HYPNOTIC ANALGESIA IN OBSTETRICS: AN ECOSYSTEMIC DESCRIPTION

by

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DEDICATION

This dissertation is dedicated to the memory of Adele Tabak who died tragically at the beginning of the year but without whom none of the research participants would have been willing to participate in the study. It is also hoped that this dissertation will play a part in keeping alive her fight for natural childbirth and the sense of integrity achieved through this.

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SUMMARY

In this study, hypnotic analgesia in obstetrics is explained in terms of ecosystemic thinking, as opposed to traditional conceptualisations of hypnosis. Five case studies were used. Each case is described in detail, as well as the therapeutic rationale behind each case, in order to present the reader with an understanding for the thinking behind the doing of ecosystemic hypnotherapy. The study utilises a new paradigm approach to research which is explained and is in keeping with ecosystemic epistemology.

KEY WORDS

Hypnotic analgesia, hypnotherapy, paradigm, ecosystemic hypnosis, systems thinking, cybernetics, epistemology, participant observer, consensual domain, domain of perturbations, constructivism, social constructionism.

CHAPTER 1

INTRODUCTION

The use of hypnosis for the control of pain during medical procedures is over 150 years old, with the first reported use of "animal magnetism" - as it was then called - dating back to 1829 (Perry & Laurence, 1983). It has since been used, amongst other things, for dental procedures [including routine fillings, root canal treatments, and extractions (Morse, 1977; Morse, Schoor & Cohen, 1984; Toth, 1985)], amputations, removal of cancerous tumours (Perry & Laurence, 1983), cesarean sections, abdominal explorations, prostate operations, biopsies (Chaves & Barber, 1976), gastrointestinal endoscopies (Jackson & Middleton, 1978), and the surgical correction of "tongue-tie" in a 4-year-old child (de Escobar, 1985).

With the advent of chemical anaesthetics, the need for, interest in, and study of hypnotic analgesia diminished. However, many authors (Barber, 1977; de Escobar, 1985; Jackson & Middleton, 1978) have pointed out that the advantage of hypnotic analgesia and hypnotic anaesthesia is that it has none of the side-effects or dangers of chemical analgesics and anaesthetics, especially where these are contraindicated, due to specific medical or personal conditions. In addition, hypnosis used as an adjunct for pain control can significantly reduce the amount of drugs needed (Chaves & Barber, 1976; Harmon, Hynan & Tyre, 1990; Morse, 1977).

Hypnotic analgesia has also found clinical use in the relief of chronic pain such as migraine, back pain (Bassett, 1992), phantom limb pain, and post-operative pain (Weiss, 1993). Especially in this area, several authors and clinicians have found it useful to speak

about two levels at which pain operates, namely the nociceptive level (pain as a neurological event) and the emotional level (Bassett, 1992; Chaves & Barber, 1976; Chertok, Michaux & Droin, 1977; Kihlstrom, 1985; Weiss, 1993). Most hypnotic interventions are directed at the emotional level. One of the most widely-used theories in the explanation of pain mechanisms, namely the gate control theory of Melzack and Wall, as explained by Whipple (1987) posits that the nociceptive input can be selectively modulated by the nervous system. There is still speculation as to whether hypnosis can impact on this process but it would presumably be via the mechanism of impacting on the emotional level of pain perception which would then modify the nociceptive experience.

The unique context of labour pain is such that the mother usually wants to be fully conscious of giving birth and able to participate actively in the process. This excludes the use of general anaesthetics (which can also prove harmful to the unborn baby). The use of epidurals or pain-relieving drugs (pethidine and nitrous oxide) is not an entirely satisfactory solution either. Apart from various birth complications that can result (such as forceps deliveries), these methods are not guaranteed nor do they always allow for full consciousness or satisfactory sensations during delivery (Chalmers, 1990). It is in this context that hypnosis is seen as a useful adjunct to other pain control methods. Apart from being an effective analgesic, Harmon et al., (1990) have also shown that hypnosis during childbirth can have the following advantages: shorter stage one labours, less medication, higher Apgar scores [a "composite rating of the neonate's physical condition on the basis of five criteria" (Harmon et al., 1990, p. 526)], more frequent spontaneous deliveries, and fewer incidents of 'baby blues' and post-partum depression.

Some of the advantages of using hypnosis in childbirth are expressed in the following statement made by a psychologist who used Lamaze methods during the birth of her first

child but hypnosis during the birth of her second child: "Subjectively, however, hypnosis felt far superior in that it provided a mental escape from the negative aspects of labor (sic) while allowing full participation in the experience of giving birth" (Weishaar, 1986, p 216).

In relation to other areas of hypnotic pain management, there seems to be a shortage of literature available on labour pain control. However, the issue most frequently raised in the literature about pain control is a search for the mechanism(s) responsible for its functioning. Attempts to deal with this issue fall into several categories, including dissociation theory (Marcuse, 1983; Miller & Bowers, 1983), neodissociation theory (Chertok et al., 1977; Hilgard, 1973), role theory (Hilgard, 1973), psychoanalytic ego theory (Hilgard, 1973), hidden observer explanations (Chertok et al., 1977; Spanos & Hewitt, 1980), trance logic (Perry & Laurence, 1983), social psychological interpretations (Spanos, 1986), imaginative involvement (Perry & Laurence, 1983), and the mediating effects of various neurochemicals including norepinephrine and endorphins (Jackson & Middleton, 1978; Kihlstrom, 1985; Marcuse, 1983).

Thus far, it seems as if there is a great deal of uncertainty in the above attempts at dealing with the issue of the mechanism working in hypnotic analgesia and it seems unlikely that clarity will be reached. The commonality in the above approaches is that they all adhere to a positivist or Newtonian epistemology which emphasises reductionism, linear causality, objectivity (Fourie & Lifschitz, 1989) and decontextuality. Within this paradigm, the search for a mechanism appears to be turning into a holy grail. It may thus be useful to consider the subject of hypnotic analgesia from a completely different paradigm in order to gain a new, possibly more useful, perspective on the subject.

The purpose of this study, then, was to look at the question of the 'mechanism(s) at work' from a different perspective. Rather than trying to find an explanatory mechanism

internal to the hypnotic subject, as has been the case in most of the literature, the explanation will be situated within the ecosystemic paradigm which emphasises the process between all participants and the way in which the meaning of behaviour is generated in order to influence experiences of reality. It is believed that this explanation will prove more useful than those mentioned above.

This researcher will adhere to a growing scientific trend by turning to a "postpositivist", "naturalist" (Lincoln & Guba, 1985), or ecosystemic epistemology. This approach considers behaviour from within an ecology of ideas and uses the principles of systems theory to study such behaviour (Fourie, 1989). As such, it can be described as holistic, acausal, ecological, and constructivistic (Fourie & Lifschitz, 1989). Lincoln and Guba (1985) delineate the following five concepts as axiomatic to the naturalistic paradigm:

> Realities are multiple, constructed, and holistic; Knower and known are interactive, inseparable; Only time- and context-bound working hypotheses (ideographic statements) are possible; All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects; Inquiry is value-bound. (p. 37)

The ecosystemic approach will not only be applied to the research design employed, but also to the conception and understanding of hypnosis. Fourie and Lifschitz (1989) and Fourie (1989) posit the following implications of an ecosystemic conceptualisation of hypnosis and hypnotherapy: hypnosis is a concept, not an entity; hypnotic behaviours are not caused; hypnotic behaviours exist within a domain of consensus; hypnotic induction is a punctuating ritual; hypnotic responsiveness is contextually specified; hypnotherapy

embodies the explicit use of hypnosis; hypnotherapy utilises the client's attributions of the power of hypnosis. From an ecosystemic point of view then, hypnosis can be defined as "a concept that describes a situation in which all participants expect the subject to perform behaviours in such a way and of such a nature that they are understood by everybody to be hypnotic" (Fourie, 1988, p 144).

The subject of child-birth was chosen for a number of reasons. As mentioned above, it represents a unique context of pain which is easily delineated by its nature. However, it was still felt that the explanations relevant to this context would be broadly generalisable to other areas of pain control. In addition, the idea of non-medical pain control is not foreign in this area and so, participants would be more open to an 'alternative' coping method.

As mentioned above, the focus of this study will be to examine hypnotic analgesia from an alternative perspective. However, in order to do this, it is necessary to first gain an understanding of hypnosis and hypnotic analgesia from the traditional paradigm. The following chapter will first deal with this, before proceeding to explain ecosystemic hypnosis.

CHAPTER 2

THEORETICAL EXPLANATIONS OF HYPNOSIS

It was previously mentioned that there are several theoretical explanations for hypnosis. These approaches can be divided into two major sub-categories, namely traditional , Newtonian, positivist approaches, and the new ecosystemic approach. This chapter will give a brief outline of these different approaches and look at how the ideas are applied in the explanation of the analgesic effects of hypnosis in general and by implication, in the specific context of labour pain.

Traditional Positivist Approaches

The traditional positivist approaches can be divided into four main explanatory categories, namely state approaches, non-state approaches, Ericksonian approaches, and the interactional approach (Allan, 1994). A fifth category within the specific area of hypnotic analgesia can be added, namely those theories concerned with discovering how hypnosis interacts with physiological mechanisms of pain control. These approaches will be explained with reference to their application in the field of pain management. Their commonalities will then be extracted.

