helped me with that as well (9:41) – the injections also helped – just to be able to handle it.	Managing baby
Researcher	So it [HypnoBirthing®] helped you afterwards as well ...	
Felicity	... Yes	
Felicity	And then also emotionally because, as I said, my husband – she was born on the Friday morning at 1 a.m., and he only got to the hospital on the Sunday evening around 6 or 7 p.m. (9:42). I know I cried a bit on the Saturday when things got a bit much, but I pulled myself out of it because, as I said, one chooses how one feels about a situation, and I used the relaxation techniques and especially the breathing again, in that situation. Just so I could be calm for the rest of the Saturday and the Sunday (9:43).	Coping without partner Psychological coping Coping without partner
Researcher	Is there anything else you can think of, that you think is important for me to know?	
Felicity	No, I think that is all ... I would definitely recommend it to anyone.	
Researcher	Thank you very much.	

Table 10: Felicity: Emergent themes from categories

CATEGORIES	EXAMPLES FROM TRANSCRIPT (DIRECT QUOTATIONS)	THEMES
Coping: Support from partner	It made a very big difference because, if I had been stressed, I would have wanted my husband with me and at that stage I couldn't because he was [out of town], and he was on his way home, but it takes about a day or two days to get here (9:8). So I think I would have handled the situation very differently if I had not been so relaxed, definitely (9:10). Well, I think if I hadn't been … ten to one I would have had post-natal depression at this point because it all builds up, and I did not allow it to do that because when you are in such a situation, you can choose, are you going to remain positive, are you going to make yourself relax, are you going to tense yourself up; that also influences the outcome of your situation. So emotionally it was definitely an advantage [in that situation] as well (9:11). And then also emotionally because, as I said, my husband – she was born on the Friday morning at 1 a.m., and he only got to the hospital on the Sunday evening around 6 or 7 p.m. (9:42).	HypnoBirthing techniques enabled her to cope emotionally in the absence of a critical social-support system. The ability to remain physically calm and relaxed enabled her to have a positive mental mind-set.

	And I used the relaxation techniques and especially the breathing again, in that situation. Just so I could be calm for the rest of the Saturday and the Sunday (9:43).	
Coping: Attitude of the medical staff	She was very, very friendly and she was just … I could see she was a little … they were very, very busy at the labour ward that night. But she moved quickly and everything, and she was just so calm as she spoke to me, and one thing that I can also say about her is that, because my husband, it was as if she knew what I was feeling because since I could not have my husband there, I really wanted to keep my wedding ring on, and … and [crying softly] she allowed me to wear it, so I asked "May I keep my ring on in theatre?" And then she said – even before I could ask her – that we'd keep my ring on, we'd just cover it with masking tape. And um … yes, that also helped me (9:14). Very important. It would have made such a big difference if she had been different. She just had such a calming effect on me. Even though I could see that she was busy, and it was only after she had done the internal exam that I realised how quickly things were happening	Sensitivity to Felicity's vulnerability and an empathic response was experienced as supportive and important to her ability to cope in the absence of her partner. The ability of the medical staff to communicate calmly and display empathy in the

	(9:15). But, yes, I was just at peace there, I just relaxed; one of the sisters [Sr Melanie] also came and sat with me and chatted with me quite a bit ... (9:21).	midst of a busy hospital environment is important to Felicity's ability to remain calm and relaxed and to cope with the emotional distress of not having her partner present.
Coping: Positive impact of HypnoBirthing®	Just to calm yourself and to relax and so that you don't necessarily have to use medication (9:2); And I must say, it really helped me a huge lot to use those techniques. Especially the "slow breathing", I used it a lot, calming myself with only that; and the visualisation, where I thought of other things, didn't concentrate on the machines and the figures and so on (9:3). I was so relaxed (9:5). I was just so calm. There was just such a calmness over me (9:6). So my whole body was relaxed. I wasn't stressed at all (9:7). Well, I think if I hadn't been … ten to one	The use of HypnoBirthing® techniques resulted in physical relaxation and mental calmness. Felicity experienced complete physical

	I would have had post-natal depression at this point because it all builds up, and I did not allow it to do that because when you are in such a situation, you can choose, are you going to remain positive, are you going to make yourself relax, are you going to tense yourself up; that also influences the outcome of your situation. So emotionally it was definitely an advantage [in that situation] as well (9:11). But, yes, I was just at peace there, I just relaxed. One of the sisters [Sr Melanie] also came and sat with me and chatted with me quite a bit ... (9:21). And then, I think I also had peace in my heart that morning because on the 2nd of May … I have been for an exam that morning, and I think if I had not done the HypnoBirthing®, I would not have accepted the fact that it was going to be a caesar quite so easily. And I think I would have been negative about it (9:24). I was very calm then, too (9:30). I thought the HypnoBirthing® would help me be relaxed, but I did not think I would be *that* relaxed (9:37). Definitely. Especially the emotional part as well	relaxation and mental calmness. The relaxation and calmness enabled Felicity to easily accept that she would not give birth naturally and would undergo a Caesarean Section [which is particularly risky for her given her medical background].

	because, because my husband could not be there (9:25). With the HypnoBirthing® … it just makes it easier because you can use those techniques to choose the positive instead of the negative and to turn it around just like that into something which may not be the way you wanted it, but you make it better. That you [aren't] negative about something, that you can change your mind-set. You are in control of your life, basically (9:29). I used the relaxation techniques and especially the breathing again, in that situation. Just so I could be calm for the rest of the Saturday and the Sunday (9:43). Time was just a blur, I did not realise how long I was there for (9:20). It was all a blur. It just felt like a very [long] time before I could hold [my baby] (9:31). If I had not done the HypnoBirthing®, I would have wanted all the time to know what is this, what are the machines doing, what does this mean ... (9:38).	The use of HypnoBirthing® techniques created with Felicity an awareness of positive and negative thoughts, enabling her to take control – experience herself as in control - and subsequently make positive choices. The use of HypnoBirthing® techniques created a sense of time distortion. Focusing on the HypnoBirthing® techniques allowed

		the participant not to be distracted by the medical environment and equipment.
Coping: Dealing with negative emotions	My fear was that I would have a caesar because I really did not want another operation. Well, I did make peace with it. And the HypnoBirthing® definitely helped me with that (9:36). I think I would probably have been quite stressed (9:22).	HypnoBirthing® enabled Felicity to easily accept having to undergo a risky medical procedure of which she was fearful previously.
Coping: Preparation	Well, I suspected that things might happen a bit more quickly than we had thought, and I must say I had prepared myself for that, and I listened to the HypnoBirthing® CD probably three times every evening. So I switched it on when I went to bed. When I woke up at midnight, I switched it on. When I woke up again at 3 a.m., I switched it on, so I was just so relaxed and I just sort-of prepared myself that things might happen that way, so, yes … (9:12). I think it is very important because, even if you don't always hear what the woman [on the CD]	The regular practice of HypnoBirthing® techniques in preparation for the birth experience was a significant factor in the degree of success experienced by the participant.

	is saying, you become so calm, quickly, that you do hear it, and it does go in, yes… listening to the CD definitely helped (9:13).	
Coping: The experience of pain	And I quite liked the idea that one won't use any medication if one should then have a natural birth (9:1). I had no pain, so [laughing] ... (9:16). Well, I was very calm and I did the HypnoBirthing®, and I didn't even really think of pain (9:17). I just knew, my baby is coming now, and I should just focus on that. I really had no pain (9:18). The only pain I had was when they put that thing on my tummy, with one of the contractions, the clip came loose ... I really had no pain at all (9:19). Perhaps also during the contractions because the sister [Sr Melanie] told me I was 5 cm dilated already, and I had no pain (9:32). The best was when they had just admitted me and hooked up those machines, I was very aware then that I was doing the visualisation – I was in another place, I wasn't really there. I certainly had no pain (9:33).	The idea of not using medication appealed to the participant and was a motivating factor in her decision to use HypnoBirthing. For Felicity, the use of HypnoBirthing® virtually eliminated pain and discomfort usually experienced during birth or a medical operation. Instrumental to this was the ability to dissociate from the surroundings and keep her attention

	I had NO pain (9:39). Yes, definitely no pain, no discomfort (9:40).	focused through visualisation and relaxation exercises.
Risk	We had to [do] a caesar in the middle of the night (9:4). It [was] my first baby, I didn't really know what to expect, especially with a caesar because I had not wanted a caesar at all (9:23). My fear was that I would have a caesar because I really did not want another operation. Well, I did make peace with it. And the HypnoBirthing® definitely helped me with that (9:36).	The use of the HypnoBirthing® techniques was successful for Felicity even though she went into labour unexpectedly and medical complications caused her to undergo a caesarean section, which posed additional risks to her. HypnoBirthing® is effective even when labour is unexpected and the

		participant has little time to "get into the mind-set" – it is immediately available to Felicity.
Managing baby	And also in the middle of the night with a screaming baby, one has to do like sit-ups to get to her in the crib next to your bed – so I think, it [HypnoBirthing®] helped me with that as well (9:41)	The techniques helped Felicity with the physical exertion immediately after undergoing a caesarean section and allowed her to care for her baby.
HypnoBirthing®	And I suffer from claustrophobia, so I don't like taking the lift, so now I have to … you know … especially when I have to go to the hospital alone with the baby, I'm going to have to take the lift, so I'm going to Lavender then. So I'm going to … it's something you can use more than once. You can use it multiple times and apply it to other situations as well (9:27). [laughing] it's for anything, yes ... if someone makes you angry, you do a quick Lavender ...	Felicity generalised the techniques learnt for labour and birth to apply them when dealing with a phobia and for relaxation at the office to relieve stress and cope with anger.

	(9:28). I always told the girls in the office, if there's a difficult situation in the office, we just do a quick Lavender – I taught them about the Lavender as well [laughing], so I used it in other places as well, so I would say doing that also definitely helped me (9:26). But if more of the women had done it, they would have been able to make things so much easier for themselves (9:34). If I had chosen to have a caesar, I might not have done the HypnoBirthing® (9:35).	Felicity would not have chosen to use HypnoBirthing® if she did not anticipate having a natural birth – her initial perception was that it was only useful for natural birth.

Table 11: Sr Melanie: Verbatim transcript of interview and coding

PERSON	VERBATIM TRANSCRIPT	CODING
Researcher	What was your role when she (Felicity) came into the hospital?	
Sr Melanie *(Though the interviewer makes use of non-verbal responses – nods of the head, etc. and the participant continues talking).*	OK with her, when she came in, she comes straight up to us first. She comes to the labour ward. She said to me "oh no", that her "waters had broken", her husband wasn't around, and she was quite emotional and upset, but looking at her, it's like any patient who walks in when their water has broken. It didn't look like she was in pain (10:1) or usually you see them when they're really sore. And the first thing that went through my mind was, "Ok, her husband's out of town, ag, she's in control, 24 hours, 48 hours, we can maybe push it till hubby gets here." The she sat down, and I starting monitoring her, and she told me the baby's breeched, and I thought, "Ok well that's not gonna work". This is around midnight, and I thought she is clearly not in labour. Really, you can see it a mile away, she's not in labour. So, we're gonna most likely add it to Andrea's list in the morning. So I palpate, and I felt, and it felt like the baby was lying transverse, which is across, which means she wasn't gonna have a normal birth (10:2), it wasn't gonna	No pain Risk No pain

	happen. So I thought it's not a problem, we will monitor her, and I will not even phone Andrews. We will add it to the list in the morning. This was about 12 'o clock. And then we did, and I asked whether she had any pain, and she said there was no pain (10:3), there was nothing wrong. And really, she didn't look like she had pain (10:4). And then I did her CTG monitoring, and you can see all the contractions she has, and you can see them go up, and I'm like, "Don't you feel these?" (10:5) And I'm trying to figure out are they Braxton Hicks, or what are they? So she said to me, "They're slightly there." But she doesn't really feel them. And I thought she has a good pain threshold, not a problem (10:6). I did the internal, did I get the shock of my life. She was 6 centimetres dilated, fully ephased cervix. I mean if she wasn't in breech, she would have delivered beautifully. It was the shock of my life; I didn't think she was that far. I immediately phoned the doctor and said, "You better get up and get here because this girl is gonna go." If that head was pushing on that cervix, she would have delivered so quickly. She really would have gone so well. So I said to her, "I thought we're going to wait for your husband – there's no way we're waiting for your husband." And then I said to her, "I though we're	No pain observed No pain reported Pain threshold Labouring No pain

	gonna wait for the morning, but there's no way we're gonna wait for the morning. This child's gonna come, and this child's gonna come now." So I phone the doctor, and I said, "You better move it. Because this woman's labouring so beautifully." (10:7) It's actually scary to see the patient's talking to you so calmly, relaxed, and you don't even realize she's actually in labour (10:8). It's actually a bit freaky. It's like, "What am I missing here? I'm missing all my skills here, because this chick doesn't look like she's in labour." And then the doctor came out and because she was just dilating so fast and handling the labour so well, we had to move quite fast to get the baby out. And then we got it out with a caesar because it was in a transverse position. You gotta deliver by a caesarean (10:9). She was calm, relaxed during the Caesar, totally, totally happy. You never saw, I never saw an inch of any indication that she was in labour, any indication that she was in pain, and then out comes the baby, and then everything's fantastic (10:10). And she just look so calm and relaxed (10:11), and I said to her – when she was in the recovery room – "You have got to deliver normally again. If you next child is in a different position, please have a normal birth, because you seem to be handling it so well." And then she said,	Risk No pain Calm Calm Coping with contractions – no pain In control

	"You know, I'm handling it so well because I did the HypnoBirth." She says, "I can feel they're there, but I'm able to cope with them." (10:12) That's when I realized, "Ah, so that's what's happening." Because she was just so well in control (10:13) – you really and truly didn't expect that she was in labour. So that's basically all I had to do with her.	
Researcher	Was this her first baby?	
Sr Melanie	It was her first baby, yes.	
Researcher	Was this different from what you normally see? With a first baby?	
	With a patient with 6 centimetres with a fully ephased cervix … the cervix is still thick, and their waters have broken. Usually when they come in and say their waters have broken, they say they've got no pain, which she said, they're usually fine. When they're 6 centimetres dilated, they're usually panting, or at least jumping the roof and panting. They say, "It's really sore", and we should do something about that. (10:14) Especially considering the cervix is so thin, which means she'd been having the contractions for quite a while (10:15), because usually the cervix thins first and then opens, so it had thinned and opened so much. And it means that she'd been having these contractions for quite a while. And, you didn't realize	Surprise at no pain No pain during contractions

	it. And usually the patients who come in like that are half jumping off the roof or saying, "I need an epidural" or saying, "Get me something for pain" or, "Hurry up and get the caesar going", or "Do something". And for her, it was like, you know, if we can wait for the morning that's fine. I'm happy to wait for the morning. But obviously, I mean when you did the internal, you realized you couldn't wait. I mean, she really, she's like, "No, this is fine, this isn't sore, I got no problems with it," (10:16). And er, really every other patient that will come through the door is practically screaming at me and usually come flying in on wheelchairs like mad things, and I mean, she walked into the ward, she said she wanted to go to the bathroom first. She was totally comfortable, calm and relaxed. (10:17) The only thing that was a little bit upsetting for her was that her husband couldn't be there, but that was just quick, quick, and then she was fine again. It wasn't like she was in pain. You could see she was disappointed that her husband couldn't be there for the birth (10:18) because he was out of town. But her mom was with her, and I mean, seriously, I didn't expect it. I really and truly didn't expect it. She shocked all of us because we all expected huffing and puffing. Usually when they're that far, they're usually	No pain reported Calm Coping without partner Surprise at no pain