State Approaches

Proponents of the state approach hold that through hypnosis, the subject is able to reach an altered state of consciousness. It is this altered state that is deemed to be responsible for the subject's ability to deal with pain in a seemingly supernatural manner. Perry and Laurence (1983) trace the beginnings of this idea to the early uses of 'animal magnetism' and the surgical use of hypnosis in India in the mid-nineteenth century. The theory began to develop into a more concrete form as Dissociation Theory. As explained by Hilgard (1973), the historical roots of this theory were planted in psychoanalytic theory with concepts such as conscious- sub-conscious- unconscious, id- ego- superego and subliminal self, all of which divided the person into bits which were believed to be separate from each other. Dissociation Theory explains the specific mechanism thought to be responsible for the analgesic effect of hypnosis in the following way. Once the subject is hypnotised, a barrier is created which separates the cognition that feels pain from the cognition responsible for communicating this experience. Alternatively, when a subject is hypnotised, it allows for the conscious cognitive attempts to control pain to be bypassed in favour of more efficient direct control of pain using hypnotic suggestion (Miller & Bowers, 1983).

It is maintained that evidence for Dissociation Theory can be found in the fact that one sometimes finds physiological indications of pain in the subject even though pain is not reported. In addition, through hypnosis, the 'experiencing part' can be accessed at a later stage and through a process of automatic writing, it is enabled to report on the pain. This evidence led to a problem for proponents of Dissociation Theory as according to this view, the dissociation between parts was believed to be complete. This would not allow for

access between parts under subsequent hypnosis or through automatic writing. Thus, Neodissociation Theory proposed that the dissociations may be partial and incomplete. According to this view, there is a dominant system in each individual responsible for executive control of the person. It is this system which allows one the experience of unitary identity. Several subordinate systems function at a hierarchically lower level to this executive system. Within these subsystems, the hierarchy is flexible. Hypnosis further facilitates shifts within this hierarchy as well as reducing the dominance of the executive system. Hypnotic analgesia is understood in much the same way as in Dissociation Theory, but Neodissociation Theory allows for access to different parts of the hierarchy of components within the subject. In a further development within this theoretical territory, the part of the individual responsible for producing the automatic writing was called the 'hidden observer' (Chertok et al., 1977; Hilgard, 1973). Although this term was initially intended metaphorically, Fourie (1998) explains that it began to be thought of as a real entity through the Newtonian process of reification. Spanos and Hewitt (1980) have criticised the hidden observer view and in an experiment which will be described in more detail in the following section, they showed that experiments proving the existence of the hidden observer do so by experimentally creating the concept. This criticism led to a polemic with Zamansky (in Fourie, 1998) and Bartis (in Fourie, 1998) in which they once again conducted experiments to prove the existence of the dissociation phenomena. However, both Spanos and his colleagues and Bartis and Zamansky fail to acknowledge the role the creation of each experimental situation played in proving their theories (Fourie, 1998).

In a study reported by Morse et al., (1984), it is evident that Dissociation Theory has become accepted wisdom. These authors state in their summary that the patient "usually

was able to dissociate and take a pleasant mental trip" (p. 27). They give no further explanation as to what is meant by dissociation but the implication is that the mind is divided and does not notice the pain when another part of it is focusing on something else.

Perry and Laurence (1983) add an additional angle to the state approaches. According to them, the success of hypnosis is related to the manner in which the hypnotic induction interacts with different degrees of hypnotic susceptibility or "receiver characteristics" (p 367). These characteristics include imagery, absorption and dissociation and may vary in either a qualitative manner (different people have different combinations and permutations of them) or in a quantitative manner (all people have all three characteristics to a different degree). The implication of this is that hypnosis enables the subject to tap into these characteristics through some kind of altered state. In addition, the mechanics of the altered state of consciousness may be different in each case - dissociation divides consciousness and acts as a filter between pain and the experience of pain while imagination competes with the pain experience for "space" within consciousness.

Non-State Approaches

Nicholas Spanos was one of the most important exponents of the social psychological or non-state explanations of hypnosis. According to this view, hypnosis is nothing more than the use of socially-influenced cognitive skills and abilities. Spanos (1986) explains that the social psychological approach views hypnotic behaviour as

> purposeful, goal-directed action that can be understood in terms of how the subjects interpret their situation and how they attempt to present themselves through their

> actions. ... "good" hypnotic subjects frequently behave *as if* (italics in original) they have lost control over their behavior ... because their preconceptions about hypnosis and the persuasive communications they receive in the hypnotic test situation define acting that way as central to the role of being hypnotized. (p 449)

Most of the work carried out by Spanos and his colleagues involves the manipulation of the research situation or context as well as experimenter expectation cues in order to show how hypnotic phenomena vary accordingly. Thus, Spanos and Hewitt (1980) showed that they could manipulate whether the 'hidden' part or the 'hypnotised' part of a subject felt pain as a result of different hypnotic suggestions. The outcome showed that Hilgard's (1973) 'hidden observer' can be seen as an experimentally created construct resulting from the subject's desire to enact the role of the good hypnotic subject. It is, however, explained that the subject's experience of a 'hidden part' is not a result of faking but the employment of a commonly used metaphorical self-description within the context of appropriate hidden observer analgesia cues. In a similar way, Stam and Spanos (1980) showed that the degree to which hypnosis is effective in reducing pain is a function of preconceptions regarding the efficacy of hypnotic analgesia as conveyed by the researcher to the subjects.

The cognitive strategies used to control pain both by subjects under hypnosis and those not hypnotised were compared by Spanos and Radtke-Bodorik (1979) and no differences were found. They thus concluded that the mechanism responsible for hypnosis is not a mysterious automatic process. Rather, it is something the subject is responsible for initiating and is nothing more than cognitive coping strategies such as distraction, imagining events inconsistent with the pain, coping verbalisations ("This isn't so bad") and relaxation. Stam and Spanos (1980) suggest that, "(hypnotic) analgesia suggestions exert

their effects by modifying the cognitions subjects engage in during noxious stimulation" (p. 760). However, although the mechanism for hypnotic analgesia is cognitive coping strategies, subjects often label these strategies as 'automatic' or 'non-volitional' as a result of experimenter demand characteristics.

Ericksonian Approaches

The theoretical basis of Ericksonian hypnosis was never formulated by Milton Erickson himself but his many followers explained and replicated his methods in terms of communications theory. They explain the basis of hypnosis as the only possible response to the special type of communication leveled at the subject by the hypnotist (Fourie, 1988). The emphasis in Ericksonian hypnosis is thus the perfection of techniques in order to obtain hypnosis under these conditions. According to Weiss (1993), Erickson described the following 11 basic hypnotic procedures to be employed for pain control: direct hypnotic suggestion for the total abolition of pain, permissive indirect hypnotic abolition of pain, amnesia, hypnotic analgesia, hypnotic anesthesia, hypnotic replacement or substitution of sensations, hypnotic displacement of pain, hypnotic dissociation, hypnotic reinterpretation of the pain experience, hypnotic time distortion, and hypnotic suggestions effecting a diminution of pain. Erickson specialised in the use of indirect techniques which supposedly by-pass consciousness, going straight to the unconscious - the site of hypnosis. Ericksonian hypnosis also emphasises the matching of subject variables or characteristics to specific techniques.

Haley's Interactional Approach

Haley (1963) focuses attention on the relationship that is seen to cause hypnosis. He takes a pragmatic stance in saying that the only valid description one can make is in terms of the hypnotic relationship (using communications theory terms) because it can be observed and is not inferred, as are the intrapsychic mechanisms. He does not deny the existence of these intrapsychic mechanisms; he only says it is fruitless to make conjectures about them. He explains that other theories focus attention on entities in themselves said to be responsible for hypnosis (magnets, the individual's nervous system, suggestion), independent of the relationship.

According to Haley (1963), hypnosis is the definition by the hypnotist and the acceptance by the subject of a paradoxical relationship within a broader complementary relationship. It is the nature of the relationship that causes hypnosis. The nature of human communication is such that it takes place on different levels at the same time - one message is qualified or framed by another message which gives it meaning. It is this very fact that allows the hypnotic participants to communicate something at one level while denying it at another level. Hypnotic induction is actually a set of paradoxical commands in which the subject tries to respond to both sides of the paradox. For example, the suggestion "do not move your hand, just notice how your hand is lifting" is actually a request for the subject not to lift his or her hand and to lift the hand. The only 'sane' response to the hypnotist's request for the subject to do something and not do it is to deny that it is the subject who is doing it and therefore to experience it as involuntary. Haley further explains involuntary (trance) behaviour in terms of the following different levels of communication: (i) a single statement about behaviour is made which is (ii) incongruent with reality but is (iii)

consistent with other statements within the trance. What we observe as a result of this is seemingly involuntary behaviour. When it comes to pain control, the subject responds passively to the pain stimulus (i above). This act is (ii) incongruent with reality. However, the behaviour is (iii) affirmed by the subject's other behaviours - self-reports of no pain, passivity, tone of voice congruent with not feeling any pain, etcetera. Thus, according to Haley, the mechanism responsible for hypnotic analgesia is the very nature of human communication patterns.