	screaming for some type of pain relief. (10:19) It was a nice surprise.	
Researcher	So the one major aspect was the pain management …	
Sr Melanie	(Nods yes)	
Researcher	… leading up to everything, and then with the c-section, was there any unusual or different from what you would expect?	
Sr Melanie	With the caesarean section, she was so calm because it happened so fast. Usually when you get the emergency caesars and you go so quickly, we walk so fast, and usually they get a little of panic wobble; she didn't have that panic wobble. (10:20) You know, they usually get to that stage where, "This is too much for me, I can't cope; I need you to slow down or something." (10:21) And we usually have to say to them, "Mom, we're gonna attack you, just bear with us, you know, but we've gotta do this." And with her we never had to say that to her. She just took everything as it came, and that was fine (10:22). You could see when she …. And because of the caesarean because the baby was lying in the transverse position, it's one of your more difficult caesarean sections (10:22) because they have to turn the baby in the right position first and then deliver the baby. Whereas if you do a normal standard caesar, it's much quicker	No panic/anxiety Coping Coping Risk

	because you cut – there's the baby's head, its wham bam thank you ma'am. Whereas with her, the baby's head was lying skew so they had to try and see if they could get the bum first or the head first, but something had to come first. Because you're cutting, and you're cutting actually into nothing, there's no pressure or anything there, so it's a bit more complicated caesar. And then, and she handled it so well (10:23). The patient will still complain about the pushing and tugging and pulling, and then she never even complained about that, and then, the most calm, relaxed, happy, patient that there was (10:24). And she's just ecstatic with everything, I mean, you really don't see that. Also the nursing staff when I went afterwards, when I checked up on her, they said she hardly ever asked for pain relief (10:25). They kind of had to force her and say, "Look, you gotta have something." But she didn't seem to want pain relief or anything; she just handled everything beautifully (10:26).	Pain / Coping Calm No pain Recovery No pain relief wanted Recovery
Researcher	If I can stay with the c-section, so it was a more complicated …	
Sr Melanie	(Nods yes)	
Researcher	…c-section than it normally would be. How does this normally affect people? Does it normally make a	

	difference, or …	
Sr Melanie	It depends on the person. Some people handle it well, but most tend to … I usually say to the patient, "If you go through a difficult time, rather go and see someone, for counselling afterward." If… just a bit post-traumatic stress, because everything doesn't go according to what they want. So then I say to them, "Look, if you need to speak to someone, here's a few names, rather phone them if you're not sure." Because they didn't have the ideal birth. It wasn't the perfect little birth you wanted. And I know for her, she desperately wanted a normal birth. But she didn't show any indication of someone who's gonna struggle with (10:27) … afterwards that's gonna need assistance for counselling because she just took everything in her stride, everything just happened so well. She was so calm and even afterwards, she was just perfect (10:28). So, I mean there was nothing that would give us an indication that she would need extra counselling (10:29). Because she was just this calm, relaxed, mother earth woman … just calm and everything.	Psychological coping Psychological coping Calm Psychological coping
Researcher	And recovery? Anything … different?	
Sr Melanie	I know that they said she handled the breastfeeding quite well (10:30), that you know usually the first-time	Breastfeeding

	moms are quite panicky about the breastfeeding, and not always sure. I mean you get very few children … I know they say it's a process … but you get very few babies that latch beautifully and off they go. But for her, she was just so calm and relaxed (10:31) that the baby just attached beautifully and everything was just perfect (10:32). You couldn't ask for a better birth experience. You couldn't ask for better breastfeeding. She was a patient that you hardly even knew she was in the ward. She never called anyone, she never needed assistance. Everything just went beautifully for her. And she said when I spoke to her, she said because she knows, and she tries to calm herself if she gets upset, and you don't even realize that she's getting upset, or you don't even realize, anything … she's just this picture of calmness (10:33). Really amazing.	Breastfeeding Baby Psychological coping
Researcher	Did you talk to her about that?	
Sr Melanie	I spoke to her about, "How did you handle the labour so well?" Because I wanted to know how the hell this woman handled it so well. So I just spoke to her more about the labour aspect. I didn't speak to her so much about the postbirth aspect - how she's handling it so well. But I spoke more to her about how she handled the labour and all the other aspects, you know, more	

	the labour and the caesar, how she managed to handle it so well.	
Researcher	Ok.	
Sr Melanie	And then [she] mentioned to me that she had done HypnoBirth for in case the baby had turned so that she could have a normal birth (10:34).	HypnoBirthing®
Researcher	Ok.	
Sr Melanie	Because that was her ultimate goal, to have a normal birth with HypnoBirthing®. So when I spoke to her, she said that she had done the HypnoBirthing®, hoping that the baby would turn (10:35). And yet it still managed to help her so well, and that's why she managed everything so well because she had had that training.	HypnoBirthing®
Researcher	Ok. So it seems that even though people go for the HypnoBirthing® because they want a normal birth. In her case even though she underwent a c-section, it was still useful to her?	
Sr Melanie	Yes, it was definitely an added benefit, you could see it (10:36). I mean, you ask the postnatal staff how your patients are doing. I always ask them, and they said, "You don't even know she's there." She's just so calm and just so natural with the baby (10:37), and …	Caesarean section Baby Calm
Researcher	mmm	
Sr Melanie	…you don't even know she's there. You just walk into	

	the room and then suddenly she's there, kind of thing. She's just this happy, calm patient. And I mean especially for her being an emergency situation (10:38), I mean any baby, I mean with her when her water broke, she didn't even expect it to break. I mean you can have your booked caesars but you do get your emergency caesars. So that was a huge advantage that she was able to be calm, being relaxed. And with being so calm and relaxed, it gives so much extra boost to the baby because it gives them extra oxygen, it's less adrenaline, and it helps that baby so much more (10:39). Because if you have a stressed out mommy, you have a stressed out baby (10:40). And then you have problems later on. Now with her being so relaxed, there was extra oxygen going to baby, there's no adrenaline going to baby, baby's heart wasn't tachycardiac, so everything was just the ideal situation (10:41). It was almost like she just came in for a normal booked caesar because she was so calm and relaxed (10:42).	Calm Emergency Baby Calm / Baby Baby / Calm Calm / Caesarean Section / Baby Calm
Researcher	So in this case, the caesar wasn't booked, it was an emergency …	
Sr Melanie	Yes. It was an emergency; it was done about 1 o'clock in the morning. It was definitely an emergency situation.	

Researcher	Did she have a c-section planned anyway?	
Sr Melanie	If the baby hadn't turned.	
Researcher	So it was anticipated that she probably would have a c-section anyway, if the baby didn't turn …	
Sr Melanie	Yeah. Baby hadn't completely turned, so what they were planning on doing at round about 38 weeks is to see if Doctor could turn the baby, if not, do a C-Section at 39 weeks. And if I remember correctly, she came in at around 3 weeks. So, I mean, it obviously happened before the time.	
Researcher	What would be the risks in a situation like this? If you had to list them, so that you could say what the risks are? And which of the risks were reduced because of the HypnoBirthing?	
Sr Melanie	The thing is if you had to look at the risks, I mean so much could have gone wrong. Really so much could have gone wrong. I mean, with lying in a transverse position, a transverse position we don't see often. With the baby lying in a transverse position, the cord could have slipped through, which means you could have had a cord presentation, which means we could have lost the baby – because the cord slides through. But with HypnoBirthing®, she was so calm, and she knew, "This is what I gotta do", and she wasn't an out of control patient. And you could do an internal	Calm Risk

	properly on her (10:43). Usually the patients will be panicky, and they're upset, and they're stressed, and they're like, "I'm a caesar, why do you want to do an internal?" Whereas she was, no she understands, and she was calm, and she knew exactly what was happening. And it was a high-up rupture with her, not a low rupture of the membrane, so therefore that membranes were still there. So at least that prevented that cord. Because she was so calm, we could see everything's alright here, the baby, there's definitely no cord prolapse happening here. So that was all a huge benefit. I mean, we could have lost the baby at the end of the day. So that's a massive benefit with it. Also, being so in control with the situation, not the panicking, not the stressing, that all helps the situation (10:44). What other risks could there be with a caesar? It's obviously, with this being a difficult position, the patients often … We've had one or two transverses this year. The patients become so anxious when they've got to flip the baby (10:45) that it actually puts the body into spasm (10:46) although they say, "I'm not supposed to be feeling pain, why am I feeling pain?" The doctors actually give them Dormicum just to deal with that because it's in such a difficult position to turn that baby, whereas we didn't have to	In control Panic/anxiety Panic Risk Calm Medication use

	do that with her – because she was calm, the muscles were fine, everything was relaxed, and the doctor could successfully turn the baby without having the mom panicking and having to give Dormicum (10:47). Because that's really a very uncomfortable position to turn the baby. So I mean that's another risk because if your mom stresses out and all your muscles contract, then it can actually tighten around the baby and then it's difficult for the doctor to turn it (10:48) because it's not your normal position. It's not like a breech or a vertex presentation, it's definitely, with a transverse, your uterus, your abdominal muscles, everything could contract around the baby, and then you're in trouble. And with her being so relaxed, we didn't have to give Dormicum, so the baby, we could turn it easily and deliver the baby easily (10:49).	Calm Risk Medication use Calm
Researcher	So she had very few drugs at the end of the day?	
Sr Melanie	Very few. Absolute minimal (10:50).	Medication use
Researcher	Anything important about the baby's health?	
Sr Melanie	She was just a very happy baby (10:51). Usually when you have a "ruk en pluk" baby, you've got to move fast and get that baby out fast. They become very irritable, like the very first few hours, we say to the mom, "Don't stress, they'll get over it, it's a bit of a shock for them." But that baby was the just the	Baby Baby Family unit

	calmest happiest thing ever (10:52). The whole little family unit was so calm (10:53). Because usually the babies, when they go through that type of birth, they're irritable, they're frustrated, they're niggly, they never really settle – they take a while. And then usually after 24 hours to 48 hours, they start to settle. But with her, she never really needed that. The baby was calm, it was fine, it drank fine, there was nothing that said we need to watch this child (10:54).	Baby
Researcher	And that's not normally what you'd expect to see in a situation like that?	
Sr Melanie	No. You'd expect to have a little bit of an irritated child. An upset little irritable baby for a while, usually, at least minimum 12 hours. Even to the extent that their blood glucose can go into a stress level because it's a difficult delivery. The baby's blood glucose was fine (10:55). It was fine throughout, so there were no problems there.	Baby Risk
Researcher	And you said, you did check up on her afterwards? And her recovery was …	
Sr Melanie	It was beautiful. There was really nothing at all. I mean she had the minimum of anything. She was absolutely happy (10:56). I mean, you could almost discharge her the next day; she was so well (10:57). But I mean, obviously we keep them in. She could	Recovery Coping Recovery

	have gone home if she wanted to, she was doing so well.	
Researcher	Doing well in terms of … psychologically? Or anything physical that was different from what you'd normally expect?	
Sr Melanie	She was more mobile. She was up and about. You know, usually you have to convince the patients to get out of the bed (10:58). And usually you have to say to them, "It will get better, just keep moving, you will get better." With her, she was up, she was about, there were no problems with it at all. She didn't really show that she has pain (10:59). She didn't show any aspects of having pain. Psychologically, even though she didn't have her husband there, she was still happy. Usually if they don't have their husband there, the whole world falls apart, and they're upset for days about it because they now missed the situation, and she'd said to me, "Ag, it's fine." Her mom was there, it's alright, "Dad's here on Sunday." Usually that's upsetting for them, and it just makes everything worse and worse and worse. But for her, it was like, "No, it's fine." And everything…she was just this picture of relaxation (10:60).	Recovery Recovery Pain Calm
Researcher	How may births or c-sections have you been with, where you've seen this kind of patient, where they are	

	that calm, that relaxed, recover that well, where the baby is that calm?	
Sr Melanie	You know, her situation was very unique because of the transverse presentation. But now let's say, it wasn't a transverse situation, if you take away the transverse … how she reacted to the whole situation, maybe one to two a year. If you're lucky, and we average about 100 caesar births per month, round about, there's about 100 to 120 per month. And maybe you'll get one or two a year that are that calm – without giving them Dormicum (10:61).	Medication use
Researcher	So, how many do you physically attend yourself?	
Sr Melanie	Anything from seven a day to three a day. It's very varied.	
Researcher	So an average of three a day … just trying to get an idea of percentage wise … in your experience, how many cases like this do you see?	
Sr Melanie	That are so calm?	
Researcher	Well. Where everything …	
Sr Melanie	Well the thing is I do know that we spoke, the other midwifes and I, about it because the other midwives also mentioned that they'd seen that she was so calm. So I spoke to them about it, and none of them that I know about had experienced this either. So like I said, we see it if they have Dormicum inside of them.	

	Literally, it's like one every six months.	
Researcher	So what she was doing was a lot like you would see with patients with Dormicum?	
Sr Melanie	Hmmm (nods yes). Dormicum just helps them, calms them, relaxes them, and it just like kind off puts them in plug. It just takes them out of the pain and the situation. Although theoretically, we don't like to give much Dormicum because it passes on to the baby, then your baby's also lazy. So we only use it if we really have to – that's with the really stressed-out patients (10:62). But I mean that's what you see, like she had, with the Dormicum they're just calm, they just lie there, and they're totally relaxed, and the Dormicum just really relaxes them and takes all their anxiety away.	Baby Risk
Researcher	And normally a case like this, would you expect that you would have to give Dormicum?	
Sr Melanie	Most likely. Because it's a very stressful situation, and yet she didn't need it (10:63).	Medication use Calm
Researcher	Anything else you can think of, that you think might be important?	
Sr Melanie	I just wish more patients would do it (10:64). It would make our lives so much easier, especially from the labouring perspective. The people see more and more that we must do everything to take the pain away, you	HypnoBirthing®

	know what I mean – take the pain away, do whatever you have to, put up an epidural, do everything. And then they say to you, "If you don't put up an epidural to take this pain away, I want a caesar." And they don't realize afterwards you're gonna have the pain. So I just wish more labouring patients would do it so that they realized, this will calm you, it will relax you and just so much of the after effects – it will bring down their blood pressure, it will calm them down, it will help their labour progress (10:65). Because when you're stressed, your labour slows down, so that's probably also why she was labouring so fast (10:66). Because the minute you're stressed, that labour, you can forget about it, the cervix tightens up, and we actually end up giving you, the labouring patients, Atarax to try and calm them so we can get the labour going. Because it like, gets to a halt. Because they're so stressed (10:66). So I actually wish that more labouring patients would be using it, so we can have that outcome that she had – obviously the caesar was not the ideal outcome - it's a transverse, you could do nothing. But her labour process, you wish that you could take that and transfer it to our patients that are actually going for normal birth. That would make a massive difference. You would have fewer epidurals	HypnoBirthing® Risk Panic / anxiety Medication HypnoBirthing® Pain

	and stuff like that (10:67). Because that's what all the patients want nowadays, they want an epidural because they don't want pain (10:68). I mean if it was like her, she didn't experience any pain – that I would love to put onto a labouring patient.	
Researcher	Thank you.	

Table 12: Sr Melanie: Emergent themes from categories

CATEGORIES	EXAMPLES FROM TRANSCRIPT (DIRECT QUOTATIONS)	THEMES
Coping: Calm and relaxed	She was calm, relaxed during the caesar, totally, totally happy, you never saw, I never saw an inch of any indication that she was in labour, any indication that she was in pain, and then out comes the baby, and then everything's fantastic. (10:10) And she just look so calm and relaxed. (10:11) She says, "I can feel they're there, but I'm able to cope with them." (10:12) She was totally comfortable, calm and relaxed. (10:17) [when she came into the ward] And then, the most calm, relaxed, happy, patient that there was. (10:24) [during caesar] She was so calm and even afterwards, she was just perfect (10:28). [referring to psych coping] She's just so calm and just so natural with the baby. (10:37) She's just this happy, calm patient. And I mean especially for her being an emergency situation. (10:38) A huge advantage that she was able to calm,	Felicity displayed remarkable calmness and relaxation, and this ability also allowed her to cope psychologically during the emergency situation.

	being relaxed, and with being so calm and relaxed, it gives so much extra boost to the baby because it gives them extra oxygen, its less adrenaline, and it helps that baby so much more. (10:39) If you have a stressed-out mommy, you have a stressed-out baby. (10:40) With her being so relaxed, there was extra oxygen going to baby, there's no adrenaline going to baby, baby's heart wasn't tachycardiac, so everything was just the ideal situation. (10:41)	The ability to remain calm and relaxed was beneficial to the health of the baby during the delivery.
	Really so much could have gone wrong. I mean, with lying in a transverse position, a transverse position we don't see often. With the baby lying in a transverse position, the cord could have slipped through, which means you could have had a cord presentation, which means we could have lost the baby – because the cord slides through. But with HypnoBirth, she was so calm and she knew, "This is what I gotta do", and she wasn't an out of control patient. And you could do an internal properly on her. (10:43) Doctors actually give them Dormicum just to deal with that because it's in such a difficult position to turn that baby, whereas we didn't	The position of the baby presented a rare complication for birth which necessitated an emergency caesarean section while, at the same time, the mother (Felicity) had a medical condition which increased risk during a medical operation.

	have to do that with her – because she was calm, the muscles were fine, everything was relaxed, and the doctor could successfully turn the baby without having the mom panicking and having to give Dormicum. (10:47) That's another risk because if your mom stresses out and all your muscles contract, then it can actually tighten around the baby and then it's difficult for the doctor to turn it. (10:48) With her being so relaxed, we didn't have to give Dormicum, so the baby we could turn it easily and deliver the baby easily (10:49). She was just this picture of relaxation. (10:60) [recovery] Most likely. Because it's a very stressful situation, and yet she didn't need it. (10:63). [didn't need meds to calm down]	The risks were, therefore, significant. Felicity's physical relaxation and calmness prevented the use of medication to calm her down during the emergency. If she was not calm and relaxed, this could have complicated the delivery, necessitated the use of medication and also impacted negatively on the baby's health. The ability to remain calm and relaxed, therefore, greatly reduced risk during

		the emergency.
Coping: Psychological coping	She was disappointed that her husband couldn't be there for the birth. (10:18) They usually get to that stage where, "This is too much for me, I can't cope, I need you to slow down or something." (10:21) [there was the absence of this panic] She just took everything as it came, and that was fine. (10:22) [during the Caesar] She didn't show any indication of someone who's gonna struggle with. (10:27) [referring to trauma, needing psychological counselling afterward] She was so calm and even afterwards, she was just perfect. (10:28). [referring to psych coping and trauma] There was nothing that would give us an indication that she would need extra counselling. (10:29). She tries to calm herself if she gets upset, and you don't even realize that she's getting upset, or you don't even realize anything … she's just this picture of calmness. (10:33) She had the minimum of anything, she was absolutely happy. (10:56) [in recovery]	A birth experience that is too overwhelming may result in psychological trauma, which could manifest as postnatal depression. Felicity's ability to cope with the situation so exceptionally well reduced the chances that she would suffer psychological trauma, and no indication was observed that the experience was traumatic for her.

Coping: Experience of pain and medication	It didn't look like she was in pain. (10:1) I asked whether she had any pain, and she said there was no pain. (10:3), She didn't look like she had pain. (10:4) "Don't you feel these?" [contractions] (10:5) And I thought she has a good pain threshold, not a problem. (10:6). It's actually scary to see the patient's talking to you so calmly, relaxed, and you don't even realize she's actually in labour. (10:8) She was calm, relaxed during the caesar, totally, totally happy, you never saw, I never saw an inch of any indication that she was in labour, any indication that she was in pain, and then out comes the baby, and then everything's fantastic. (10:10) She says, "I can feel they're there, but I'm able to cope with them." (10:12) Usually when they come in and say their waters have broken, they say they've got no pain, which she said, they're usually fine. When they're 6 centimetres dilated, they're usually panting or at least jumping the roof and panting. They say, "It's really sore", and we should do something	Felicity's ability to eliminate pain through the use of HypnoBirthing techniques was surprising and exceptional to the medical staff, to the point of being frightening and creating some fear that something could be wrong. Felicity's degree of relaxation, calmness and absence of pain

	about that. (10:14) Which means she'd been having the contractions for quite a while. (10:15), She's like, "No, this is fine, this isn't sore, I got no problems with it." (10:16). [referring to the internal examination] She shocked all of us because we all expected huffing and puffing – usually when they're that far, they're usually screaming for some type of pain relief. (10:19) And she handled it so well (10:23). [during the caesar, referring to pain, tugging and pulling] hardly ever asked for pain relief (10:25) [in recovery] She didn't seem to want pain relief or anything, she just handled everything beautifully. (10:26) [in recovery] She didn't really show that she has pain. (10:59) [in recovery while moving about] They want an epidural because they don't want pain. (10:68) [what people want nowadays]	was exceptional and not representative of a typical case of labour. The medical staff were completely surprised by her ability to eliminate pain and even offered her pain medication which she mostly declined.
Coping: Use of medication	Doctors actually give them Dormicum, just to deal with that because it's in such a difficult position to turn that baby, whereas we didn't	Often medical staff have to administer medication to

	have to do that with her – because she was calm, the muscles were fine, everything was relaxed, and the doctor could successfully turn the baby without having the mom panicking, and having to give Dormicum. (10:47) With her being so relaxed, we didn't have to give Dormicum, so the baby we could turn it easily and deliver the baby easily. (10:49). Very few. Absolute minimal. (10:50) She had the minimum of anything, she was absolutely happy. (10:56) [in recovery] If you're lucky, and we average about 100 caesar births per month, round about, there's about 100 to 120, per month; and maybe you'll get one or two a year that are that calm – without giving them Dormicum. (10:61). Most likely. Because it's a very stressful situation, and yet she didn't need it. (10:63). [normally they would have given meds] The minute you're stressed that labour, you can forget about it, the cervix tightens up, and we actually end up giving the labouring patients Atarax to try and calm them so we can get the labour going. Because it like, gets to a halt because they're so stressed. (10:66).	patients in order to reduce pain to allow them to cope with labour and birth. Felicity, however, experienced hardly any pain, and declined most medication offered, only accepting some medication after the caesarean section, but still less than what was offered to her.

Coping: In control	Because she was just so well in control. (10:13) Being so in control with the situation, not the panicking, not the stressing, that all helps the situation. (10:44)	Feeling in control reduces panic and stress and allows for an overall better experience.
Coping: Recovery	Hardly ever asked for pain relief. (10:25). She didn't seem to want pain relief or anything. She just handled everything beautifully. (10:26). She had the minimum of anything, she was absolutely happy. (10:56) [meds in recovery] You could almost discharged her the next day, she was so well. (10:57) She was more mobile. She was up and about. You know, usually you have to convince the patients to get out of the bed. (10:58). She didn't really show that she has pain. (10:59) [in recovery while moving about]	Felicity declined most medication offered to her, accepting only the minimum amount needed after the caesarean section. Her recovery was remarkably quick, faster than most patients undergoing a caesarean section.
Coping: Family unit	The whole little family unit was so calm. (10:53).	Felicity's ability to remain calm and relaxed also allowed the rest of the family to remain calm.

Risk	The baby was lying transverse, which is across, which means she wasn't gonna have a normal birth. (10:2) And then we got it out with a caesar. Because it was in a transverse position, you gotta deliver by a caesarean. (10:9) Because the baby was lying in the transverse position, it's one of your more difficult caesarean sections. (10:22) Really so much could have gone wrong. I mean, with lying in a transverse position, a transverse position we don't see often. With the baby lying in a transverse position, the cord could have slipped through, which means you could have had a cord presentation, which means we could have lost the baby – because the cord slides through. But with HypnoBirth, she was so calm, and she knew, "This is what I gotta do", and she wasn't an out of control patient. And you could do an internal properly on her. (10:43) That it actually puts the body into spasm. (10:46) [anxiety when flipping the baby] That's another risk because if your mom stresses out and all your muscles contract, then it can actually tighten around the baby and then it's	The risk to the patient (Felicity) was significant. The operation is described by medical staff as more complicated (and therefore risky) than usual, and the patient had a medical condition which further complicated matters. If Felicity was not so calm and relaxed, it could have made it

	difficult for the doctor to turn it. (10:48)[which didn't happen] Even to the extent that their blood glucose can go into a stress level because it's a difficult delivery. The baby's blood glucose was fine. (10:55) We don't like to give much Dormicum because it passes on to the baby, then your baby's also lazy. So we only use it if we really have to – that's with the really stressed-out patients. (10:62) The minute you're stressed that labour, you can forget about it, the cervix tightens up, and we actually end up giving the labouring patients Atarax to try and calm them so we can get the labour going. Because it like, gets to a halt. Because they're so stressed. (10:66).	difficult for the doctor to deliver the baby. Her ability to remain calm and relaxed, therefore, aided in the delivery of the baby through a Caesarean Section.
Risk: caesarean section	It was definitely an added benefit, you could see it. (10:36) [having done HypnoBirthing® in the hope of a normal birth] With her being so relaxed, there was extra oxygen going to baby, there's no adrenaline going to baby, baby's heart wasn't tachycardiac, so everything was just the ideal situation. (10:41)	While HypnoBirthing® would have greatly aided in a natural delivery, it also helped significantly in this case with the

		caesarean section.
Risk: Emergency	She's just this happy, calm patient. And I mean especially for her being an emergency situation. (10:38)	Felicity remained calm and relaxed, even though it was an emergency.
Managing baby	The baby just attached beautifully and everything was just perfect. (10:32). She's just so calm and just so natural with the baby. (10:37) A huge advantage that she was able to calm, being relaxed, and with being so calm and relaxed, it gives so much extra boost to the baby because it gives them extra oxygen, its less adrenaline, and it helps that baby so much more. (10:39) If you have a stressed out mommy, you have a stressed out baby. (10:40) With her being so relaxed, there was extra oxygen going to baby, there's no adrenaline going to baby, baby's heart wasn't tachycardiac, so everything was just the ideal situation. (10:41) She was just a very happy baby. (10:51) Usually when you have a "ruk en pluk" baby, you've got to move fast and get that baby out fast. They become very irritable, like the very	Felicity's ability to remain calm and relaxed had both physical and psychological benefits for the baby.

	first few hours. We say to the mom, "Don't stress, they'll get over it, it's a bit of a shock for them." But that baby was the just the calmest happiest thing ever. (10:52) The baby was calm, it was fine, it drank fine, there was nothing that said we need to watch this child. (10:54) Even to the extent that their blood glucose can go into a stress level because it's a difficult delivery. The baby's blood glucose was fine. (10:55) We don't like to give much Dormicum because it passes on to the baby, then your baby's also lazy. So we only use it if we really have to – that's with the really stressed-out patients. (10:62)	
Managing baby: Breastfeeding	They said she handled the breastfeeding quite well. (10:30) She was just so calm and relaxed. (10:31)	Felicity's ability to remain calm and relaxed allowed her to breastfeed well.
HypnoBirthing®	She had done HypnoBirthing® for in case the baby had turned so that she could have a normal birth. (10:34). She said that she had done the HypnoBirthing®,	The medical staff

	hoping that the baby would turn. (10:35). I just wish more patients would do it. (10:64) So I just wish more labouring patients would do it. So that they realized, this will calm you, it will relax you and just so much of the after effects – it will bring down their blood pressure, it will calm them down, it will help them labour progress. (10:65) You would have fewer epidurals and stuff like that. (10:67)	would prefer that more women do HypnoBirthing® because of the benefits of reduced blood pressure, relaxation, helping with labour progress, and fewer epidurals and medication.
HypnoBirthing®: Labouring	Labouring so beautifully. (10:7)	

Table 13: Sr Monique: Verbatim transcript of interview and coding

PERSON	VERBATIM TRANSCRIPT	CODING
Researcher	Briefly describe your qualifications and professional experience.	
Sr Monique	I am a HypnoBirthing® educator trained in the Mongan Method November 2011. Since then I have used the training to teach small classes. I have also used it at births and to help moms with fears during the pregnancy and minor ailments such as heartburn etc.	
Researcher	Briefly describe – as you would to a member of the public – what it is that you actually do (in relation to Hypnotherapy/HypnoBirthing® with pregnant women).	
Sr Monique	I teach moms to use self-hypnosis to enable calm and comfortable birth and pregnancy.	
Researcher	Please provide an estimate of the number of clients you have seen with Hypnotherapy/HypnoBirthing® as primary method of intervention.	
Sr Monique	21 patients for birth. I have used it with patients suffering with heartburn, fears in pregnancy and postnatally (11:1).	HypnoBirthing® uses
Researcher	In your own practice, what are the experiences of	

	women making use of HypnoTherapy/HypnoBirthing® during the pregnancy and birth? You can talk about this in general, but if possible, please also refer especially to high-risk pregnancies.	
Sr Monique	They have found it very useful. Some of them have surprised me by tailoring it amazing in situations of crises that was not foreseeable at the time of the teaching/course. Felicity was one such a patient. (11:2) She was able to adjust what she was taught to keep her calm when she lost a great deal of blood during her c-section due to endometriosis scars (11:3).	HypnoBirthing® uses HypnoBirthing® uses
Researcher	What are their hopes and wishes about their pregnancy and birth? (This is your own observation or experience of this – the things that they talk about with you).	
Sr Monique	I think the biggest hope and dream for a high-risk pregnancy is a healthy baby and mom (11:4). They also talk about the stress of the situation. I think decreasing the stress is an important goal (11:5).	Hopes and expectations Stresses and fears
Researcher	What are their fears and anxieties about their pregnancy and birth? (This is your own observation or experience of this – the things that they talk about with you).	
Sr Monique	They talk about being in a position where they do not	Stresses and fears

	have control (11:6). While they may perceive it as control of the situation, in reality, the only control we do have is over ourselves and our responses, perceptions, physical reactions, etc.	
Researcher	What have you found to be especially helpful to them?	
Sr Monique	The fear release script, also the deepening scripts where you teach them to use a keyword (of their choice) to help them calm themselves and their body down (11:7). Also practicing the breathing and the rainbow relaxation cd every day helps them to go deeper quicker (11:8).	Helpful Helpful
Researcher	What is your own experience of the use of Hypnotherapy/HypnoBirthing® as psychological support to women/couples during their pregnancy/birth?	
Sr Monique	It is a wonderful skill that enables calmer mothers to manage pregnancy and birth far more capably. It also becomes a life skill (11:9).	Calm Psychological support
Researcher	In your own observation of women/couples who make use of Hypnotherapy/HypnoBirthing®, what do they find helpful, or not helpful, during this process?	
Sr Monique	The calming techniques, the breathing is a great help (11:10). Many of the normal birth patients give birth	Psychological support

	quickly (11:11).	Calm Birth
Researcher	What is your own experience/observation of the *effectiveness* of Hypnotherapy/HypnoBirthing® in dealing with high-risk pregnancy or physical/medical complications during pregnancy/birth?	
Sr Monique	It enables the mom to control her pulse and adrenaline, in other words, to avoid the fight and flight response (11:12). This is of significance for her and the baby in a high-risk situation and can make the difference between a life or death result for foetus and mother. Decreasing the pulse to a normal rate also contributes to both mother and baby not losing blood as quickly during a bleeding incident (11:13).	Helpful Risk
Researcher	Please describe how you made use of Hypnotherapy/HypnoBirthing® with the relevant client. You may include your own experiences – your own thoughts, feelings and observations during this process. Also include comments about your client's responses, the effectiveness of the treatment/intervention or anything that you think may be important. Please write in conversational style, as if you are having a casual conversation with someone, without editing your thoughts or comments. Tell it in the form of a start, from beginning to end, adding as	

	much or as little detail as you are comfortable with.	
Sr Monique	Felicity prepared for a normal uncomplicated birth (11:14). Looking at her history of endometriosis, bleeding and procedures, I now realize that this was very positive thinking on her part. She also realized that her husband was possibly going to miss the birth (11:15). We proceeded normally with all the classes. I taught her the relaxation, breathing and then deepening techniques. I taught her how to use self-hypnosis and to use words to induce it quicker or to come back to awareness quickly. We did the fear-release exercise. She never shared what those was (they are not asked). She was very calm and her confidence grew. She practiced every day and night to go to a calm state, deepening and how to manage her contractions (11:16). We did the Esdaile state scripts, and she did very well with this. She was so confident and calm and very ready for birth (11:17). Going into labour, she experienced no pain whatsoever (11:18). Her husband was out of the country as she prepared herself for birth. Her mother took her to the hospital. She realized that the baby was in transverse lie, and when the doctor arrived and realized that she was dilating very quickly with a transverse lie (with risks of cord prolapse etc. looming), she remained perfectly	Hopes and expectations Negative expectation Preparation Calm No pain Risk / Calm Calm

	calm (11:19). I saw her in hospital the day after the c-section. She was calm, almost euphoric (11:20). She had used the deepening techniques. Even the night staff commented on how calm she was, that she never complained of pain, took very little analgesics and managed well (11:21). After the birth, she coped well. She had lost nearly two litres of blood and had a premature baby. She persevered and expressed the milk for a month before she gave up. She did not produce a lot due to the blood loss. She remained very calm through all this (I think most women may have gotten depressed) (11:22). When baby got to six weeks, her husband had to leave the country again. She had finally gotten to the point of realizing just how serious her experience had been, how much blood she lost and how the doctors had fought to save her life. This combined with husband being away left her tearful and emotional. She used the Hypnobirthing® to calm herself down and reconnect with baby (she almost felt a bit alienated from baby due to the trauma of baby's birth) (11:23). She used the Hypnobirthing® script where you go back to the pages of your life book and change the picture for the bonding (perception) and the colour. In this script, you step into the picture and make it your own. She is thriving and	No pain / Calm Medication Risk / Calm HypnoBirthing® use of bonding with baby / Calm

	doing very well. She even managed to support her mom and dad (mom had a stroke 14 days ago). She has now turned from emotional to their pillar of strength. Baby is nearly ten weeks, and her husband is due back in a few weeks. She is coping well. I will help her to use Hypnobirthing® when she plans the next pregnancy as her uterus is very scarred due to the endometriosis.	