Physiological Mechanisms and Hypnosis

There is an increasing attempt to understand the mechanism of hypnotic analgesia in terms of the way it interacts with physiological mechanisms. To this end, there are two main areas of study. The first is an attempt to understand hypnotic analgesia from within the Gate Control Theory of pain posited by Melzack and Wall in the 1960s (Whipple, 1987). Secondly, medical scientists are attempting to discover the neurochemicals directly responsible for hypnotic analgesia as well as the mechanism by which this occurs.

Whipple (1987) explains that according to the Gate Control Theory of Melzack and Wall, the nervous system contains mechanisms which can selectively modulate nociceptive input (pain as a physiological event) as opposed to emotional input. Pain messages travel along two different types of fibres (A-delta and C fibres). Activity in the A-delta fibres act to inhibit pain stimuli in the C fibres, thus 'closing the gate' to pain . Toth (1985) adds that

> pain signals are modified by neurones (sic) on the cortex as well as by controls in the limbic system, brain stem and spinal cord. Thus, the Gate Control Theory offers a

partial theoretical explanation for the way hypnosis can alter perception of pain through changing cognitive, emotional and sensory aspects of the pain experience. (p 117)

He goes on to explain that the discovery of the physiological structures responsible for the Gate Control Theory are valuable in that they provide a physiological basis for Dissociation Theory - although nociceptive information is registered, it is blocked off (dissociated) from consciousness by an amnesic process.

Without making specific reference to the Gate Control Theory, Barber (in Jackson & Middleton, 1978) explains that pain is a multidimensional concept incorporating the type of pain as well as the emotional reaction component (fear, anxiety, etc). Patients feel more pain when they are anxious. Hypnosis decreases anxiety and thus is effective because it helps the patient to relax.

Turning now to the neurochemical studies, there have been attempts to link endorphins - key neurotransmitters involved in the pain and reward systems in the brain (Palfai & Jankiewicz, 1991) - to hypnotic analgesia. However, Goldstein and Hilgard (in Whipple, 1987) as well as Barber (in Toth, 1985) showed that the endorphin transmitter system is not the mechanism responsible for hypnotic analgesia. A different area was explored by Sternbach (1982). Although he admits that very little is known about the neurochemical mechanisms involved in hypnotic analgesia, he hypothesised that dopamine, serotonin and acetylcholine may be involved. His findings were not scientifically significant but did suggest a trend in the direction that acetylcholine may be involved. Thus, the theories on the neurochemical mechanism involved in hypnotic analgesia are inconclusive at present.

Staying within the realm of neuropsychology but moving away from neurochemicals, Roig (1961, in Werner, Schauble & Knudson, 1982) proposed that the

"hypnoreflexogenous" method of hypnosis (which combines principles of conditioned reflexes with hypnosis) causes a deep psychological sedation. It has been observed that the cortical excitability is extremely low in this state and it is believed that this aids in the lessening of pain.

Commonalities in the Traditional Approaches

The common characteristics of the above five approaches to hypnotic analgesia can only be understood with reference to the assumptions found within the Newtonian, positivist paradigm. These will only be mentioned briefly now as a fuller discussion will follow in the next chapter.

Briefly, the traditional positivist paradigm is that general system of ideas or world view based on the assumptions of John Stuart Mill in the mid-nineteenth century (Lincoln & Guba, 1985) and the ideas of Isaac Newton which formed a framework for scientific research since that time, most notably in Newtonian physics. The first major assumption is the belief in an objective reality separate from the observer. This reality is also believed to be independent from the context in which it is observed and unchanging from one context to another. The reality can be broken down into its parts in order to be better understood. These parts act in relation to one another in a linear way, causing effects from these interactions. Furthermore, the parts are believed to be separate entities from one another, influencing each other only in this linear manner. Finally, as a result of the above assumptions, there is a tendency to infer the existence in reality of the concepts used to explain causal relationships. This is called reification. In simple terms then, the main

assumptions can be summarised as belief in an objective reality, decontextuality, reductionism, linear causality, dualism, and reification (Lincoln & Guba, 1985).

In terms of the above, it is clear to see how the state approaches adhere to the belief in an objective reality. The intrapsychic world is viewed as existing independent of the observer regardless of context. Furthermore, this world is reduced to different components (conscious and subconscious; a hierarchy of parts) which are then dissociated from each other. The dissociation is caused in a linear manner by the process of hypnotic induction and analgesia is caused by the dissociation process, by the shift in hierarchy facilitated by the trance or by direct hypnotic suggestion. As a slight variation, it is proposed that the linear relationship may be influenced by different receiver characteristics which directly improve or hamper the trance state. Finally, the dissociation barrier and the Hidden Observer are prime instances of explanatory concepts becoming reified.

Within the non-state approaches, the objective reality of hypnosis is an implied assumption. Furthermore, the fact that theorists find it very difficult to clearly define what is meant by the trance state but still use the concept unquestionably and assume it to be recognised as such by all those working with it, shows the extent to which it is held to be part of a decontextual, general, unchanging, objective reality. In their explanation, proponents of this approach (such as Stam and Spanos (1980) mentioned above) tend to reduce the hypnotic analgesic mechanism to cognitive coping strategies. Other components of the reality of hypnosis are implied in the linear explanation that hypnosis is caused by experimenter cues and the context. The experimenters all seem to feel that they can manipulate hypnosis in a linear manner in order to investigate the phenomenon. In their concept of experimenter cues, the tendency to reify is apparent.

Ericksonian hypnosis is not really all that different in general terms to the state approaches, differing mainly in the specific emphasis on techniques (Weiss, 1993). Once again, there is belief in the objective existence of the hypnotic state which can be caused by the application of a suitable technique. The belief in hypnosis as an objective entity is highlighted by the indirect hypnotic induction technique which 'tricks' the subject into becoming hypnotised. In the case of hypnotic analgesia, there is a choice from 11 such techniques which need to be matched to specific subject characteristics. This matching of technique with subject in order to maximise the trance, highlights the linear logic. In addition, the techniques themselves are another instance of objective reality (Fourie, 1991, 1992).

Haley's (1963) Interactional approach seems on the surface to differ significantly from the other approaches in that it describes hypnosis from a different vantage point. However, on closer examination, it too falls into the positivist paradigm in that it encompasses many of the positivist assumptions. Clearly Haley views hypnosis as an objective entity which is caused in a linear manner by the type of relationship established by the hypnotist with the subject. The way in which Haley separates different parts of the communication sequence into separate bits and the context into different layers is clearly adherence to the assumption of reductionism. In addition, the use of the frame metaphor is in danger of falling prey to reification.

The physiological approaches to hypnotic analgesia offer the clearest instance of the positivist assumption of dualism in that they are attempts to discover how the mind causes changes in the body, with mind and body considered as two separate entities. The above is also evidence of linear causality at work. Once again, there is belief in an objective reality and a search for objective physiological mechanisms such as fibres, neurochemicals and

parts of the brain said to be responsible for hypnotic phenomena. Explanations are then reduced to these physiological mechanisms and parts. Furthermore, the Gate Control Theory is yet another instance of an invitation to reification in its use of the gate metaphor.

Table 2.1 on the following page is a summary of the above ideas and shows how each characteristic fits into the different approaches.

Ecosystemic Approach

The ecosystemic conceptualisation of hypnosis represents a paradigm shift in thinking. In order to understand this shift, it may be useful to first understand the historical background out of which it grew.

History and Background

According to both Haley (1971) and Guerin (1976), the family therapy movement arose during the 1940s and 1950s. Guerin attributes the focus on families to the aftermath of World War II as well as to a growing dissatisfaction with the limitations of individual therapy. Haley (1971) comments on the shift in focus to complex systems and total ecologies within the social sciences. At this time, a growing number of therapists and researchers from around the world began to see that the social context in which emotional dysfunction was found was important in understanding and in working with such problems. Minuchin (in Minuchin, Montalvo, Guerney, Rosman & Schumer, 1967) began studying families of delinquent boys. Bateson (in Bateson, Jackson, Haley & Weakland, 1956) researched the communication patterns in the families of schizophrenic patients and out of

Table 2.1

Summary of Characteristics in Traditional Hypnosis

	STATE	NON-STATE	ERICKSONIAN	HALEY	PHYSIOLOGICAL
OBJECTIVE REALITY	- intrapsychic world	- implied	- hypnotic state - 11 techniques	- hypnotic state	- hypnotic state - neurophysiology
DECONTEXTUAL	- intrapsychic world	- implied	- 11 techniques		- hypnotic state - neurophysiology
REDUCTIONISTIC	- components of intrapsychic world: conscious, subconsious; different hierarchical levels	- hypnotic analgesia as cognitive coping strategies - experimenter cues - context		- separation of communication sequence - layers of message	- neurochemicals, fibres, parts of the brain
LINEAR CAUSALITY	- hypnotic induction causes dissociation - hypnotic analgesia caused by dissociation, shift in hierarchy or hypnotic suggestion - trance quality affected by receiver characteristics	- hypnosis caused by experimenter cues and context - hypnotic phenomena can be directly manipulated	- hypnosis caused by suitable technique matched to the subject	- hypnosis caused by complementary relationship	- hypnosis causes physiological changes which cause analgesia
DUALISM					- separation of mind and body
REIFICATION	- dissociation barrier - hidden observer	- experimenter cues		- frame metaphor	- gate metaphor

his collaboration on this work with Haley, the double bind concept arose. Bowen (in Guerin, 1976) focused on the symbiotic relationship between mothers and their schizophrenic children. Perhaps one of the most important developments in the family therapy movement at this time was the application of principles from both General Systems Theory and Cybernetics in an attempt to better understand families. According to Sluzki (1985), the two disciplines developed with remarkable similarities but more recently, the developments in cybernetic epistemology have more relevance for the field of therapy. Sluzki explains that the field of cybernetics originated from communication engineering as a means of understanding how systems are regulated. The focus here was on how systems either maintained or changed their organisation using concepts such as positive and negative feedback, homeostasis, morphostasis, escalation, calibration, etcetera. At this stage, the field of family therapy adopted these concepts and used them to act on faulty family systems in strategic and structural ways. In both the philosophical underpinnings and in the actions of family therapists, the observer was understood to be separate from the system being observed and acted upon. However, the validity of this assumption came into question when it was realised that in the act of observing the system, the system itself changed (for example, it was no longer a family but a family plus therapist). Thus, Second-Order Cybernetics developed as a conceptual or paradigm shift in which the observer's role was included in the construction of the reality being observed. Thus, it became important for the observer to reflect on his or her contribution to the observed system and to try to understand the recursiveness involved. In real terms, this shift in thinking meant that the therapist could not

observe an objective system on which he or she could act in a linear manner. Instead, the therapist could only work with his or her subjective experience of being in the system.

The work of Maturana and Varela (1987) built on the concepts found in Second-Order Cybernetics and had far-reaching implications for ecosystemic thought especially with regards to therapy and a theory of change. According to Maturana (1988), a living system is by definition structure determined (everything that the system does is determined by its structure or components), autopoietic (continuously self-producing) and constantly moving, interacting or drifting against its background or medium. As a result of its autopoietic nature, the system constantly needs to maintain its organisation (that which defines the system). It does this by changing its structure but at the same time, the structure determines what changes are possible - if the structure is plastic, it is more able to change. There are only two kinds of change that the living system can undergo: those that allow for the organisation to be maintained and those in which the organisation is destroyed. The former involves a change in structure while the latter involves a change or dissolution of organisation. Structural changes are said to be triggered by structural interactions that Maturana and Varela (1987) term perturbations. In order for a trigger to perturb the organism, the organism needs to perceive a difference. It is this difference that causes the organism's structure to change in such a way that it will accommodate this difference in the future (Johnson-Van Heerden, 1993). Perturbations can either arise out of the medium in which the system is to be found (external perturbations) or from within the system (internal perturbations). External perturbations or "perturbations of the environment do not determine what happens to the living being; rather, it is the

structure of the living being that determines what change occurs in it. This interaction is not instructive" (Maturana & Varela, 1987, pp. 95-6). It must be remembered that the structural changes in the system can also trigger perturbations in the medium. In addition, other unities or systems constitute (part of) the medium and in this way, systems are mutually perturbing to one another. The recursivity inherent in this process lays the basis for the notion of structural coupling. Maturana and Varela (1987, p.75) "speak of structural coupling whenever there is a history of recurrent interactions leading to the structural congruence between two (or more) systems". A history of structural couplings between two or more living systems leads to the establishment of a consensual domain which is usually manifested through linguistics. According to Fourie (1992), it is important to remember that a consensual domain does not refer to a situation in which all elements or unities are in agreement, but rather, "to a way of being together in which the situation is mutually defined" (p. 1161). The consensual domain is thus the space in which triggers constitute perturbations - the domain of perturbations (Maturana & Varela, 1987), that is, if a trigger falls outside of this structural space, it will not perturb the system.

With this background in place, it is possible to understand what is meant by ecosystemic hypnosis.

Ecosystemic Hypnosis

Fourie and Lifschitz (1985, 1988, 1989) and Fourie (1988, 1989, 1995) delineate a number of interlinking characteristics of ecosystemic hypnosis. An explanation of these will follow.

Hypnosis is a concept, not an entity. Hypnosis is not an objective, independent entity existing in reality. Instead, it is a concept used to describe a situation in which the behaviours performed by all involved are agreed by all involved to be belonging to that class of behaviour called 'hypnosis'. Traditionally, this involves a specific set of actions by a 'hypnotist', 'subject' and 'observers'. In other words, hypnosis is "a concept that describes a situation in which all participants expect the subject to perform behaviours in such a way and of such a nature that they are understood by everybody to be hypnotic" (Fourie, 1988, p. 144). Furthermore, by their act of agreeing that particular behaviours in the specific situation constitute a hypnotic situation, the participants become actively involved in constructing the situation as hypnotic. Thus, it can be seen how hypnosis is not an objective entity in an independent reality but the "definition of a constructed reality" (Fourie, 1995, p. 303).

Hypnotic behaviours are not caused in a linear way but are mutually qualified as hypnotic. It is not the hypnotist who causes the subject to become hypnotised through an induction. Instead, when all involved experience the situation as one in which hypnosis is occurring and the individual experiences of each person involved influences the experiences of the others, thus confirming the situation as hypnotic, then hypnosis is said to be occurring. This process is said to be mutual, recursive and ongoing. Thus, hypnosis can be described as arising out of a specific pattern of interaction which may be organised by the individual mutually designated as the hypnotist, but not caused or determined by the hypnotist. Indeed, according to the ideas of Maturana and Varela (1987) as seen above, it is impossible for the hypnotist

to cause hypnosis in another. All the hypnotist can do, is arrange a context to which the 'subject-designate' will respond in a structure-determined manner.

Hypnotic behaviours exist within a domain of consensus. Through the mutual qualification of the situation as hypnotic, all participants involved come to share an understanding of the situation as hypnotic. In terms of the work of Maturana and Varela (1987) as explained above, the process is one of different autopoietic unities experiencing a history of structural couplings and thus establishing a consensual domain. The consensual domain serves to delineate which behaviours will be seen as hypnotic and which behaviours will not. In any particular situation constructed as hypnotic in this way, both the immediate consensual domain actively established by the participants and the broader consensual domain implied by cultural factors, for instance, will impact on this delineation of behaviours and on the subjective experience of the participants. Thus, there is a specific Western consensual idea that the subject is the site of hypnosis. Western culture, too, gives rise to the expectation that the subject will experience a sensation of 'depth' while certain cultural domains such as mystics and drug addicts experience a sensation of 'height' (Fourie & Lifschitz, 1989).

The hypnotic reality exists in a linguistic domain. The mutual qualification of a situation as hypnotic involves structural coupling amongst those involved and the establishment of a consensual domain which is actualised within a linguistic domain. In other words, in order for a situation to be defined by all involved as a hypnotic one,

there needs to be an exchange of ideas and finally agreement, about the situation. Fourie (1995, p. 304) explains further that

> (s)uch exchange, in turn, can only occur through verbal and nonverbal language, that is, through dialogue or narrative (Hoffman, 1990). Hypnosis, as the definition of a constructed reality, is, therefore, embedded in narrative. In fact, it *is* (italics in original) narrative; that is, it is communicated meaning".

Hypnotic induction is a punctuating ritual. As seen above, hypnosis is not caused in a linear manner, but rather in a recursive, mutually qualifying situation. Thus, the hypnotic induction is not necessary in terms of causal factors. However, it is a ritual that is expected by most people as a necessary part of hypnosis and thus further serves to qualify the situation as one in which hypnosis is about to occur. For the same reasons, a waking-up ritual and 'debriefing' serve as rituals which mark the hypnosis as coming to an end.

There is no hypnotic susceptibility, only "hypnotic responsiveness" (Fourie & Lifschitz, 1988, p. 174). Following from the understanding that hypnosis does not take place within an individual but arises out of a consensual domain, the variations in the ways specific individuals respond to the hypnotic situation can be understood as a function of the ways in which the particular conceptualisations of hypnosis held by each participant fits with the other conceptualisations around him or her. The term 'susceptibility' implies a causal relationship and views the site of hypnosis as situated within the subject. The metaphor 'hypnotic responsiveness' implies mutuality and

reciprocity which places responsibility for the creation of a hypnotic situation on all participants. The practical implications of this distinction will become clear in the following discussion of the therapeutic use of ecosystemic hypnosis.

Ecosystemic Hypnotherapy

It should come as no surprise that the ecosystemic understanding of problems is not the traditional positivist understanding of the problem residing within an individual, having been caused in a linear way. So too, the treatment of problems does not lie in the application of 'cures' by an expert to the troubled individual.

Building on the ideas of consensual domains and linguistics presented above, Efran and Lukens (1985) and Anderson and Goolishian (1988) explain that problems exist only in language. They do not exist within a problematic component within the troubled individual. Thus, the problem is only a problem to those languaging about it or those who share a consensual domain about the problem. However, while there is some degree of shared understanding of the problem, each person involved in the consensual domain experiences it from a particular point of view. Thus, there is no single correct view of the problem, but multiple views constructed in language. Each individual, including the therapist, is thus responsible for his or her view of the problem.