Table 14: Sr Monique: Emergent themes from categories

CATEGORIES	EXAMPLES FROM TRANSCRIPT (DIRECT QUOTATIONS)	THEMES
Coping: Psychological coping	Calmer mothers to manage pregnancy and birth far more capably. It also becomes a life skill. (11:9) The calming techniques, the breathing is a great help. (11:10)	The ability to be calm is beneficial to the mother during pregnancy and birth.
Coping: Hopes and expectations	Biggest hope and dream for a high-risk pregnancy is a healthy baby and mom. (11:4) Felicity prepared for a normal uncomplicated birth. (11:14).	Felicity wanted and prepared for a natural uncomplicated birth.
Coping: Stresses and fears	They also talk about the stress of the situation. I think decreasing the stress is an important goal. (11:5). They talk about being in a position where they do not have control. (11:6). She also realized that her husband was possibly going to miss the birth. (11:15).	
Coping: Calm and relaxed	Calmer mothers to manage pregnancy and birth far more capably. It also becomes a life skill. (11:9).	The use of HypnoBirthing® techniques enabled

	The calming techniques, the breathing is a great help. (11:10). She was so confident and calm and very ready for birth. (11:17) [after classes] She realized that the baby was in transverse lie, and when the doctor arrived and realized that she was dilating very quickly with a transverse lie (with risks of cord prolapse etc. looming), she remained perfectly calm. (11:19). She was calm, almost euphoric. (11:20) [day after the C-Section] Even the night staff commented on how calm she was, that she never complained of pain, took very little analgesics and managed well. (11:21) She remained very calm through all this (I think most women may have gotten depressed). (11:22) She used the Hypnobirthing® to calm herself down and reconnect with baby (she almost felt a bit alienated from baby due to the trauma of baby's birth). (11:23)	Felicity to remain calm and relaxed even when facing the risks of a complicated delivery. HypnoBirthing® enabled Felicity to use only minimal medication in dealing with discomfort. HypnoBirthing® enabled Felicity to bond with her baby after a traumatic birth.
Coping: The experience of pain	Going into labour, she experienced no pain whatsoever. (11:18) Even the night staff commented on how calm	The ability to remain calm and relaxed reduced or

	she was, that she never complained of pain, took very little analgesics and managed well. (11:21)	eliminated pain, allowing her to accept minimal medication.
Coping: Birth experience	Many of the normal-birth patients give birth quickly. (11:11)	HypnoBirthing® clients generally give birth more quickly.
Coping: Use of medication	Even the night staff commented on how calm she was, that she never complained of pain, took very little analgesics and managed well. (11:21)	The use of medication was greatly reduced.
Coping: Preparation	She practiced every day and night to go to a calm state, deepening and how to manage her contractions. (11:16)	Preparation and practice is critical to ensure effective use of HypnoBirthing® techniques.
Risk	This is of significance for her and the baby in a high-risk situation and can make the difference between a life or death result for foetus and mother. Decreasing the pulse to a normal rate also contributes to both mother and baby not losing blood as quickly during a bleeding incident. (11:13) She realized that the baby was in transverse lie,	The effective use of HypnoBirthing® techniques can save the life of the mother and baby during a complicated delivery.

	and when the doctor arrived and realized that she was dilating very quickly with a transverse lie (with risks of cord prolapse etc. looming), she remained perfectly calm. (11:19) She remained very calm through all this (I think most women may have gotten depressed). (11:22) [coping with breastfeeding and premature baby]	HypnoBirthing® allows the mother to remain calm and relaxed even when facing an emergency.
HypnoBirthing® uses	Heartburn, fears in pregnancy and postnatally. (11:1) Tailoring it, amazing in situations of crises that was not foreseeable at the time of the teaching/course. Felicity was one such a patient. (11:2) She was able to adjust what she was taught to keep her calm when she lost a great deal of blood during her c-section due to endometriosis scars. (11:3) She used the Hypnobirthing® to calm herself down and reconnect with baby (she almost felt a bit alienated from baby due to the trauma of baby's birth). (11:23) [bonding] The fear-release script, also the deepening scripts where you teach them to use a keyword (of their choice) to help them calm themselves and their	HypnoBirthing® enables the participant to cope more effectively with unexpected crisis situations. Felicity effectively used HypnoBirthing® to remain calm and relaxed and increase bonding with her baby. Apart from improved

	body down. (11:7) Also practicing the breathing and the rainbow relaxation cd every day helps them to go deeper quicker. (11:8) It enable the mom to control her pulse and adrenaline, in other words to avoid the fight and flight response. (11:12)	psychological coping, HypnoBirthing® provides control over physiological functions such as fight-flight response, heart rate and blood pressure, all of which are factors that influence the outcome of an emergency delivery.

APPENDIX B

DANELLE'S CASE: INTERVIEW TRANSCRIPTS AND DATA ANALYSIS

Table 15: Danelle: Verbatim transcript of interview and coding

PERSON	VERBATIM TRANSCRIPT	CODING
	The interview starts after pleasantries were exchanged. The purpose of the study was explained to Danelle, as well as the use of audio equipment. The researcher discussed the consent form with the participant, and the interview started after Danelle signed the consent form.	
Researcher	Thank you for agreeing to see me. This will be very useful to me. If you can tell me, in your own words, starting wherever you like, your story of your pregnancy. What your expectations were, the HypnoBirthing®, and how things went for you. And tell the story any way you like.	
Danelle	That's a long story to tell. The HypnoBirthing®, I first heard ... I read an article in a magazine about it – a pregnancy magazine. And I said this sounds interesting because I am so into holistic therapies	

	with my work as a beauty therapist. And I thought is sounds like a brilliant concept. My good friend who lives nearby, when I told her about the article, she said that she was about to do a course with Ms Stabler, and then she lost her little girl. A gynaecologist – she's both hers and mine – she actually told her about Ms Stabler and the HypnoBirthing®. And then I spoke to my doctor about it, and she was so *pro* towards it (13:1). She just said, "It's something that can really help you and it doesn't matter how you give birth in the end, it just can help you even if it's a c-section ... (13:2)	Attitude medical staff Attitude medical staff HypnoBirthing® uses
Researcher	mmm...	
Danelle	...it's something that you could use." And I really thought it was something that, not only for a birth, but something that you could sort of use throughout life, and in my salon, I need to be calm, you need to be relaxed – with a little baby in the house I just thought ... you know ... it can only help me ... (13:3)	HypnoBirthing® uses
Researcher	[Nodding "yes"]	
Danelle	... not only just with the birth, but with the rest of it. And I can't even remember when I first came to you [directed at Ms Stabler], about five months? When I was about five months along.	
Ms Stabler	[Nodding "yes"]	

Danelle	Em, and it was a few weeks before we got our pregnancy scare, and I was about 29 weeks, we had two sessions by then.	
Ms Stabler	[Nodding "yes"]	
Danelle	And then one Friday evening, I just felt horrible pain, and I later ended up going to hospital (13:4). And I went, I started going into labour – I was dilating, and I had contractions, so they gave me medication to try and stop it all. And I had cortisone injections for if she was born so that her lungs could be a bit stronger. That's why she's crying so ... vividly now ... [laughing]	Risk – early labour
Researcher	[Laughing]	
Danelle	She's got well-developed lungs. And I stayed in hospital for two days and came out on the Sunday, and now I was on strict bed rest for ten days. Em, and I was on medication still for five days to try and stop everything and that's when Ms Stabler came to see us here at home (13:5). And we didn't do a normal session, it was such a lovely day, that day, I felt so cooped up and home and I was so ... it was this whole thing, and I was scared, and she came and it was just the most calming session of everything we did (13:6). It was wonderful, I loved it. My mom was visiting, and she was in the room, and she	HypnoBirthing® other uses Calming Calmness Calm

	actually said to me afterward, she could feel the calmness just radiating towards her (13:7). She could just feel this peace and calm over here (13:8). And when she saw me and my husband afterward, she said, "You look like what I can feel", [laughing] "What's going on now?" It was so special. And then luckily, afterwards, all was well and ... all was well afterwards. And after 10 days, we saw the doctor again, and she said, "Everything was fine", and I could start going back to work slowly. Ja, I actually couldn't believe it. I felt surreal, after the big scare, all of the sudden, everything went back to normal.	
Researcher	So you started with the HypnoBirthing® before the "big scare"?	
Danelle	Yes, two sessions, and it was a big scare.	
Researcher	So you had two sessions, and then you went into labour?	
Danelle	[Nodding "yes"]	
Researcher	And then you had a session with Ms Stabler?	
Danelle	[Nodding "yes"]	
Researcher	And did you go into hospital?	
Danelle	Yes.	
Researcher	Did you have the session before, or after?	
Danelle	Afterwards, when we came home. Ja, then I was on bed rest, I couldn't go to her, and we [inaudible] an	

	appointment for that week so I phoned her and asked, “Please can you come here, I’m not allowed to move.” [laughing]	
Researcher	And then you had the session. And you talk about the calmness. .. But I don’t know anything about what that is like, so how do you explain that?	
Danelle	I was very anxious about what happened and scared about what’s going on. “Is she gonna come?”, and “She’s so small”. I don’t want this to happen now ... Ms Stabler did a different session with us that day, I didn’t know what she ... [directed to Ms Stabler] you told us a few sessions later that it wasn’t a proper part of the course, that is was just, sort of something, to help me relax and stay calm. And it, really, I just felt wound up and anxious and scared, and she [directed to Ms Stabler], you just did sort of a relaxing exercise with me ... (13:9)	Risk Fear/Anxiety
Researcher	[Nodding “yes”]	
Danelle	...you didn’t talk about anything HypnoBirthing®, or ... it was just like a hypnosession, to relax me and it really did. I could go into this wonderful state of calm and relaxation and, like I couldn’t even do in labour, and I don’t know, it might be part of why she [baby] got all calm again and decided to stay inside, you know? (13:10) Em, but I really felt good	Calm/relaxation Baby

	afterwards, and I felt calm, and I felt, "Everything was going to be OK. It's not this big crisis and all is well with the world again." [laughing] (13:11)	Calm
Researcher	[laughing]	
Danelle	That's the best way I can explain it to you.	
Researcher	So if I try to understand...and what I hear you saying is that there was the physical calmness...	
Danelle	Yes, go ahead... [Researcher paused as Danelle is also attending to her baby]	
Researcher	... physical calmness, in terms of relaxing ... But you're also saying that there was fear and anxiety that the baby may arrive too early and that it might not be good for her, and that was also ... a big part of it ...	
Danelle	Yes.	
Researcher	So after the session, you no longer had that anxiety?	
Danelle	No, I didn't. I just felt really calm, you know, and whatever will happen, will happen. Whatever that may be. Sort of ... I didn't feel like she's not gonna come now, everything will be fine, it's just felt like whatever's gonna happen, it should be okay. (13:12)	Calm Anxiety/fear
Researcher	[Nodding "yes"]	
Danelle	[inaudible- readjusting microphones]	
Researcher	So there was a physical and an emotional aspect ...	
Danelle	[Nodding "yes"]	

Researcher	Physical relaxation, and emotionally – the fear and anxiety ... How did you know the HypnoBirthing® was working for you?	
Danelle	I am a very tense person by nature, I get stressed very easily (13:13), and I know, I can feel it, it goes up in my shoulders, I get stomach aches, I struggle with Irritable Bowel Syndrome [inaudible, microphone noise], I get stressed easily (13:14), and I know how to make myself relax, and I don't always get it right. I try and I try, you know, take deep breaths, do this, do that, stay calm, and sometimes, it just doesn't work. And this [HypnoBirthing®] really helps (13:15). Throughout every session that we did, I walked out there, and just felt so calm and so (13:16) ... and I couldn't really get it right on my own, as good as you [directed at Ms Stabler] did it with me. And my husband couldn't get me to that state either, really. I wanted you [directed at Ms Stabler] there, at a labour actually (13:17). I thought, "You would be helpful now" (13:18). [laughing] It's different, I didn't think I had confidence in myself to get me to that state whereas she talked me through it (13:19). You immediately just get so relaxed and so peaceful and calm, and you can really go to a special calm	Stress Stress Effectiveness of HypnoBirthing Calm Husband/partner Failure to do it on her own / Practitioner present Failure Failure – confidence Calm

	place and feel that everything's good (13:20).	
Researcher	How do you explain that? That you're not able to do it by yourself so well, but then with her, you can do it?	
Danelle	I told her when I first started, I've got this weird thing with hypnotherapy, I don't really think it works, (13:21) I [inaudible – referring to stage hypnotism] … this is just ridiculous, and I asked if it's like that, you know, what does it involve? How is it different? And she explained to me it's completely different. There's a strange way that they work about it [referring to stage hypnotism], to go into this chicken-like state. I don't know, I trust her [referring to Ms Stabler], and I've got faith in how she does it, in how she ... (13:22) When I try to do it, go into your happy place, go into your subconscious, it feels like I'm sort of ... talking nonsense to myself (13:23). Whereas when she does it, it is so real, and so do-able. She says just go to this happy place and then I can't relax as well as when she does it. I didn't practice enough at home (13:24). Most times when I did practice, I just felt, em, and then I got to Ms Stabler again and then it just felt so perfect, and I thought, "How could this not work? She could do it, I couldn't do it myself" (13:25). The whole	Failure – does not believe it works Trust in practitioner Failure – disbelief Practice/preparation and failure Failure to it alone Trust in practitioner Failure

	labour, it was good, you actually have to speak to my doctor because I said to her afterwards, "I don't know if the HypnoBirthing® did work" (13:26). And she said to me, "It did work because by the time you were fully dilated, that's the time when you started taking over." And she said to me, "If I offered you a c-section now, would you say yes?" And I said, "Yes, I would take it, I would take anything" (13:27). And she said, "No, it's not necessary, you're there, you're fully dilated, and you just need to push now." And she was fantastic. And then I ... told my husband to quickly go get the camera, it's in this pocket there ... and she [gynaecologist] said to me, "By that stage, women are so out of control, in pain, screaming the roof off, so it must have worked." I didn't expect it to be that painful (13:28). So I don't know. But the [background noise] lasted three hours … [background noise]. So, it was successful, and so two weeks afterward – it's a traumatic experience – life changing, no-one who's not had it before can relate (13:29). It's something that just changes you completely. And a c-section, I just don't think it's the same experience. Really, only a mom who's done it will know. And two weeks afterwards, you	Pain Pain Effectiveness Pain Pain Pain

	start re-living it and thinking what I could have done more, or better, or try and [noise] the pain better (13:30). And now, I'm over it. Now, I think I've sort of made my peace with how it happened and ... my doctor thinks I did brilliantly ... the doctor ... she just says the whole thing was so calm and, "You were so calm, you didn't scream, and you were so calm, and you told me in a normal voice to do this and to do that" ... (13:31) So I think it went well, if I could do it over, I wouldn't change anything. I'm so glad it all went as planned. It's just the pain that I didn't cope with as well as I thought I would (13:32).	Pain - coping
Researcher	But the pain, your doctor, even she thought it was less than what she would have expected?	
Danelle	Ja, she said to me, that em, "Women by this stage, how they look are completely different to how you are looking now." Her words were, "People are swinging from the chandeliers by this stage. And you're just talking in a normal voice and speaking to your husband." And even though the contractions were really painful, in between them, I was focused and normal and not still screaming the roof off (13:33).	Pain
Researcher	[Nodding "yes"]	
Danelle	She thinks it made a big difference. Because I said	

	to her afterwards, “I don’t know if it worked.” She said to me, “Definitely it worked. Because you don’t know what people look like.” (13:34) But I have never done it before, so I don’t know. I have nothing to, sort of, compare it to ...	Effectiveness
Researcher	So it’s difficult, obviously, for you to make a comparison because ...	
Danelle	... it is difficult ...	
Researcher	... you’re looking at this from a very subjective point of view, in terms of your experience – it would be nice if there wasn’t so much pain – but from her perspective, being able to compare, she thinks that ...	
Danelle	...she definitely thinks that it made a big difference.	
Danelle	[Danelle attends to her baby]	
Researcher	You said that you had a hard time doing it by yourself [HypnoBirthing®]. And that when she [the HypnoBirthing® instructor] did it with you, it was a lot easier.	
Danelle	[Nodding “yes”]	
Researcher	What do you think made that difference?	
Danelle	I think that ... I feel it’s her profession, she knows how to do it. And I don’t (13:35). And I don’t have the faith in myself to do it (13:36). It feels like when I try to talk myself into that calm space, then I don’t	Failure – disbelief Trust in practitioner Failure –

	"believe myself" (13:37). Whereas when she does it, she knows what she's doing. [inaudible noise] (13:38)	confidence Failure – confidence Trust in practitioner
Researcher	So maybe ... confidence ... you had confidence in her but not so much confidence in yourself ...	
Danelle	... mmm [nods "yes"]	
Researcher	Is it possible that you did not have a good sense of when it was working or not working, so that ... because you said that you don't know when it worked or if it worked ...	
Danelle	Ja. That's ... that can be it. If you do it and you don't know if you're actually relaxed, and I'm not all that familiar with all the exercises. (13:39) And like the "glove thing", there's no way I could do that on myself, that it works (13:40). I keep thinking, "Oh this is nonsense, it's just not working" (13:41). And my husband wasn't sort of in a space where he could do it with me. I don't know if he felt, weird ... (13:42)	Failure Failure – disbelief Failure – negative self-talk Husband/partner
Researcher	[Nodding "yes"]	
Danelle	When she did it, it was fine, and we could both get into that space, but alone, I don't know ...(13:43)	Failure

Researcher	So the trust in the person teaching you HypnoBirthing is ...	
Danelle	... very important ...	
Researcher	Very important.	
Danelle	No, you absolutely have to have confidence, in them and, you know, their ability to do what they do.	
Researcher	How did you know this is the approach you want to follow?	
Danelle	When I went to her right at the beginning to discuss the whole thing, I liked it from the beginning. When you're gonna get along with someone or not get along with someone – I knew I would get along with her. I liked her, and I liked the content of the course. When I met her, I thought if she's doing it, I'm going to give it a try. (13:44)	Trust in practitioner Failure – "trying"
Researcher	You did some preparation as well?	
Danelle	Mmm [nods "yes"]	
Researcher	How important do you think the practice and preparations are in the process?	
Danelle	Very [important]. I really think I didn't practiced enough. I don't know if it would have made a difference if I did practice more, so ... (13:45) [directing attention to her baby].	Practice/preparation Failure
Researcher	What was the impact of using HypnoBirthing® – in	

	terms of your husband – what was his experience of the process?	
Danelle	It did, it worked. He was quite sceptical in the beginning, but he knew I wanted to really do it, so ... (13:46) He wanted me to give birth, normal, but with epidural, that was his ideal. When Ms Stabler talked us through what medication does and, you know, the whole medical side of things, he sort of started realising that it is best to, if you can do it, naturally without any pain medication. And em, I think he was just scared that, obviously for the pain that I would be going through [attending to baby] ... (13:47) But he was fantastic on the day. He was. He was calm, and so supportive, and just kept on asking me, "Do you need anything?" Putting wine gums in my mouth and ... he was brilliant. And he's not one for needles, and blood, and ... So he's not one for the whole medical physical thing, and he actually looked when the head came out, and I said to him, "Why do you look?" and he ... and I asked, "Doesn't it freak you out?" And he said, "No." And he's quite a calm soul. But I think the best thing the course did for him was to let him know that this is the best way to do it. (13:48) And when I was reading the book ,I was telling him the whole history about what it was	Husband/partner Scepticism Anxiety Pain Husband/partner Husband/partner Husband/partner

	like way back then, and he actually found it very interesting. (13:49)	
Researcher	So it convinced him ...	
Danelle	Yes ...	
Researcher	...that this was the best way to do things?	
Danelle	Yes ...	
Researcher	Gave him peace of mind? That he does not have to be afraid for you...?	
Danelle	Yes. Because the doctor will never say to you, "I think, this is the way to do it." So they don't really tell you the pros and cons and the "this and the that". They let you make up your own mind. Whereas in the prenatal class, that's where they actually tell you all the different options, birth, and so on. That was the important thing, actually learning about this.	
Researcher	How did the HypnoBirthing® ... after the birth, how did it affect you? Did you still use it?	
Danelle	I was so sore, and it was bleeding. And while I was breastfeeding I just tried to get myself into that calm state, and sometimes it worked and other times, it was just too painful, and she just cried too much, and it was just too big of a struggle (19:50). I haven't thought about it in the last week or so, but it has gone, everything has gone ... better and smoother and easier. I am very anxious about going	Breastfeeding Pain Effectiveness

	back to work, and I gonna really have to practice some HypnoBirthing® calmness, just to get myself into that state where I can think it's manageable (13:51) to try and work again because at this stage, I just don't know how on earth you do it. But I'm sure when she gets a bit bigger.	Stress HypnoBirthing® uses
Researcher	Do you think, did the HypnoBirthing® have any influence on her [baby]?	
Danelle	She was quite alert when she came out, and she didn't take the breast that easily, but she did manage to feed a few hours after she was born. But she actually was quite calm in hospital. It was when we came home that she started sort of ... I think she had a bit of colic, I know she had lots of what looked like, sort of digestive pain, you know. She was cramping and this and that, so I don't know if it was just from something I didn't eat right, or whatever. She's not a sleepy baby at all, so I don't know if the HypnoBirthing® was supposed to make them calm and relaxed. Or if it's supposed to make them alert and awake and active babies. She's not a sleepy one. She'll take her naps, but she'll be awake for long stretches at a time. If you think about it, that's probably the way it's supposed to be, so you have a lethargic baby. But she's not a very calm, sleepy	

	soul.	
Researcher	One thing I want to go back to. You said you actually wanted Ms Stabler there [at birth]. Do you think that ...	
Danelle	... I think it would have helped. I think that's one thing about HypnoBirthing® because you go through this whole course with this one person, and then suddenly on the big day, that person isn't there. And I think back to the video she showed us, and a lot them ... is actually there. And I really think it would have helped, if you [direct at Ms Stabler] would have helped me through some of the ... because I listened to my doctor, more than I listened to anyone else, and she is very good, she helped me to get into that calm relaxed state. (13:52)	Practitioner present during birth
Researcher	Anything else that you think is important about your whole experience, as it related to the HypnoBirthing®?	
Danelle	Mmm [nods "no"], I don't know. I do think you have to practice a lot at home, to be able to do it yourself, I didn't do it enough (13:53). Because like I said, when she [HypnoBirthing® instructor] did it with me, it was all easy and good (13:54), and like that you could do the "glove" and you could "float" and you could do whatever. But to do it on your own	Practice/preparation Trust in practitioner/ Failure

	... Me and my husband never once … he felt awkward reading the scripts (13:55), especially because it's in English. I think if the scripts would have been in Afrikaans, he might have had more confidence to read it to me at home (13:56). He tried to sort of do it, but, a few times translating it and using his own words, but it just, it wasn't the same (13:57). I think what helped as well with the course, is that Ms Stabler is sort of an "outsider". She's not one of your close friends or your husband or your mother, or you know, someone that's so close to you that you've known forever, its ... we've just met you and only for this, for the course, that's how we, you know, we got together, and I think that makes a big difference too. Because it feels sort of weird and awkward doing it with someone, this new thing, that you're not used to, that you've never done before – and you've know each other forever. Now suddenly we have to do this "weird thing" – not weird but, you know what I mean, it's not something that we've been used to doing, and he felt a bit strange doing this whole thing with me (13:58). So, maybe if I practiced more, I don't know, the pain would have been less (13:59). But at the end of the day, it still went as I wanted it to go. There was just more	Husband/partner Husband/partner Effectiveness Pain / Partner Practice/preparation Pain

	pain involved than I thought there was going to be (13:60).	
Researcher	But you got the result that you wanted?	
Danelle	Yes. That's what I wanted.	
Researcher	Would you recommend this to anyone else?	
Danelle	I would and I have.	
Researcher	Thank you very much.	

Table 16: Danelle: Emergent themes from categories

CATEGORIES	**EXAMPLES FROM TRANSCRIPT (DIRECT QUOTATIONS)**	**THEMES**
Coping: Attitude of medical staff	And then I spoke to my doctor about it, and she was so *pro* towards it (13:1). It just can help you even if it's a c-section ... (13:2)	Danelle was encouraged by the positive attitude of her doctor to attending the HypnoBirthing® programme.
Coping: Positive emotional impact of HypnoBirthing® - Calmness	I was scared, and she came, and it was just the most calming session of everything we did. (13:6) Said to me afterward, she could feel the calmness just radiating towards her. (13:7) She could just feel this peace and calm over here. (13:8) It was just like a hypnosession, to relax me and it really did. I could go into this wonderful state of calm and relaxation and, like I couldn't even do in labour, and I don't know, it might be part of why she [baby] got all calm again and decided to stay inside, you know? (13:10) I really felt good afterwards, and I felt calm, and I felt, "Everything was going to be OK. It's not	HypnoBirthing® effectively reduced fear and anxiety experienced during early labour and promoted feelings of calmness and control.

	this big crisis and all is well with the world again." [laughing] (13:11) I just felt really calm, you know, and whatever will happen, will happen. Whatever that may be. Sort of ... I didn't feel like she's not gonna come now, everything will be fine, it's just felt like whatever's gonna happen, it should be okay. (13:12) Throughout every session that we did, I walked out there and just felt so calm and so … (13:16) You immediately just get so relaxed and so peaceful and calm, and you can really go to a special calm place and feel that everything's good. (13:20)	Danelle experienced feelings of tremendous calmness and relaxation during HypnoBirthing® sessions and training.
Coping – Positive emotional impact of HypnoBirthing® – Trust in the practitioner	I don't know, I trust her [referring to Ms Stabler], and I've got faith in how she does it, in how she ... (13:22) Most times when I did practice, I just felt, em, and then I got to Ms Stabler again and then it just felt so perfect, and I thought, "How could this not work?" She could do it, I couldn't do it myself. (13:25) Because I said to her afterwards, "I don't know if the HypnoBirthing® did work." (13:26) I feel it's her profession, she knows how to do it.	Danelle had complete faith in her therapist, but experienced failure when attempting to use the techniques by herself.

	And I don't. (13:35) Whereas when she does it, she knows what she's doing, [inaudible noise]. (13:38) When I went to her right at the beginning to discuss the whole thing, I liked it from the beginning. When you're gonna get along with someone or not get along with someone – I knew I would get along with her. I liked her, and I liked the content of the course. When I met her, I thought if she's doing it, I'm going to give it a try. (13:44) Because like I said, when she [HypnoBirthing® instructor] did it with me, it was all easy and good. (13:54)	Danelle decided to give it a "try", which implied a negative expectation of failure.
Coping: Dealing with negative emotions - Feelings of failure	And I couldn't really get it right on my own, as good as you [directed at hypnotherapist] did it with me, and [my husband] couldn't get me to that state either, really, I wanted you [directed at hypnotherapist] there, at a labour actually. (13:17) I thought, "You would be helpful now." (13:18) I didn't think I had confidence in myself to get me to that state whereas she talked me through it. (13:19	Danelle experienced failure when attempting the techniques on her own and desired to have the therapist present during labour and birth to assist her.

	I told her when I first started, “I’ve got this weird thing with hypnotherapy; I don’t really think it works.” (13:21) When I try to do it, go into your happy place, go into your subconscious, it feels like I’m sort of ... talking nonsense to myself. (13:23) I didn’t practice enough at home. (13:24) Most times when I did practice, I just felt, em, and then I got to Ms Stabler again and then it just felt so perfect, and I thought, “How could this not work?” She could do it, I couldn’t do it myself. (13:25 I feel it’s her profession, she knows how to do it. And I don’t. (13:35) And I don’t have the faith in myself to do it. (13:36) When I try to talk myself into that calm space then I don’t “believe myself”. (13:37) If you do it and you don’t know if you’re actually relaxed, and I’m not all that familiar with all the exercises. (13:39) And like the “glove thing”, there’s no way I could do that on myself, that it works. (13:40) I keep thinking, “Oh this is nonsense, it’s just not working.”(13:41)	Danelle did not believe that HypnoBirthing® would actually be effective. Danelle feels that she did not practice enough for the techniques to be effective. Danelle developed feelings of self-doubt. She failed to use the techniques successfully, but the hypnotherapist obtained excellent results with her.

	When she did it, it was fine, and we could both get into that space, but alone, I don't know ...(13:43) I really think I didn't practiced enough. I don't know if it would have made a difference if I did practice more, so ... (13:45) Because like I said, when she [HypnoBirthing® instructor] did it with me, it was all easy and good. (13:54) The whole labour, it was good, you actually have to speak to [my doctor] because I said to her afterwards, "I don't know if the HypnoBirthing® did work." (13:26) Whereas when she does it, she knows what she's doing, [inaudible noise]. (13:38) When I met her, I thought if she's doing it, I'm going to give it a try. (13:44)	
Coping: Dealing with negative emotions - Stress	I am a very tense person by nature, I get stressed very easily. (13:13) I get stomach aches, I struggle with Irritable Bowel Syndrome [inaudible, microphone noise] I get stressed easily. (13:14) I am very anxious about going back to work, and I gonna really have to practice some HypnoBirthing® calmness just to get myself into	Danelle experiences herself as more stressed and anxious in general.

	that state where I can think it's manageable. (13:51)	
Coping: Dealing with negative emotions - Anxiety and fear	I was very anxious about what happened and scared about what's going on, "Is she gonna come", and, "she's so small". I don't want this to happen now ... [the hypnotherapist] did a different session with us that day, I didn't know what she ... [directed to hypnotherapist] you told us a few sessions later that it wasn't a proper part of the course, that is was just, sort of something, to help me relax and stay calm. And it, really, I just felt wound up, and anxious and scared, and she [directed to the hypnotherapist] you just did sort of a relaxing exercise with me ... (13:9) I just felt really calm, you know, and whatever will happen, will happen. Whatever that may be. Sort of ... I didn't feel like she's not gonna come now, everything will be fine, it's just felt like whatever's gonna happen, it should be okay. (13:12) I think he was just scared that, obviously for the pain that I would be going through [attending to baby]... (13:47)	HypnoBirthing® effectively reduced fear and anxiety associated with early labour.