If problems are constructed in language, then they must be solved through language. However, because systems are structure determined, the therapist cannot predict the outcome of a particular intervention or design an intervention with a specific outcome in mind. The most the therapist can do is enter the "problem-

organizing" (Anderson & Goolishian, 1988) consensual domain and perturb it in language until the problem changes and is open to alternative possibilities or until it is no longer considered to be a problem. In this way, the problem is said to have been "dis-solved" (Anderson & Goolishian, 1988).

From this explanation, it should be clear that the ecosystemic use of hypnosis in therapy would not involve applying hypnosis to a passive subject in order to cure the problem. Instead, hypnosis is used as a tool with which to perturb the ideas or consensual domain about the problem. Fourie (1989) explains that the potency of hypnotherapy lies in the power attributed to it by the therapy system. "Hypnosis is therefore employed, from an ecosystemic perspective, not because it possesses intrinsic capacities or powers, as is traditionally thought, but because clients and families believe in such intrinsic powers of hypnosis" (Fourie, 1989, p. 6).

It is thus clear that from an ecosystemic point of view, hypnotherapy involves the explicit (as opposed to 'indirect') use of hypnosis. Furthermore, it becomes important to first establish a consensual domain about hypnosis and hypnotherapy with all involved. Thus, the therapist first needs to discover the ideas in the system about hypnosis. These are then incorporated into the hypnotic experience. At no time does the therapist attempt to correct misconceptions as "(e)cosystemically seen there are only conceptions of hypnosis, and no misconceptions" (Fourie, 1989, p. 21; underlined in original). In this way, the hypnotic responsiveness of the designated subject is increased as a better fit between therapist and subject is facilitated.

Fourie (1989) describes several guiding principles for conducting a hypnotherapy session from within an ecosystemic conceptualisation. However, it should be clear that within this framework, it is impossible to take a 'cookbook' approach. The

overarching aim is to use hypnosis as a powerful perturber of ideas within the problem-organising consensual domain. As discussed above, the system may consist of more than just the person in whom the problem would traditionally be seen as situated. Thus, hypnotherapy becomes a tool with which to perturb the entire system - namely, all those languaging about the problem. It thus becomes important for hypnotherapy to be conducted in the presence of the members of the consensual domain, as opposed to being conducted merely with the subject. The other members present also serve the powerful function of helping to qualify the experience as one in which hypnosis has occurred.

The main function hypnosis serves is to act as a powerful confirmer of a therapeutic reframe (redefinition of the problem so that it is more amenable to alternative solutions or dis-solution). A number of traditional hypnotic techniques such as age-regression, relaxation, metaphorical stories and images, post-hypnotic suggestions, and systematic desensitisation can then be used in conjunction with the reframe. Some of these will be elaborated on in the case studies. However, the general principle by which they work is that the reframe is confirmed by the hypnotic technique which is then confirmed by the reframe, and so on, in a circular fashion.

Ecosystemic Hypnotic Analgesia

Finally, the specific ecosystemic understanding of hypnotic analgesia needs to be explained in terms of the above discussion.

Von Foerster (1984) explains how we invent or construct a reality that we experience as being objectively real. In his explanation, he shows by way of several

perceptual and neurological phenomena that we sometimes perceive what is not 'there' and do not perceive what is 'there'. He condenses this into the dictum: "If I don't see I am blind, I am blind; but if I see I am blind, I see" (p. 43). He goes on to interpret these phenomena in terms of what he calls "the principle of undifferentiated coding" (p. 45). This means that a nerve cell does not encode the physical nature of the stimulus. What is encoded is a quantitative experience, not a qualitative one. At this point, the argument becomes relevant to the question of pain. Von Foerster (1984) says:

> 'out there' there is no light and no color (sic), there are only electromagnetic waves; 'out there' there is no sound and no music, there are only periodic variations of the air pressure; 'out there' there is no heat and no cold, there are only moving molecules with more or less mean kinetic energy, and so on. Finally, for sure, 'out there' there is no pain. (p 46)

Von Foerster then goes on to explain that we are responsible for creating the quality attached to a specific quantity of experience. Thus, we are responsible for creating the subjective experience of a sensation such as pain. Since we generate ideas and experiences through language, the experience of pain is thus generated in language and pain as a problem is thus a problem constructed in language. When seen in terms of a languaged problem, pain becomes amenable to language based dis-solution and the therapist can choose to use hypnosis as a tool to perturb the pain-organising system.

Conclusion

This chapter has outlined the various conceptualisations of hypnosis, emphasising the differences in thinking about hypnosis between the traditional positivist approaches and the ecosystemic approach. Perhaps one of the main differences is that while the traditional approaches seem to be concerned with the mechanics and doing of hypnosis and hypnotic analgesia, the ecosystemic approach takes a meta-perspective, concerning itself with the thinking behind hypnosis. This difference represents a paradigm shift.

The following chapter will further explain what is meant by paradigms and paradigm shifts and look at the implications this has for research.

CHAPTER 3

RESEARCH DESIGN

This chapter will discuss the research approach adopted in this study. In order to do this, it will first describe a shift that has been occurring in the philosophy of science and then place this study within a specific scientific context.

Paradigms and Paradigm Shifts

According to Schwartzman (1984), the term paradigm was first defined by Kuhn (in Schwartzman, 1984) to mean "a model for legitimate problems and their solutions for a scientific community" (p. 223). Lincoln and Guba (1985) further explain that paradigms represent a certain way of thinking about the world, especially containing our hidden metaphysical assumptions. As such, they automatically influence the way we act, including the way we go about our (scientific) exploration of the world.

When Kuhn first used the paradigm concept, it was in order to describe "the history of the physical sciences (which) displays a clearly discernible pattern of periods of so-called normal science followed by scientific revolutions" (Mouton & Marais, 1990, p. 145). In trying to make sense of the changes in science's guiding principles, Kuhn described a pattern in which a particular scientific paradigm would remain dominant for a time, followed by a period of questioning the assumptions and validity of the

accepted paradigm - a scientific revolution - and then the return to 'normal science' in which there was once again, general acceptance of the prevailing metaphysical assumptions. Lincoln and Guba (1985) delineate three of these "paradigm eras" (p. 15), namely prepositivist, positivist, and postpositivist. This chapter will be concerned with the latter two, as they have most current relevance.

Positivist Research

The basic assumption underlying positivist or 'old paradigm' research is that there is an objective reality that can be known. Lincoln and Guba (1985) cite Mill and Newton as proponents of this mechanistic approach, based on the thinking of Descartes which established the scientific criteria of "the rational objectivity of science in which the scientist was supposedly able to become 'pure spectator'" (Schwartzman, 1984, p. 225). Schwartzman goes on to explain that one of the basic characteristics of this mechanistic science, based on the "metaphor of the billiard table" (Lincoln & Guba, 1985, p. 21) was that it was atomistic, breaking phenomena up into bits in order for them to be measured, manipulated and understood.

Following these understandings of the nature of reality and the insistence on certainty of knowledge, a method of scientific inquiry was developed to meet these demands. According to Shapiro (1986), the method was based on empiricism and rules of logic. Gelso (1985) describes this type of research as quantitative, molecular, experimental, nomothetic, and occurring in the laboratory. In this way, it was expected that science could "obtain more unbiased maps of reality" (Atkinson & Heath, 1987, p. 9).

Problems with the Positivist Approach

For the purpose of this study, critiques of the positivist approach can, perhaps, be grouped into two categories. Firstly, there are fundamental questions about the validity of this paradigm. Secondly, there is some doubt as to the appropriateness of using methods designed for natural science, in order to study the social sciences.

Major challenges to the status of positivism as a valid scientific world-view came, from amongst others, Einstein, Heisenberg and Popper. As explained by Shapiro (1986), Popper argued that it is logically impossible to ever positively prove a scientific claim. The most one can do is to prove a claim false, or probably true on the grounds that it has not yet been proven false. Thus, there is only the appearance of truth. According to Lincoln and Guba (1985), in terms of certain of the constraints laid down by positivism, many of Einstein's thought experiments would have been considered nonscientific. Furthermore, his concept of relativity and work with quantum physics brings the assumptions of absolute truth about an objective, unchanging world into question. Lastly, the work of Heisenberg which showed that both the position and momentum of an electron cannot be determined at the same time, because of the influence of the observer on these phenomena (Lincoln & Guba,1985), shook the positivist notion of the detached scientific observer.

It was perhaps this last idea that had the greatest implications for the practice of positivist science. The notion of value-free observation began to crumble and Popper realised that "our discoveries are guided by theory, rather than theories being discovered due to observation" (Keeney & Morris, 1985). In fact, it is probably the

very emphasis that positivist research places on control that is responsible for this phenomenon as the researcher needs to delineate the boundaries of the research beforehand, which can only result in the confirmation of old knowledge and not in the discovery of something new (Kirk & Miller, 1987). In this way, observers actively participate in their observations and influence their research.