Coping: Preparation and practice	I really think I didn't practiced enough. I don't know if it would have made a difference if I did practice more, so ... (13:45) I do think you have to practice a lot at home to be able to do it yourself. I didn't do it enough. (13:53) So, maybe if I practiced more, I don't know, the pain would have been less. (13:59)	Danelle did not practice enough in her own estimation. Did the little amount of practicing impact on the feelings of failure, or did the fear of failure cause the limited practicing?
Coping: The experience of pain	And she said to me, "If I offered you a c-section now, would you say yes?" And I said, "Yes, I would take it, I would take anything." (13:27) And she [gynaecologist] said to me, "By that stage, women are so out of control, in pain, screaming the roof off, so it must have worked." I didn't expect it to be that painful (13:28). And so two weeks afterward – it's a traumatic experience – life changing, no-one who's not had it before can relate. (13:29) And two weeks afterwards, you start reliving it and thinking what I could have done more, or better, or try and [noise] the pain better (13:30). [My doctor] thinks I did brilliantly ... the doctor	Danelle experienced her labour and giving birth as very painful and did not feel at the time that the HypnoBirthing® was working for her.

	... she just says the whole thing was so calm and, "You were so calm, you didn't scream, and you were so calm, and you told me in a normal voice to do this and to do that"... (13:31) It's just the pain that I didn't cope with as well, as I thought I would. (13:32) Ja, she said to me, that em, "Women by this stage, how they look are completely different to how you are looking now." Her words were, "People are swinging from the chandeliers by this stage." And you're just talking in a normal voice and speaking to your husband, and even though the contractions were really painful, in between them, I was focused and normal and not still screaming the roof off. (13:33) I think he was just scared that, obviously for the pain that I would be going through [attending to baby] ... (13:47) I was so sore, and it was bleeding. And while I was breastfeeding, I just tried to get myself into that calm state, and sometimes it worked and other times, it was just too painful, and she just cried too much, and it was just too big of a struggle. (19:50) So, maybe if I practiced more, I don't know, the	Danelle doubts herself and wonders whether

	pain would have been less. (13:59) There was just more pain involved than I thought there was going to be. (13:60)	more practice would have improved her experience.
Risk	And then one Friday evening, I just felt horrible pain, and I later ended up going to hospital. (13:4) I was very anxious about what happened and scared about what's going on: "Is she gonna come", and, "She's so small". I don't want this to happen now ... [my hypnotherapist] did a different session with us that day, I didn't know what she ... [directed to Ms Stabler] You told us a few sessions later that it wasn't a proper part of the course, that is was just, sort of something, to help me relax and stay calm. And it, really, I just felt wound up, and anxious and scared, and she [directed to hypnotherapist] you just did sort of a relaxing exercise with me ... (13:9)	Danelle went into early labour which caused her anxiety and fear, which was relieved by the HypnoBirthing® techniques in a session with the therapist.
Husband as partner in HypnoBirthing®	And I couldn't really get it right on my own as good as you [directed at hypnotherapist] did it with me, and [my husband] couldn't get me to that state either, really, I wanted you [directed at hypnotherapist] there, at a labour actually.	Danelle could not get a good hypnotic response on her own, when compared to that

	(13:17) And my husband wasn't sort of in a space where he could do it with me. I don't know if he felt, weird ... (13:42) He was quite sceptical in the beginning, but he knew I wanted to really do it, so ... (13:46) I think he was just scared that, obviously for the pain that I would be going through [attending to baby] ... (13:47) But I think the best thing the course did for him was to let him know that this is the best way to do it. (13:48) And when I was reading the book, I was telling him the whole history about what it was like way back then, and he actually found it very interesting. (13:49) But to do it on your own ... Me and [my husband] never once … He felt awkward reading the scripts. (13:55) I think if the scripts would have been in Afrikaans, he might have had more confidence to read it to me at home. (13:56) I think what helped as well with the course is that [my hypnotherapist] is sort of an "outsider". She's not one of your close friends or your	achieved by the hypnotherapist. Danelle's husband was sceptical about the HypnoBirthing® – what was the impact of this on her belief in the process?

	husband or your mother, or you know, someone that's so close to you that you've known forever, its ... we've just met you and only for this, for the course, that's how we, you know, we got together, and I think that makes a big difference too. Because it feels sort of weird and awkward doing it with someone, this new thing, that you're not used to, that you've never done before – and you've know each other forever. Now suddenly we have to do this "weird thing" – not weird but, you know what I mean, it's not something that we've been used to doing, and he felt a bit strange doing this whole thing with me. (13:58)	It was awkward for Danelle and her husband when he tried the techniques with her.
Managing the baby	It was just like a hypnosession, to relax me, and it really did. I could go into this wonderful state of calm and relaxation, and like I couldn't even do in labour, and I don't know, it might be part of why she [baby] got all calm again and decided to stay inside, you know? (13:10)	Danelle feels that her ability to respond in a calm and relaxed manner to the early labour may have allowed her to prolong her pregnancy.
Breastfeeding	I was so sore, and it was bleeding. And while I was breastfeeding I just tried to get myself into	The HypnoBirthing®

	that calm state, and sometimes it worked and other times, it was just too painful, and she just cried too much, and it was just too big of a struggle. (19:50)	techniques were effective with breastfeeding some of the time.
HypnoBirthing® uses	It's something that you could use. And I really thought it was something that, not only for a birth, but something that you could sort of use throughout life. And in my salon, I need to be calm, you need to be relaxed – with a little baby in the house, I just thought ... you know ... it can only help me ... (13:3) And that's when [the hypnotherapist] came to see us here at home. (13:5) I am very anxious about going back to work, and I gonna really have to practice some HypnoBirthing® calmness, just to get myself into that state where I can think it's manageable. (13:51) She just said, "It's something that can really help you, and it doesn't matter how you give birth in the end, it just can help you even if it's a c-section" ... (13:2)	Danelle's motivation for doing HypnoBirthing® included the prospect of being able to manage stress in general. Danelle was also encouraged by the doctor's opinion that HypnoBirthing® could be useful even in the case of a caesarean section.

HypnoBirthing® effectiveness	And this [HypnoBirthing®] really helps (13:15). And she [medical doctor] said to me, "By that stage, women are so out of control, in pain, screaming the roof off, so it must have worked." I didn't expect it to be that painful. (13:28) Because I said to her afterwards, "I don't know if it worked." She said to me, "Definitely it worked because you don't know what people look like." (13:34) I was so sore, and it was bleeding. And while I was breastfeeding, I just tried to get myself into that calm state. And sometimes it worked, and other times, it was just too painful, and she just cried too much, and it was just too big of a struggle. (19:50).	Whilst Danelle was very uncertain about the effectiveness of HypnoBirthing®, her doctor was convinced that it was very effective.
	I think if the scripts would have been in Afrikaans, he might have had more confidence to read it to me at home. (13:56) [language] He tried to sort of do it, but, a few times translating it and using his own words, but it just, it wasn't the same. (13:57)	The language difference might have impacted on the level of comfort in using the HypnoBirthing® scripts.
Presence of the practitioner during labour and	... I think it would have helped. I think that's one thing about HypnoBirthing® because you go through this whole course with this one person,	Danelle had complete confidence in her

birth	and then suddenly on the big day, that person isn't there. And I think back to the video she showed us, and a lot them ... is actually there. And I really think it would have helped, if you [direct at hypnotherapist] would have helped me through some of the ... because I listened to [my doctor] more than I listened to anyone else. And she is very good; she helped me to get into that calm relaxed state. (13:52) And I couldn't really get it right on my own, as good as you [directed at hypnotherapist] did it with me, and [my husband] couldn't get me to that state either. Really, I wanted you [directed at hypnotherapist] there, at a labour actually. (13:17) I thought, "You would be helpful now." (13:18)	hypnotherapist and wanted her present during the labour and birth to assist her with the HypnoBirthing® techniques. She is convinced that her presence would have made a big difference.

Table 17: Ms Stabler: Verbatim transcript of interview and coding

PERSON	VERBATIM TRANSCRIPT	CODING
Researcher	Briefly describe your qualifications and professional experience.	
Ms Stabler	Diploma in Clinical Hypnotherapy and Hypno-analysis (UK) (2005) Psychosexual Disorders Therapist (UK) (2010) HypnoBirthing® Practitioner (UK) (2011) Hypno-Band Practitioner Hypno-Tension Practitioner Parts Therapy Facilitator (UK) 2012 WSN Practitioner 2013 Member of "Association for Professional Hypnosis and Psychotherapy" FAMSA Family Foundation Course "Nutritional Therapy" and "Weight management and consulting" Diplomas (Stoneridge College, UK) Diploma "Sports Psychology" – in progress Taught "Hypnosis for Birth" component of the HypnoBirthing® Practitioner Programme in Cape Town, 2012/2013 I run a full-time professional hypnosis business in Knysna. I am currently teaching the 10-month "Professional	

	Hypnotherapy Practitioner Programme" in Knysna and Cape Town on behalf of my college "The Essex Institute" in Southend-on-Sea in the UK.	
Researcher	Briefly describe – as you would to a member of the public – what it is that you actually do (in relation to Hypnotherapy/HypnoBirthing® with pregnant women).	
Ms Stabler	I conduct 5 x 2.5 hour childbirth education classes as part of the HypnoBirthing® Programme to encourage pregnant mothers to birth calmly, and plan for a natural birth, yet be prepared should she require intervention, due to special circumstances. Through this programme, birthing companions are prepared to support the birthing mother during her pregnancy and birthing.	
Researcher	Please provide an estimate of the number of clients you have seen with Hypnotherapy/HypnoBirthing® as primary method of intervention.	
Ms Stabler	Hypnotherapy = 107 clients in three years HypnoBirthing® = 2 complete programmes, 3 couples currently on course Three pregnant mothers who didn't have sufficient time to complete the entire programme, yet required	

	some assistance to remain confident in natural childbirth.	
Researcher	In your own practice, what are the experiences of women making use of HypnoTherapy/HypnoBirthing® during the pregnancy and birth? You can talk about this in general, but if possible please also refer especially to high-risk pregnancies.	
	Women feel empowered with correct knowledge (12:1). They feel more confident to manage their birthing (12:2). They deal with the possibility of interventions by medical staff, feeling confident to ask challenging questions to clarify their status under challenging circumstances (12:3). Excess anxiety is alleviated by reclaiming their own bodies and birthing (12:4). Mothers who are utilizing HypnoBirthing® for their second pregnancy are aiming to have a more comfortable experience than the first birthing (12:5). One mother perceived that her first birthing was life-threatening, yet once the facts were explored, under hypnosis, using a method of fear-release, she realized that it was not as life-threatening as originally	Empowerment/ knowledge Confidence Confidence Anxiety Comfort Positive anticipation Fear

	thought. She replaced fearful anticipation with positive anticipation (12:6). High-risk pregnancies I have dealt with:- 1. Breech presentation – Utilising the HypnoBirthing® "Breech Turn Script", we attempted to relax the mother so that if it were possible for her breech baby to turn, it might be more feasible. The baby remained in breech position. Despite this, the pregnant mother was confident to go into natural labour when her baby was ready and laboured for 10 hours to allow natural birthing hormones to flow through herself and her baby before the planned c-section was done. This also made her feel as though she had done everything known to her that would be in the interests of her baby's wellbeing (12:7). 2. Early onset of labour at approximately 28 weeks – Mother was understandably anxious when this unexpected special circumstance arose. During a home visit, I utilised a calming and confidence-building script. She reported having felt more relaxed afterwards where prior to the session, she was very 'up-tight'. This appears to have made the recommended bed rest and medication more effective (12:8).	Risk Risk / Anxiety

Researcher	What are their hopes and wishes about their pregnancy and birth? (This is your own observation or experience of this – the things that they talk about with you).	
Ms Stabler	Mothers want to experience natural birth and come to HypnoBirthing® to train their bodies and minds towards this goal (12:9). They aim to be empowered throughout the birthing process to remain calm and in control (12:10). They are often looking for facts to empower themselves in the face of persuasion by medical professionals, to undergo unnecessary interventions and c-sections (12:11). One mother is petrified of hospitals and wants to birth at home. She is responsibly acquiring as much knowledge and training as possible to do so safely and calmly (12:12).	Hopes and wishes Calm Control Empowered Medical persuasion Risk / Calm
Researcher	What are their fears and anxieties about their pregnancy and birth? (This is your own observation or experience of this – the things that they talk about with you).	
Ms Stabler	They generally appear to be fearful of the idea of experiencing pain during labour, any possible harm to their babies (12:13).	Risk Fear Pain

Researcher	What have you found to be especially helpful to them?	
Ms Stabler	The relaxation exercises. The ability to remain calm and focus if they should be experiencing discomfort during labour (12:14). Knowledge as to what is actually happening to their bodies. Information about how to ensure that the labour process is not interrupted by outside influence (12:15). Partners feel more certain about asking questions and how to play their role during the labouring process (12:16). In general, they feel better prepared (12:17).	Calm Empowerment Medical interruption Partners Preparation
Researcher	What is your own experience of the use of Hypnotherapy/HypnoBirthing® as psychological support to women/couples during their pregnancy/birth?	
Ms Stabler	Psychologically, the women/couple feel they are taking responsibility for their own birthing, body and outcomes (12:18). They feel less violated by professionals prodding and poking and directing their pregnancies and birthing (12:19). Having planned for a natural birth, they feel they did everything they possibly could, and therefore do not have regrets later for simply side-stepping the natural birth idea and	Psychological support Medical interference

	being coerced into a c-section, induction or excessive pain-relief drugs (12:20). Couples are better prepared should special circumstances arise which lead to a different outcome than originally planned for (12:21). HypnoBirthing® skills can still be utilized with c-sections etc. (12:22). Less postnatal depression likely due to regrets (12:23).	Empowered Medical interference Risk c-section / HypnoBirthing use Postnatal depression
Researcher	In your own observation of women/couples who make use of Hypnotherapy/HypnoBirthing®, what do they find helpful, or not helpful, during this process?	
Ms Stabler	One of the breathing skills used to "breathe the baby down" appears to be difficult to grasp for first-time mothers. Those who do go into the birthing phase of labour expecting to breathe their babies down are sometimes met with disdain from impatient medical staff, who then tell them to "push". This goes against what they have learnt in HypnoBirthing® classes, but when they are feeling tired and wanting the labouring process to end, they then begin to listen to medical staff and are disappointed afterwards that they	Medical

	couldn't breathe their babies down (12:24).	interference
Researcher	What is your own experience/observation of the *effectiveness* of Hypnotherapy/HypnoBirthing® in dealing with high-risk pregnancy or physical/medical complications during pregnancy/birth?	
Ms Stabler	So far, it seems that the mothers are able to calm themselves and their bodies, which reduces the likelihood of stress-induced complications (12:25).	Calm Risk
Researcher	Please describe how you made use of Hypnotherapy/HypnoBirthing® with the relevant client. You may include your own experiences – your own thoughts, feelings and observations during this process. Also include comments about your client's responses, the effectiveness of the treatment/intervention or anything that you think may be important. Please write in conversational style, as if you are having a casual conversation with someone, without editing your thoughts or comments. Tell it in the form of a start, from beginning to end, adding as much or as little detail as you are comfortable with.	

Ms Stabler	Early onset of labour at approximately 28 weeks – Parents were understandably anxious when this unexpected special circumstance arose. They had completed the first full HypnoBirthing® class with me. They asked if I was prepared to conduct the next class at their home as the mother had been put on bed-rest and medication to stop her contractions. I felt that any mention of birthing/opening up/etc. could be detrimental to keeping the pregnancy intact. During the home visit, I utilised a calming and confidence-building script. The process congratulated the mother, mother's body, baby and father for the fantastic work they were all doing to create and maintain the pregnancy. The wording alluded to the fact that when baby and mother's body were ready for birthing, it would take place. The script appealed to the mother and baby's inner wisdom to know when that time would be. Parents felt calmer and accepted the outcomes more readily, reducing unnecessary stress to exacerbate the already challenging circumstances. This appears to have made the recommended bed rest and medication more effective (12:25). Mom went to full term with pregnancy, and apparently, her physician even gave her permission	Calm Augments medical treatment

	to return to work, which involved a lot of standing. The mother said that, after the home visit, she and her husband both felt less stressed about their circumstances and more accepting, should their baby arrive prematurely (12:26). She described herself as someone who is inclined to be easily stressed and felt amazed at how effective the hypnotherapy was. (12:27)	Calm Risk Calm - effective

Table 18: Ms Stabler: Emergent themes from categories

CATEGORIES	**EXAMPLES FROM TRANSCRIPT (DIRECT QUOTATIONS)**	**THEMES**
Coping: Attitude of medical staff	They are often looking for facts to empower themselves in the face of persuasion by medical professionals to undergo unnecessary interventions and c-sections. (12:11) Knowledge as to what is actually happening to their bodies. Information about how to ensure that the labour process is not interrupted by outside influence. (12:15) They feel less violated by professionals prodding and poking and directing their pregnancies and birthing. (12:19)	Information about birth empowers women to be proactive in making decisions about birth instead of allowing the medical profession to make decisions on their behalf.

	Having planned for a natural birth, they feel they did everything they possibly could, and therefore do not have regrets later for simply side-stepping the natural-birth idea and being coerced into a c-section, induction or excessive pain-relief drugs. (12:20) One of the breathing skills used to "breathe the baby down" appears to be difficult to grasp for first time mothers. Those who do go into the birthing phase of labour expecting to breathe their babies down are sometimes met with disdain from impatient medical staff, who then tell them to "push". This goes against what they have learnt in HypnoBirthing® classes, but when they are feeling tired and wanting the labouring process to end, they then begin to listen to medical staff and are disappointed afterwards that they couldn't breathe their babies down. (12:24)	When there is a discrepancy between what the women in labour wants and what the medical staff want, they often pressure women into decisions that leave them with regret afterwards.
Coping: Psychological support	Psychologically, the women/couple feel they are taking responsibility for their own birthing, body and outcomes. (12:18)	HypnoBirthing® allows women to be proactive in making decisions about their

		birthing.
Coping: Positive emotional impact of HypnoBirthing® – Positive Anticipation	One mother perceived that her first birthing was life-threatening, yet once the facts were explored, under hypnosis, using a method of fear-release, she realized that it was not as life-threatening as originally thought. She replaced fearful anticipation with positive anticipation. (12:6) Mothers want to experience natural birth and come to HypnoBirthing® to train their bodies and minds towards this goal. (12:9)	HypnoBirthing® provides an opportunity to correct misconceptions and deal with negative emotions.
Coping: Positive emotional impact of HypnoBirthing® – Knowledge and empowerment	Women feel empowered with correct knowledge. (12:1) They are often looking for facts to empower themselves in the face of persuasion by medical professionals to undergo unnecessary interventions and c-sections. (12:11) Knowledge as to what is actually happening to their bodies. Information about how to ensure that the labour process is not interrupted by outside influence. (12:15) Having planned for a natural birth, they feel they did everything they possibly could and therefore do not have regrets later for simply side-stepping	HypnoBirthing® empowers women to be proactive in making decisions and taking control of their birthing as opposed to being passive recipients of a medical service.

	the natural birth idea and being coerced into a c-section, induction or excessive pain-relief drugs. (12:20)	
Coping: Positive emotional impact of HypnoBirthing® – Calmness	They aim to be empowered throughout the birthing process, to remain calm and in control. (12:10) One mother is petrified of hospitals and wants to birth at home. She is responsibly acquiring as much knowledge and training as possible to do so safely and calmly. (12:12) The relaxation exercises. The ability to remain calm and focus if they should be experiencing discomfort during labour. (12:14) [...is helpful to them] So far, it seems that the mothers are able to calm themselves and their bodies, which reduces the likelihood of stress induced complications. (12:25) Parents felt calmer and accepted the outcomes more readily, reducing unnecessary stress to exacerbate the already challenging circumstances. This appears to have made the recommended bed rest and medication more effective. (12:25) [after therapy session]	The ability to attain calmness and relaxation is experienced as empowering.

	The mother said that, after the home visit, she and her husband both felt less stressed about their circumstances and more accepting, should their baby arrive prematurely. (12:26) She described herself as someone who is inclined to be easily stressed and felt amazed at how effective the hypnotherapy was. (12:27)	
Coping: Positive emotional impact of HypnoBirthing® – Confidence	They feel more confident to manage their birthing. (12:2) They deal with the possibility of interventions by medical staff, feeling confident to ask challenging questions to clarify their status under challenging circumstances. (12:3)	Women are more confident to make decisions and take control of their birthing.
Coping: Positive emotional impact of HypnoBirthing® – Comfort	Mothers who are utilizing HypnoBirthing® for their second pregnancy are aiming to have a more comfortable experience than the first birthing. (12:5)	Especially with subsequent pregnancies, HypnoBirthing® provides the possibility of comfort during birthing.
Coping: Positive emotional impact	They aim to be empowered throughout the birthing process, to remain calm and in control.	The ability to remain calm

of HypnoBirthing® – Control	(12:10)	provides women with a feeling of being in control of the birthing.
Coping: Dealing with negative emotions – Coping: Dealing with negative emotions – Anxiety and Fear	Excess anxiety is alleviated by reclaiming their own bodies and birthing. (12:4) Early onset of labour at approximately 28 weeks – Mother was understandably anxious when this unexpected special circumstance arose. During a home visit, I utilised a calming and confidence-building script. She reported having felt more relaxed afterwards where prior to the session, she was very 'up-tight'. This appears to have made the recommended bed rest and medication more effective. (12:8) One mother perceived that her first birthing was life-threatening, yet once the facts were explored, under hypnosis, using a method of fear-release, she realized that it was not as life-threatening as originally thought. She replaced fearful anticipation with positive anticipation. (12:6) They generally appear to be fearful of the idea of experiencing pain during labour, any possible harm to their babies. (12:13)	Physical relaxation and calmness also reduces anxiety. Negative expectations, fear and anxiety can be replaced with positive expectations.

Coping: Dealing with negative emotions – Post-natal depression	Less post natal depression likely due to regrets. (12:23)	HypnoBirthing® may reduce the incidence of post-natal depression.
Preparation and practice	In general, they feel better prepared. (12:17)	Women feel more prepared for birthing.
Experience of pain	They generally appear to be fearful of the idea of experiencing pain during labour, any possible harm to their babies. (12:13)	Fear of pain and harm to their baby is a common emotional experience of women.
Risk	Breech presentation – Utilising the HypnoBirthing® "Breech Turn Script", we attempted to relax the mother, so that if it were possible for her breech baby to turn, it might be more feasible. The baby remained in breech position. Despite this, the pregnant mother was confident to go into natural labour when her baby was ready and laboured for 10 hours to allow natural birthing hormones to flow through herself and her baby before the planned c-section was done. This also made her feel as though she	The confidence and calmness allows women to be content with the birthing even if it did not progress as planned.

	had done everything known to her that would be in the interest of her baby's wellbeing. (12:7) Early onset of labour at approximately 28 weeks – Mother was understandably anxious when this unexpected special circumstance arose. During a home visit, I utilised a calming and confidence-building script. She reported having felt more relaxed afterwards where prior to the session, she was very 'up-tight'. This appears to have made the recommended bed rest and medication more effective. (12:8) One mother is petrified of hospitals and wants to birth at home. She is responsibly acquiring as much knowledge and training as possible to do so safely and calmly. (12:12) They generally appear to be fearful of the idea of experiencing pain during labour, any possible harm to their babies. (12:13) Couples are better prepared should special circumstances arise which lead to a different outcome than originally planned for. (12: 21) So far, it seems that the mothers are able to calm themselves and their bodies, which reduces the likelihood of stress induced complications. (12:25)	HypnoBirthing® techniques reduce anxiety from unexpected complications with the pregnancy. HypnoBirthing® alleviates fear and anxiety and promotes calmness.

	The mother said that, after the home visit, she and her husband both felt less stressed about their circumstances and more accepting, should their baby arrive prematurely. (12:26)	
Partners	Partners feel more certain about asking questions and how to play their role during the labouring process. (12:16)	Women and their partners are more proactive and in control during labour.
HypnoBirthing uses	HypnoBirthing® skills can still be utilized with c-sections etc. (12:22)	HypnoBirthing® can be used with caesarean births as well as natural births.
Augment medical treatment	Parents felt calmer and accepted the outcomes more readily, reducing unnecessary stress to exacerbate the already challenging circumstances. This appears to have made the recommended bed rest and medication more effective. (12:25)	HypnoBirthing® reduces stress and is an effective adjunct to medical treatment.

Table 19: Dr Oliver: Verbatim transcript of interview and coding

PERSON	VERBATIM TRANSCRIPT	CODING
Researcher	What I would like to do is ask you a few general questions and then a few specific questions about the birthing experience of Danelle.	
Dr Olivier	That's fine.	
Researcher	What percentage of your patients undergo a hypnotherapy programme for childbirth?	
Dr Olivier	Let me say, of those who want a vaginal delivery, about half would want to do it. We don't have large numbers, and of course, there are many who want caesareans.	
Researcher	More or less what percentage want to have caesars as opposed to those who want natural births?	
Dr Olivier	About 50/50.	
Researcher	50/50?	
Dr Olivier	Yes. Our sister here at the hospital, she also goes through the HypnoBirthing® programme with them during the antenatal classes, you know, so there are many of them who have the idea that they would like to do it (HypnoBirthing®). We really try to take trouble, if one can just keep them in that peaceful phase, so that they just don't ... Sometimes you find that they are very motivated, and if the waves [making wave-like motions], the 'surges', are too bad, then one finds it	

	difficult to get them focussed again.	
Researcher	And those who want to do a caesar, or have to, is there anything specific for them, or do they also do the programme?	
Dr Olivier	One of my patients did the programme, and I also reminded her during the caesar to do it.	
Researcher	Was there any specific way that you noticed that the programme made a difference for her?	
Dr Olivier	I truly can't remember.	
Researcher	If the group who do have caesars should attend the programme, do you think they would benefit from it?	
Dr Olivier	I think they should. I definitely think they would. I think they are bound to benefit from it, but to quantify that and to prove it ...	
Researcher	Yes, that is my job ...	
Dr Olivier	[Laughter]	
Dr Olivier	They would definitely have to benefit from it, you know, because they are immediately calmer, they have fewer endorphins, the birth process is more peaceful ... (14:1).	C-Sections
Researcher	[Nodding "Yes"]	
Dr Olivier	We also try to do our caesareans as 'gently' as possible, you know, so the baby comes out, minimal handling initially, put down, no stimulation, lights off, wait for the umbilical cord for at least a minute or two minutes,	

	so you know we try and do everything as calmly as possible. So it will help if the mother is also calmer (14:2).	Calm
Researcher	It looks as if the general perception is that HypnoBirthing® is just for natural births, and ...	
Dr Olivier	...if you don't go that route, then it is automatically out. Yes. No, I agree, it is about the perception. But I do think many people still have the misconception regarding HypnoBirthing®, that they associate it with hypnosis, and ...	
Researcher	Yes.	
Dr Olivier	... and I don't know, to me it's more like just "relaxed birthing". And relaxed breathing (14:3).	Calming and relaxed
Researcher	Yes ...	
Dr Olivier	I don't know if you agree ...	
Researcher	Yes, there are so many myths about hypnosis and such programmes that many people are scared off by the idea of hypnosis. And it does appear that there is a much larger percentage of people where you are who are interested in HypnoBirthing® than here in Port Elizabeth.	
Dr Olivier	[Yes] we seem to be dealing with 'alternatives' here.	
Researcher	Why is that, do you think?	
Dr Olivier	I think our people here are more focussed on the natural. You know … and on alternative treatment	Natural and alternative

	(14:4). They arrive here with the birth plan and everything (14:5).	healing Preparation
Researcher	Okay.	
Dr Olivier	Look, they've done their homework, and they really want to … I think there is much more awareness of what the delivery and the pregnancy and the baby can do (14:6).	Preparation
Researcher	[Mmm …] That's quite interesting.	
Dr Olivier	It's … I don't know if this is in your questionnaire, there are two things … two things that could um … bring me back to the HypnoBirthing®. And that is, that when they get to full dilation and have to begin pushing, well, then you can't … we don't use the word "push" at all …	
Researcher	Yes.	
Dr Olivier	Here is my card [produces a laminated card with terms and phrases relating to HypnoBirthing®]... "birth and breathing down", you know, and "birth breathing", so you can't tell them to "push" at all ...	
Researcher	Yes ...	
Dr Olivier	...and I have had patients who were so calm at that stage, they are flying somewhere, that they don't get the sensation to push (14:7). One [patient] did not get that sensation for two hours [that's the longest I've come across so far] with the head right there. So it's ... and	Calm Risk

	the ... so it can be quite a problem for me. It's very easy to get them to full dilation with the head low, but what do we do to get that baby out of there because they come with the idea, Ms Stabler or this person or that person said, "You just breathe" ... "just breathe the baby out ... Your body will push the baby out". I think that is a bit … oversimplified. It will be like that with the second or third baby.	
Researcher	What is the risk or the problem if they should ...	
Dr Olivier	... two hours ...	
Researcher	Yes.	
Dr Olivier	In the first place, I want to go to sleep [laughing]. Secondly, you're struggling at that stage to monitor the baby with its head so low (14:8). You know, and then sometimes they ask you, "But you said I was ready, why isn't it happening? Why isn't the baby coming?"	Risk
Researcher	Yes.	
Dr Olivier	You know…the patient, they themselves are asking that [question] then. Do you think one should just wait then? Do you think if one waits long enough the baby will come? [laughing].	
	[laughing]	
Dr Olivier	The very first HypnoBirthing® I did was in Knysna a couple of [years] ago. Rene came along. Rene was in Knysna at that stage, and Rene did the HypnoBirthing	

	classes, and then she went to England. And Rene was by my side. So she was there for the whole labour [process]. And she coached her through. It went beautifully until full dilation and then we had this … okay, you know it is now time, we can, the baby is going to come now, and [then] you just don't get that "power". In the end, I told Rene, "I know I'm not allowed to say it, but it's now time to *p u s h*", and I spelled the words out for the therapist. And then she began talking to her again and "breathing down" and I can't tell you the time...and eventually I did a suction because she was exhausted. She couldn't push any more by the time she realised she had to push. So that's the only thing, there is....The HypnoBirthing® is, hypnolabour is fantastic, but that birthing part, that is difficult for me.	
Researcher	This is interesting because the impression I got is that it goes so quickly ...	
Dr Olivier	It is very quick, but then ...	
Researcher	Okay.	
Dr Olivier	And I, um, that one that I can specifically talk about ... and they all [took] about two hours plus, you know, during which you really try and give them a chance and [keep them] as calm as possible … but good heavens if you have to switch on the suction after two hours ...	