Turning now to the second arena of criticisms, the methods of natural science have been deemed unsuitable for the human sciences by thinkers in the field. Shapiro (1986) explains that since its inception in the late nineteenth century, psychology has had to debate whether it belongs to the natural sciences or whether it should develop its own, human brand of science. It is not in the scope of this thesis to discuss the political consequences of this debate, which centre around acceptance of psychological truths or wisdom by other disciplines. However, Shapiro explains that it seems more useful to differentiate psychology as a human social science which requires understanding from those natural sciences which require explanations of causes. In addition, he points out that natural science investigators are in the unique position of being both the subject and object of their research. Once again, the direct involvement of the observer with the field of observation is striking. The words of Bateson (in Schwartzman, 1984, p. 229) encapsulate this point of view quite clearly: "We have this massive addiction to physical metaphors which, as far as I know, are completely inapplicable to the life and epistemology of real organisms living in a real world."

Postpositivist Research

Following from the questions about the validity of the positivist paradigm, a new way of thinking about research is coming into being. In Kuhn's (in Mouton & Marais, 1990) terms, many would consider this to be part of a scientific revolution and has resulted in the postpositivist research paradigm, also known as naturalistic, qualitative research or new paradigm research.

New paradigm research is characterised by a phenomenological and holistic perspective (Moon, Dillon & Sprenkle, 1990) which advocates research that is qualitative, molar, naturalistic, idiographic, and most likely to be conducted in field settings as these tend to have more relevance for real life (Gelso, 1985) . It is experiential and linguistic (meaning and truth are language-based within a specific social context) and because the investigator is embedded in the research, he or she becomes both subject and object (Shapiro, 1986). The investigator strives for a multiple, both-and perspective, encapsulating heuristic truth (Auerswald, 1987) within a specific social context (Moon et al., 1990). The participants in the research are viewed as active agents with goals and intentions (Gelso, 1985) and this participatory stance is seen to be ethical, recognising the connection between the observer and the observed (Keeney & Morris, 1985). The research is aimed at achieving a subjective understanding (Shapiro, 1986) in terms of pattern, rather than measurements of behaviour.

Perhaps the most important assumption in the new paradigm approach is the view on the nature of reality, or metaphysics. In its extreme, this view questions the

existence of an objective, independent reality and at the very least, holds that "even if there is an ontologically real world, we can never have objective access to that world" (Atkinson & Heath, 1987, p. 8). This is because, as explained above, the observer is intrinsically involved in the observation and is a part of the system under examination. As a result of this, the researcher needs to be aware of his or her involvement in the observations and has a responsibility to establish, as far as possible, what this involvement entails. Atkinson and Heath explain that in presenting their research, the investigator needs to draw a number of distinctions in order to organise the raw data so that it can be analysed according to a specific theoretical framework. This process is seen as an inevitable part of the human attempt at understanding. However, it is suggested as both useful and necessary if the researcher's integrity is to be maintained, that "we might benefit from more clearly showing each other how we have drawn distinctions in organizing the world of experience" (Atkinson & Heath, 1987, p. 13). In line with this, the research process can be described as a "task of re-examining, i.e., re-searching what we have done to construct a particular ... reality" (Keeney & Morris, 1985, p. 548) in which researchers take responsibility for their particular manner of punctuating events (Colapinto, 1979).

The Question of Legitimacy

The question of legitimacy in positivist research is dealt with in terms of strict criteria of internal and external validity and much attention is paid to scientific methods which guarantee, as far as possible, the validity of findings (Reason & Rowan, 1981). Of course, the whole question of validity is encountered only from

within the paradigm assumptions of generalisability and the achievement of absolute knowledge. Thus, it should be clear that when the basic assumptions are different, the issues of validity and legitimisation change.

For new paradigm researchers, "(t)here is no question that the naturalist is at least as concerned with trustworthiness as is the conventional inquirer" (Lincoln & Guba, 1985, p. 294). Even though the notion of objectivity - and thus, objective methods of validity - is rejected, the notion of relative legitimacy (Atkinson & Heath, 1987) by which the usefulness of research can be judged, is held dear. In this regard, conventional objective methods are no longer useful as other criteria are required. Lincoln and Guba (1985) posit four criteria by which to judge the legitimacy of research. Absolute truth values of positivist science are replaced by credibility with reference to a specific context. It becomes important to judge the applicability of a study according to the notion of transferability rather than generalisability. Dependability is achieved by taking real, natural changes in the participants into account rather than controlling for them. Lastly, the notion of neutrality falls away with the assumption of objectivity and is replaced by the notion of confirmability. Kuhn (in Atkinson & Heath, 1987) approached the problem of legitimacy in a similar manner, using the criteria of accuracy, consistency, scope, simplicity and fruitfulness - criteria we naturally use to make decisions in everyday life.

With the shift in paradigms, a shift in the responsibility for legitimacy can be observed. In moving away from methods inherent to the research process which ensure validity, the burden of proving legitimacy becomes shared by all involved in the process and by all with something at stake. "In the absence of certainty,

knowledge is an ethical matter, one in which the judgement of each stakeholder must count" (Atkinson, Heath & Chenail, 1991).

Authors such as Atkinson and Heath (1987) and Lincoln and Guba (1985) list and explain numerous ways of achieving the type of new paradigm research legitimacy discussed above. However, only those of relevance to this study will be discussed below.

"Since the researcher is the primary data collection instrument in most qualitative studies, it is important to make the researcher role clear and to make any known researcher biases explicit when reporting qualitative studies" (Moon et al., 1990, p. 360). Reason and Rowan (1981) explain that this awareness is necessary in order to keep a perspective on the researcher's involvement in the context to prevent him or her from becoming too much a part of it. It could be considered elitist to assume that one can ever know oneself well enough to be aware of all biases and values but even so, it is important to know oneself as the instrument of inquiry, considering the involvement of the observer in the observed, as well as possible.

As mentioned above, perhaps the most important self-awareness the researcher should have is of those epistemological assumptions guiding any distinctions drawn. Following from their constructivist understanding, Atkinson and Heath (1987) believe that the presentation of findings in the old paradigm is limited because the data is presented only after having been organised and categorised. Thus, the reader is given no opportunity to question the researcher's construction and has to concur with the researcher's validity appraisals. The alternative they offer is for the researcher to provide as much true raw data as possible, so that the reader can determine issues of legitimacy. In order to do this, the researcher needs to possess good writing skills,

providing as much information in the form of sufficiently rich descriptions, as possible. An ethnographic approach is useful in this regard.

The last point on new paradigm legitimacy relevant to this study is that of referential adequacy (Lincoln & Guba, 1985). It has been suggested that raw data should be stored in archives, in the way in which it was collected so that interested others may have access to it so that they can make their own inferences, without being influenced by the subjective filtering of the original researcher.

Method of Inquiry Employed in this Study

The method of inquiry employed in this study falls under the postpositivist paradigm which is in line with ecosystemic thinking, as described in the previous chapter. By now, it should be clear that perhaps the most important aspect of this type of research is to understand the thinking behind the conclusions and descriptions of the researcher. To this end, Keeney and Morris (in Atkinson & Heath 1987) have described cybernetic ethnography as ideal. Using this approach, descriptions are presented so that it is possible for the reader to retrace or "re-search" the investigator's line of thinking.

The research was conducted with five pregnant women. The significant system [which "includes all those units (persons or institutions) that are activated in the attempt to alleviate problems brought to professionals for a solution" (Boscolo, Cecchin, Hoffman & Penn, 1987)] involved in each case differed according to personal circumstances. At times, the women worked with the researcher alone while the husbands or fathers-to-be were included in other instances; certain cases required

the incorporation of ideas from the obstetrician and ante-natal coach. In each case, time was taken to first explore the idiosyncratic ideas in the system with regards to hypnosis, labour pain, and ways in which hypnosis could be utilised. Hypnosis was then introduced experientially into the system and incorporated into the specific needs of the system

The case studies in the following chapter will be described in detail, allowing the reader as much personal contact with the events as they unfolded in each case. In this way, it is hoped that the reader will be able to draw distinctions of his or her own. At the end of each case, a metaperspective is given. In this section, the distinctions drawn by the author both as therapist and as researcher can be traced and an understanding of the process in each case can be reached.

Conclusion

Although this study explicitly employs a specific postpositivist approach, it is not the intention to be prescriptive. Pragmatics dictates that methods are chosen according to what will most usefully fulfill the requirements at hand. It must be remembered that what is considered useful will vary depending on the research and it seems more legitimate to do what is useful than to do what is idealistic. As Gelso (1985) states, "Knowledge is best advanced under conditions of methodological diversity rather than adherence to a single research paradigm" (p. 63). This research approach represents one of those facets.

CHAPTER 4

RESEARCH RESULTS

This chapter will give a detailed, narrative description of the five cases undertaken for the study. In this instance, the term 'narrative' is taken to mean "communicated meaning" (Fourie, 1995, p. 304) and as such, is explicated from a subjective or "participant observer" (Moon et al., 1990, p. 360) point of view. The description will be in such a manner as to draw attention to the ecosystemic rationale behind each case. For this purpose, each case will be described in full and then a metaperspective will be given. While the metaperspective sections will concentrate on explaining the therapeutic rationale, the case study descriptions will be detailed enough to give the reader a feel for the characteristics of ecosystemic hypnosis described previously.