	then you are quite fed-up that you didn't do so from the start.	
Researcher	That's very interesting.	
Dr Olivier	Perhaps one could work something into the programme. Because they get here with the perception that "there is no need to push, the body will eject the baby, it's an ejection reflex".	
Researcher	Okay.	
Dr Olivier	But that is all I wanted to ...	
Researcher	What is the impact on you as practitioner when your patients do the HypnoBirthing® programme?	
Dr Olivier	You know, I'm really happy when they do it, and the reason is – and that's what I tell them, too – that it's something they can use later on in their lives as well (14:9).	HypnoBirthing ® uses
Researcher	Mmm.	
Dr Olivier	The impact is not just for now. They can learn things, and they can always apply the technique in future (14:10).	HypnoBirthing ® uses
Researcher	At the birth, is there usually someone who accompanies the person, or not?	
Dr Olivier	Either her husband or sister Annalie.	
Researcher	And does she have training in the HypnoBirthing® ...	
Dr Olivier	Yes, yes.	
Researcher	So there is usually someone who knows the	

	programme?	
Dr Olivier	Yes.	
Researcher	Something mentioned by some participants was that they would have liked the hypnotherapist to have been present at the birth, and because they don't always have medical training, that is often not the case, and their job is done when the classes are done. What do you think about that?	
Dr Olivier	You see, I think, I think if any of the hypnotherapists were actually there during the labour process, then they would see what our problem is.	
Researcher	Do you think it would help if they ...	
Dr Olivier	I think it will help. Yes, I think it will help (14:11).	Practitioner present during labour
Researcher	So, for instance, if someone were to make use let's say of a doula, and it is someone who knows the programme, then ...	
Dr Olivier	That would help, yes. We use … if we use a doula, we use Lana here, very competent, but she didn't do the hypnotraining specifically, but she has done quite a lot with us. So she is familiar with the programme. But I also think it would be a good thing if the therapist could be present at least at one or two births, to see what the circumstances are (14:12). Because it's very	Practitioner present during labour

	pretty, outside the room, you know, but sometimes inside the room, the … the wheels come off. So I don't think it necessary for everyone. I really think, you know, because if you know the programme and you have a sister who can help you, then I don't think they're always needed.	
Researcher	And those patients who may do less well than one expects, can one assume those are patients who are a bit more anxious ...	
Dr Olivier	Yes, definitely.	
Researcher	Would it help if the hypnotherapist assessed which patients were more in need of help ...	
Dr Olivier	Yes, that would be good ...	
Researcher	... so that they can adapt to the needs of the patient ...	
Dr Olivier	...yes, the process is fragmented (14:13). When the classes are done, the therapist's work is done, but then the birth is still to come. It would be good if there could be on-going support (14:14).	Fragmented process Fragmented – continued support
Researcher	In Danelle's case specifically, she mentioned that everything went very well, except that she had more pain than she had expected.	
Dr Olivier	Yes. She was still laughing and chatting until the end. So I actually told her the other day, "But Danelle, you were looking so good until the end". [She said] " ...yes,	

	but it was flipping sore". So I said, "I realise that, but the way you handled it"…it never looked as if she was in serious pain. So from my perspective she did fantastically. I always say she never lost her personality.	
Researcher	Mmm.	
Dr Olivier	She was bearing down already. And then I would talk to her, and she would laugh. And it was not a hysterical laugh. You know, she was still communicating whereas often people are completely overwhelmed by pain at that stage, by the moment (14:14). She went through it very calmly, but now, afterwards, she says it was very sore to her (14:15). From my point of view, I think she handled the pain fantastically well, but she still feels it was too much (14:16). And next time she'll do an epidural [laughing] (14:17).	Pain Pain Pain Pain
Researcher	If you compare her experience to that of people who don't do the programme ...	
Dr Olivier	Much more peaceful, much calmer, much more in control, much more there – present – the co-operation is fantastic ... (14:18).	Calm and in control Cooperation
Researcher	She can't compare, of course ...	
Dr Olivier	Mmm [shaking head "No"]. And I don't think she did that well.	
Researcher	I wonder if somewhere along the way ...	
Dr Olivier	... she got the impression ...	

	... that she would not have pain, or that there wouldn't be any pain ... and that that caught her on the wrong foot ...	
Dr Olivier	That's possible, yes [nodding "Yes"]. You know, so I think it is, you know, one could almost say, tell them there is going to be … pain ... but one is not allowed to use [the word] "pain" – but the fact is just, it is sore, it's just a way to handle it.	
Researcher	She also says she [came in] early, at 34 weeks ...	
Dr Olivier	Yes. She came in at 34 weeks in the night with pain … we didn't know why … but it was so bad, she could barely walk into the hospital. And her words on that Saturday – it was her stork tea; she missed her own stork tea. She said to me, "If this is not labour yet, and it hurts so much, what will THAT be like?" (14:19)	Pain and negative expectation
Researcher	That's very interesting. So it is a self-hypnotic suggestion ...	
Dr Olivier	Exactly. And I also told her, but now … [telephone rings and the doctor attends to the call] (14:20). So where were we? And so I told her, but at 34 weeks, it was unexpected. You weren't prepared, and you know there must be something wrong if you … at that stage … so there [were] many things counting against you (14:21).	Pain Risk

Researcher	So I wonder whether that experience ...	
Dr Olivier	Yes, whether it had a negative impact. And those were her exact words, “If it’s so damn sore now already....” (14:22).	Pain and negative expectation
Researcher	If that had an impact, perhaps it means that if one pays attention to such … that one might address [the matter] beforehand, which might make a difference for such a person.	
Dr Olivier	You see, I did try to make that mind switch at that stage, and Ms Stabler worked with her, and then she stayed in the house for a week, and she … Ms Stabler went on with the sessions. So one hopes that if there had been something, one could have caught it, but perhaps deep down there is still this perception (14:23). But she never seemed to me to be in such severe pain. It’s true she did tear, which I had to suture, but even with that, I could tell her, “Danelle, return to your space” ... and [she was] peaceful (14:24). She was peacefully breathing. So to my mind she did fantastically.	Pain Pain
Researcher	So perhaps that is something one could attend to specifically [in] a programme, where there may be critical incidents that may have an impact later, and if one could be sensitive to such incidents one might adapt a programme ...	

Dr Olivier	Exactly. To get around that (14:25). [Phone rings and the doctor attends to the call].	Pain
	[At this stage, it is clear that one of the doctor's patients is having an emergency and is on her way, and time is of the essence.]	
Researcher	Just with regard to high risk, any patients who had a high-risk pregnancy and who also did the HypnoBirthing® programme?	
Dr Olivier	Mmm [shook head "No"] No, I can't think of anyone right now. If I look at all of them, there are many of them who don't do the official programmes at all, for financial reasons, but sister Annie helps them with the meditation, with the visualisation, with the CDs, with the book as well, you know, so if I tell you we try and do 25% of it, then it is not an official training.	
Researcher	Those who don't do the official programme, do they do other antenatal classes as well?	
Dr Olivier	They do … yes. But that is free of charge, at the hospital. And then they include the HypnoBirthing® in the antenatal classes.	
Researcher	Those who come for a caesar – is there anything you can think of that one could include in the programme, HypnoBirthing® or anything else – what [kind of] support do they need?	
Dr Olivier	I think it has tremendous value if they can be calm	HypnoBirthing

	(14:26). That they can bond more easily and initiate breastfeeding more easily (14:27). Because look, we try nowadays to keep the baby in the theatre, on the mother. We don't remove the baby. We have even got a baby ready, in theatre, to begin suckling. You know, but they are so anxious and nervous that everything is just ...	® uses HypnoBirthing ® and C-Section
Researcher	... yes ...	
Dr Olivier	So if they can be calmer, the bonding and the breastfeeding will go better – that is my hypothesis (14:28).	HypnoBirthing ® use
Researcher	And in terms of the HypnoBirthing®, if one should adapt the programme, what would you like to see change in the programme?	
Dr Olivier	Just the labour, just that pressure, how do we get over the hurdle between full dilation to baby out? That little stretch. And then there one little thing they should build into the programme – 2 o'clock in the morning, mom's upset, baby colicky and screaming, that the mommy can get back to a calm state again ... (14:29).	Calm
Researcher	So again, perhaps – something that is not fragmented, that doesn't […] just after the first part ...	
Dr Olivier	Yes. [The doctor's patient has arrived and there is no more time for the interview].	
Researcher	Thank you very much.	

Table 20: Dr Oliver: Emergent themes from categories

CATEGORIES	EXAMPLES FROM TRANSCRIPT (DIRECT QUOTATIONS)	THEMES
Coping: Calmness	So it will help if the mother is also calmer? (14:2) ...and I don't know, to me it's more like just "relaxed birthing". And relaxed breathing. (14:3) ...and I have had patients who were so calm at that stage, they are flying somewhere, that they don't get the sensation to push. (14:7) Much more peaceful, much calmer, much more in control, much more there – present – the co-operation is fantastic.... (14:18) And then there one little thing they should build into the programme – 2 o'clock in the morning, mom's upset, baby colicky and screaming, that the mommy can get back to a calm state again ... (14:29)	HypnoBirthing® patients are substantially more in control and calmer than patients who did not undergo the training. HypnoBirthing® can benefit mothers in dealing with a crying and upset infant.
Coping: Natural health	I think our people here are more focussed on the natural. You know … and on alternative treatment. (14:4) They arrive here with the birth plan and	People with a natural or alternative approach to healing

	everything. (14:5)	(as opposed to medical approach) take more responsibility to control the labour and birth process.
Coping: Cooperation	Much more peaceful, much calmer, much more in control, much more there – present – the co-operation is fantastic ... (14:18)	Medical practitioners experience HypnoBirthing® patients as calm and in control, and more cooperative with the medical staff during labour.
Coping: Psychological support fragmentation	...yes, the process is fragmented. (14:13) When the classes are done, the therapist's work is done, but then the birth is still to come. It would be good if there could be on-going support. (14:14)	There is fragmentation in the process of support, i.e. the HypnoBirthing® training takes place before labour. During labour the medical staff take over, and after

		birth, the mother deals with the infant alone unless she needs help. There is not enough continuity in this process that is intended to support the mother.
Preparation and practice	They arrive here with the birth plan and everything. (14:5) Look, they've done their homework, and they really want to … I think there is much more awareness of what the delivery and the pregnancy and the baby can do (14:6).	HypnoBirthing® clients tend to take more responsibility for the planning and the process of labour and birth because there are more informed.
Experience of pain	You know, she was still communicating whereas often people are completely overwhelmed by pain at that stage, by the moment. (14:14) She went through it very calmly, but now, afterwards, she says it was very sore to her. (14:15) From my point of view, I think she handled the pain fantastically well, but she still feels it was	Danelle was managing the pain much better than she realised.

	too much (14:16). And next time she'll do an epidural. [laughing] (14:17) She came in at 34 weeks in the night with pain … we didn't know why … but it was so bad, she could barely walk into the hospital. And her words on that Saturday – it was her stork tea; she missed her own stork tea. She said to me, "If this is not labour yet, and it hurts so much, what will THAT be like?" (14:19) Exactly. And I also told her, but now … [telephone rings and the participant attends to the call] (14:20) Yes, whether it had a negative impact. And those were her exact words, "If it's so damn sore now already ... " (14:22) You see, I did try to make that mind switch at that stage, and Tracy worked with her, and then she stayed in the house for a week, and Tracy … Tracy went on with the sessions. So one hopes that if there had been something, one could have caught it, but perhaps deep down there is still this perception. (14:23) I could tell her, "Danelle, return to your space" ... and [she was] peaceful. (14:24) Exactly. To get around tha.t (14:25)	Danelle's early labour and pain experience created an expectation that later labour would be excruciating. During the hypnotherapeutic preparation, attention could be given to underlying beliefs or critical incidents which may create fear and thus interfere with the ability to obtain hypnotic phenomena such as

		analgesia or anaesthesia.
Risk	...and I have had patients who were so calm at that stage, they are flying somewhere, that they don't get the sensation to push. (14:7) In the first place, I want to go to sleep [laughing]. Secondly, you're struggling at that stage to monitor the baby with its head so low. (14:8) And so I told her, but at 34 weeks, it was unexpected. You weren't prepared, and you know there must be something wrong if you … at that stage … so there [were] many things counting against you. (14:21)	A potential risk from a medical perspective is that complete calmness may interfere with the urge to "push", and at this stage, monitoring of the infant is difficult.
HypnoBirthing® uses	They would definitely have to benefit from it, you know, because they are immediately calmer, they have fewer endorphins, the birth process is more peaceful ... (14:1) I think it has tremendous value if they can be calm. (14:26) That they can bond more easily and initiate breastfeeding more easily. (14:27) So if they can be calmer, the bonding and the breastfeeding will go better – that is my hypothesis. (14:28)	The calmness associated with HypnoBirthing® allows for a calmer birth even when doing a caesarean section. The calm and

	That it's something they can use later on in their lives as well. (14:9) The impact is not just for now, they can learn things, and they can always apply the technique in future. (14:10)	relaxed response of HypnoBirthing® facilitates bonding and breastfeeding.
HypnoBirthing® practitioner present during labour	I think it will help. Yes, I think it will help. (14:11) But I also think it would be a good thing if the therapist could be present at least at one or two births, to see what the circumstances are. (14:12)	It would be beneficial for the HypnoBirthing® practitioner to be present during labour and birth, or at least during some of them.

APPENDIX C

INFORMED CONSENT FORM

Dear Respondent,

That you for agreeing to participate in the research study on the experiences of women of hypnotherapy (HypnoBirthing®) as psychological support during high-risk pregnancy.

This study is being undertaken as the full requirement for the degree of M.A. Psychology at the University of South Africa during 2012 and 2013. Should you have any questions regarding the official status of this research, you may contact the Research Supervisor, Dr. Madri Jansen van Rensburg at madri@resilienceanalysis.com.

Please take a few minutes to complete the informed consent form below. This form has been designed to ensure that research participants are aware of their rights and obligations, and have all the information necessary to provide informed consent. The researcher will answer any questions you may have about the research before you sign this form.

*The researcher is Mr. Werner van der Westhuizen (student number: 47225181), and he can be contacted at wernervdw@yahoo.com or telephonically at 082*******.*

Please ensure that you read the following information carefully, making sure you understand each section before indicating your consent for participation by placing your signature at the end of the form.

Researcher Information

You agreed to participate in a research study that explores your experiences of HypnoBirthing® sessions conducted during your pregnancy by a HypnoBirthing® practitioner. The researcher is a qualified social worker who has undergone further training in hypnotherapy and he is therefore competent to conduct research in this area. Should you have any further questions about the qualifications or experience of the researcher, please do not hesitate to enquire.

Voluntary Participation

Participation in the research study is voluntary. Participants should not feel coerced or pressurised in any way to participate in the study.

Termination of Participation

Participation in the study is voluntary, and participants may terminate their participation at any time without any obligation. The right to self-determination is held in the highest regard.

Confidentiality

The identity of the research participants, as well as their personal information will remain confidential and no personal information will be made public from which participants can be identified. The identity of the research participants will be known only to the researcher and the referring or participating parties in each case (for may for example include a medical

practitioner or nurse). Please note that there are certain legal limitations that to confidentiality that apply to all mental health professionals. All interviews will be recorded, and any identifying information in the recordings will be removed or altered to protect the identity of the participants. The information obtained during the interviews (which exclude identifying details) will be used for the research study and may be published for scholarly or academic purposes.

Prevention of Harm

It is important that participants suffer no harm as a result of participating in the study. Participants will not be required to do anything that will place them at risk in any way.

Unintended Consequences

While being interviewed, it is possible that the content of the discussion or interview may be sensitive or emotionally upsetting, although care will be taken to ensure the emotional comfort of the participants. Each participant remains in control of the content being shared during the interview, and should only discuss content that they are comfortable sharing with the researcher.

Potential Benefits

There are no direct benefits anticipated for the participants of this study, other than the knowledge that by participating in the study they are contributing to the body of professional knowledge which is intended to benefit other women who undergo HypnoBirthing® during pregnancy.

Payment and Cost

Research participants are not expected to carry any cost as a result of participating in the research. Participants are not remunerated in any manner for participating in the research.

Indemnity

Ultimately each research participant is the expert of their own body and mind, and has to take responsibility to do what is in their own best interest. By signing this consent form, the research participants agrees not to hold the researcher or university liable for any damages that may result, directly or indirectly, for participating in this research study.

Questions or Concerns

Please take care that all questions and concerns have been addressed by the researcher to your satisfaction. If there are any questions or concerns which have not been addressed by the researcher completely, please discuss these to your complete satisfaction before signing the consent form below.

I, …….. hereby provide my full and informed consent for participation in the research study. Any questions and concerns I had have been completely answered and explained to my satisfaction. I am aware that I may withdraw from the study at any time.

SIGNATURE DATE