In accordance with ethical considerations of confidentiality, the names (and in some instances, personal details) of the participants have been changed.

Rivka (21 yrs) and Shmuel (27 yrs)

This couple came from a very religious Jewish background and were both children of Rabbis. I knew Rivka as we were both from the same synagogue community and I initially approached her to see if she would take part in this study. At the time, she and Shmuel (who did not speak much English) had come from overseas for the birth

of the baby and they were staying with her parents. This was to be their second child. Before agreeing to participate, she consulted with her husband and they both consulted with other Rabbis as to the acceptability of using hypnosis.

We began the first session by discussing the concerns Rivka and Shmuel had about hypnosis. Rivka was concerned that it was so powerful that it could have an effect on her baby's personality. We then began to talk about what hypnosis actually was. Rivka said that she felt hypnosis helped one to relax and take one's mind off the world. However, she was concerned that this would not be enough to take her mind off the labour pain because her last experience of labour had been very bad. She mentioned that she felt this was partly because her obstetrician had not been very caring. I took this opportunity to introduce the idea that the attitude of those around one impacts on the way pain is experienced. As we continued to discuss their ideas, it became evident that Shmuel saw the whole exercise as something between Rivka and myself and not including himself. We continued to speak about Rivka's last birth experience which Shmuel described as "terrible". For religious reasons, they could not have any physical contact during the labour and birth and Shmuel had felt that there was nothing he could do to help his wife. In the light of this information, I suggested to them that the hypnosis might be something that Shmuel could do for his wife and would thus form a connection in the face of their physical disconnection. However, I was later to discover that the disconnection went far deeper than this. I then suggested that since Rivka had said that hypnosis was similar to relaxation, we should practise a relaxation exercise. Immediately, they began to argue over who would relax and who would watch. Rivka was adamant that Shmuel should experience what she was going through and I wondered out loud whether this

included her experience of labour. Eventually, I managed to point out to them that in the same way that people relax in different ways, they also become hypnotised in different ways and that it was important to find a unique method of hypnosis for each person. I pointed out that what they shared was actually this difference and in this way, the fact of their differentness could become a point of connection. Once this idea was put forward and seemingly accepted, Rivka agreed to try the relaxation and as her relaxation became deeper, we found that by talking to her, Shmuel was able to help her regulate her breathing and help her to relax further. Rivka was then able to imagine herself in a very special place and to imagine a special object for herself. We then spoke about her experience and Rivka said that she felt she could try to go to this special place during labour. At this point, Rivka and Shmuel seemed to be more unified than they had at the beginning of the session and I asked them to practise breathing together, as they had done during this relaxation exercise. Shmuel was then to instruct Rivka to go to her special place and he was then to try to guess what this place was, but she was not to tell him whether he was correct or not.

The second session began with a discussion of their homework. They had practised but there had been problems with achieving the same degree of relaxation and Rivka had found it more difficult to go to her imagined place. They began to ask me for guidance about how to go about this more effectively. Instead of answering them directly, I began to speak about how closeness, breathing together, and hypnosis could become associated with less pain. Shmuel responded by repeating the request for specific guidance and I responded to this by speaking about the wide range of possible trance behaviours. I then asked whether Shmuel had been able to guess Rivka's secret place but he had not and Rivka remained secretive about this.

However, they explained that Shmuel had tried to guess her place by imagining a place of his own and building from this. I then suggested that we try to create a third special place together and went through the process of guiding them through a joint relaxation exercise in which they imagined a place together by building on each other's images and finally, discovering their own special object in this shared place. While speaking about this experience, Rivka brought up the issue of them speaking different languages but Shmuel rejected this as a problem, saying that all Rivka needed was to be able to "go deeper" into hypnosis. After discussing how she would know if this was happening, I began to set the scene for a "proper hypnotic trance". Rivka felt that she should lie on the couch and she spontaneously closed her eyes. I asked her to concentrate on the feelings in her body and to notice any changes. I asked her to then focus on the rhythm of her breathing and notice how this was connected to her other body movements. I suggested that as she breathed in, her shoulders would begin to feel lighter and mentioned that her shoulders were connected to her arms and hands. I suggested that we wait for any changes and suggested that her hands might begin to feel lighter. I then turned to Shmuel and asked him whether he thought Rivka's left or right hand would feel lighter first. He thought it would be her left hand. I asked him to watch Rivka's left hand and see how its movements were connected to her breathing. I then asked him whether he thought her fingers or wrist would begin to feel lighter first and he selected her fingers, specifically her index finger which had begun to twitch slightly. I remarked on this and suggested that her finger would continue to move on its own, adding that she might begin to feel as if her entire hand wanted to lift. I said it would be best not to make her hand lift, but just to wait for it to feel like it wanted to lift. Although

Rivka's hand did not lift completely, she was surprised by the movements in her fingers and mentioned this once she had opened her eyes. She mentioned that she had expected not to be able to hear anything while she was in a trance and she also expressed surprise at her sense of control. We discussed the fact that Rivka felt the trance was not "deep" enough but I pointed out that it would take time to learn how to go into a trance and that there had been several distractions. I then remarked on how easily Shmuel had been able to predict Rivka's experience and explained that I thought this must be related to the breathing homework they were doing which was strengthening their connection. In light of this, I asked them to carry on practising the breathing exercise but to keep the hypnosis for our sessions. I asked Rivka also to try to help Shmuel relax and opened up the possibility of them experimenting with their own ways of helping the other relax. I re-emphasised the importance of the breathing exercise before the session ended.

The third session began, as had the second, by reviewing the homework. They said that the relaxation exercise had been getting easier, and Rivka said, "He's very good, he's my husband." I remarked that I was pleased about this because I was beginning to be worried that they were not connected enough. Rivka asked me if I was referring to their communication but I said that I was talking less about verbal communication and more about intuitively being able to feel the other's experience. I went on to say that this would possibly help Rivka feel that the birth was not something that she was going through alone, but that they could each experience it in their own ways which would be different from before. However, Rivka was still complaining that they couldn't get "deep" and that she could not do the hypnosis for herself. She said that she wanted to try "real" hypnosis. Shmuel said that he was worried that Rivka might

not come out of the trance. I responded by saying that she would come out when she was ready. I then faced Rivka and in a serious voice that was softer than before, I asked her to concentrate on me and ignore everything else. I then asked her to notice if anything changed or if everything remained the same. I explained that those things that changed did so in order to keep things constant and that she was not to allow the changes - unless they had to happen. She asked if she could close her eyes and I said she could only do so when she had to. Her eyes seemed to be becoming heavy and tired and eventually she did close them. I then asked Rivka to notice the difference between having her eyes open and closed and to concentrate on this difference while I talked to Shmuel. I also asked her to notice any changes in her body. Turning to Shmuel, I asked him to watch for any changes in Rivka. At this point, Rivka interrupted our conversation to ask if she could lie down. I said that that just as her tired eyes had been a sign that she was ready to go into a trance, her desire to lie down was a sign that she was ready to let go even further and I suggested that she just sink into the couch. I carried on talking to her, suggesting that she would go deeper, relax, go down into the couch and sink in heavily, breathing deeply all the time. At this point, her arms slipped down to her sides. I emphasised that she was unaware of her present surroundings and that she would find herself in her special place but that in her special place she would find a door. I asked her to open the door and told her that as she did so, she would see ten steps which she should start walking down. At this point, I turned to Shmuel and in a normal speaking voice, explained the difference between the physiological and emotional components of pain. I said that it was through our control over the emotional component that we would be able to control the feeling of pain. I explained that it was important not to interfere with the

physiological component because it was important for the body to experience this so that the uterine muscles would contract properly. I explained further that Rivka would need to start associating the contraction with discomfort and not with pain. As she got closer to the birth, she would begin to experience positive and negative feelings. I explained to Shmuel that his role was to help Rivka get in touch with the way she was feeling and to learn to anticipate her positive and negative feelings through the breathing exercise. I encouraged Shmuel to become very aware of Rivka between this and the next session. I mentioned that this might be an unconscious awareness that he developed because, by the mere fact that we had been in the room during Rivka's hypnosis, we both might have been affected by it. I explained that the breathing exercise was a conscious process but that the awareness he developed would be unconscious and that things would probably be different between the two of them. I then turned to Rivka and asked her if she could hear me. Rivka replied that she wanted to go deeper still. I told her that she should use her unconscious mind to help her go deeper but continued to give her suggestions related to her breathing, heavy eyes, becoming unaware of the couch, sounds being different. I pointed out to her how heavy her arms had become and asked Shmuel to pick them up and drop them. He tried with both arms, confirming their heaviness. I then turned back to Rivka and asked her to raise her finger as a sign when she was ready to come out of the trance. Her breathing began to get lighter and quicker and I took this as an indication that she wanted to come out of the trance. I suggested that she should start walking back up the stairs and that when she reached the top, she would open her eyes in her own time. Once her eyes were opened, I instructed her not to move until she felt completely normal again. I also instructed her not to talk too much, just to notice how she felt

different now - I especially commented on how she felt more tired now - and to notice throughout the week how she would feel different and especially how pain would feel different. I then instructed both Shmuel and Rivka to continue practising their breathing exercise and reminded Shmuel to do the homework discussed during Rivka's trance, namely to become unconsciously aware of Rivka's positive and negative feelings.

I did not do any further work with Rivka and Shmuel as Shmuel was unfortunately called back to the army overseas and Rivka preferred not to work with me alone. However, she was quite upset that she had to have the baby without him there. Nevertheless, I did hold a feedback session with Rivka about a month after the baby had been born.

Rivka said that she had first experienced back pain and then contractions. She went to the hospital at about midnight and tried to use the breathing to help with the pain. At 03:00 she was given an epidural and the baby was born at about 06:00. Rivka said that the labour had been quite painful in comparison with her last labour but that the birth had been a different experience. I asked her to elaborate on this. She explained that this time, she had been able to push and to work with it and that it had been a better experience. She then mentioned that the whole thing had been difficult though, because Shmuel hadn't been there. I asked her to elaborate on this and she said that although it had been very hard, she had tried to be strong because she knew it had not been his fault. I then asked her about the experience of the sessions. She answered by saying that the pain during labour had been too strong for her to have gone to her special place. I called her attention to the actual experience of the sessions and she said that it was a good thing to know about because she never knew

when she might need it. I asked her what specifically she thought she had gained. She explained that she had learned to sit and think and relax but that it could not have worked during the birth because the pain was even too strong for the breathing. To prove her point, she said that eventually the epidural had also worn off. I asked how well she and Shmuel had worked together while he had been here. She said that they had only worked together for a bit because he had been under a lot of pressure during the day and so, they had only been able to practise at night before going to sleep. She went on to say that the whole time before the birth had been very pressurised. Rivka explained that she could not know if the birth would have been different if Shmuel had been around; perhaps she would have been more able to relax. She also realised how important it was to have someone else around to help with the hypnosis. However, she said that she would always have the experience of the hypnosis. I was about to terminate the feedback session but Rivka suddenly seemed pressed to explain to me why the hypnosis had not worked for her, referring again to the incomplete sessions and Shmuel's call back to the army. I remarked that these were part of life's unexpected events which we possibly could have incorporated into the whole hypnosis experience but which we had no way of knowing about in advance.

Metaperspective

From the outset, it is important to point out several of the characteristics of ecosystemic hypnosis that are evident in this case[1]. Right from the start, Rivka

[1] The characteristics of ecosystemic hypnosis will be explained in this case only in order to give the reader a feel for the practical application of these characteristics. In further cases, the specific characteristics should be clear from the case descriptions.

attributed great power to hypnosis to the extent that she believed it could have an effect on the personality of her baby. This made it a useful tool with which to work. At the outset, it was important to establish a consensual domain (Maturana & Varela, 1987) within which we could work. This was achieved through discussions about Rivka and Shmuel's ideas of hypnosis, questions to me and experiences of hypnosis which were qualified by all involved as hypnotic. This mutual qualification was evident in the way in which discussions with Shmuel further qualified Rivka's behaviour as hypnotic, at the appropriate times. Furthermore, the case clearly demonstrates the explicit use of hypnosis. As far as the induction is concerned, breathing and eye closure as well as a change in the therapist's voice tone were agreed to be appropriate induction behaviours and served as a punctuating ritual; in the same way, a return to natural breathing and opened eyes served as a waking-up ritual. Another important part of the post-hypnotic ritual were the post-hypnotic discussions about the hypnotic experience which further served to confirm the experience as hypnotic. These also served as convenient spaces in which to use the hypnotic experience for therapeutic means, as will be explained below. Finally, it was important to create a hypnotic experience that would be congruent with Rivka's expectations and fit with these, rather than forcing her experience into a pre-conceived framework. For this reason, the therapist chose to work with an image of descending stairs in response to a request for "depth".

During the first session, Rivka had mentioned the problem of lack of support from her obstetrician as contributing to her experience of pain during the birth of her first child. Shmuel agreed with this and it seemed as if there was a consensual domain (Maturana & Varela, 1987) in this area. This opened up the therapeutic possibility

that an experience of more support would help her deal more effectively with her perception of pain. As the sessions unfolded, it became increasingly clear that Rivka did not feel adequately supported by her husband. This was evident by the manner in which they tended to subtly undermine one another, their different home languages, Shmuel's explicit distancing of himself from the situation, Rivka's need to retreat to her own secret space during the guided relaxation and her need to keep this secret and even the religious laws which forbade contact between the husband and wife once she had gone into labour. Thus, my over-riding therapeutic hypothesis (Palazzoli, Boscolo, Cecchin & Prata, 1980) was that Rivka's experience of pain was heightened by her sense of isolation and having to cope alone. To this end, the hypnotherapeutic interventions were all intended to perturb (Maturana & Varela, 1987) the way the system had organised itself around this principle. Once this organising principle had been questioned, the system would be open to other possibilities. Thus, the hypnosis was used as a tool to address a systemic problem rather than being a technique with inherent power to create change.

From the start, the breathing homework created a context in which Rivka and Shmuel had to spend more time with one another. In addition, the purpose of this was not just to spend any time together but to help Rivka prepare for the birth. It seemed as if Rivka felt quite fragile about her position and so, by asking Shmuel to try to guess her secret place, I was asking him to put in some extra effort which it seemed as if Rivka was needing, without making her feel too vulnerable by divulging the nature of her secret place. In a subsequent session, once we had spent some time working in this relationship dynamic, I used a joint guided relaxation exercise to introduce the possibility that Rivka and Shmuel could create a combined image. However, I still

allowed for the possibility that there could be individuality within the shared closeness by asking them to discover their own secret object within this shared space. Once we had started working with hypnosis per se, I was able to overtly link the therapeutic hypothesis and the breathing homework to the hypnotic experience when Shmuel was able to predict which of her fingers would move first. In this way, the hypnotic experience was used to create a feeling of increased closeness. This idea was strengthened once more by the repetition of the breathing homework and at the beginning of the third session when Rivka acknowledged that the homework was getting easier with Shmuel's help. At this point, however, Rivka seemed to have a degree of discomfort at getting so close to Shmuel so I revised my initial hypothesis. It now seemed that although on one level, it was important for them to be connected, on another level, it was important for Rivka to maintain her independence. This had actually already become evident in the joint guided relaxation but now, I tried to enact (Minuchin, 1977) this idea by reinforcing Rivka's independence in and control over her own hypnotic experience. Finally, I continued to overtly link their improved closeness to an improved ability to cope with pain.

The outcome of this case served to confirm my initial therapeutic hypothesis. Rivka had to have the baby alone but she pointed out to me that she had begun to realise how important it would have been to have had Shmuel with her. However, she continued to make excuses for him and in so doing, she illuminated the reason she had had to become so self-sufficient.

Perhaps one of the biggest problems in this case was the status of my relationship with the couple. Being social acquaintances and not just therapist-clients, the area that I was given tacit permission with which to work was severely limited. In effect, I

had no 'mandate' to perturb sensitive areas of their marriage which would have been necessary for this type of work to have had more of an effect. This continued to be a problem in some of the other cases, but not to the same extent.

Amanda (22 yrs) and Doug (24 yrs)

Amanda and Doug were both psychology honours students and expressed an interest in working with me from both a personal and a learning point of view. I started the first session by asking them why they wanted to use hypnosis. Amanda said that she wanted to try to have a natural birth without an epidural and hypnosis was a potential tool for this. Doug said that it had sounded interesting but he thought that one needed a long time to develop the skill so he was not sure if they would be able to learn quickly enough. However, he added that perhaps Amanda had the ability to learn quickly. Neither of them had any formal academic knowledge of hypnosis. They had seen hypnosis shows and understood that one had to be receptive and able to relax. Doug said that he wasn't like that at all; in fact, he described himself as fairly tense. Amanda said that at a show once, she had unsuccessfully tried to participate in group hypnosis. She had, however, once been hypnotised in class by a psychology lecturer who had induced the trance by talking to her but she had begun to feel as if she were falling and had become afraid and very aware of what was happening around her. The sense of loss of control had been frightening. Doug thought that he had been hypnotised once in a music therapy class. It had been a strange experience - somewhere between sleeping and being awake - but he only had a vague memory of it. Amanda said that she believed to be hypnotised, one had to be physically but not

mentally relaxed. Doug said that it had something to do with a different consciousness. He explained that when he was hypnotised, it was as if his subconscious was coming to the fore and then he said, "It's amazing how it's coming back to me now." He elaborated, saying that his subconscious had acted itself out and that it had all made sense when he woke up. It had been something about himself that he had not been prepared to accept but it had all become very apparent during the hypnosis. I remarked that from listening to them, it seemed as if Amanda would need to be guided into hypnosis while Doug would probably be able to hypnotise himself. Amanda said that she remembered when she was hypnotised, her sense experiences changed and things sounded further away. She added that she thought a person could only be hypnotised if they were willing. Doug agreed. Amanda felt that she should only be hypnotised during labour and not for the delivery. I then explained that their keen sense of motivation as well as the urgency resulting from the time pressure would probably make them more receptive to hypnosis, as the literature suggested. Amanda then asked me if I would be able to know beforehand if the hypnosis would work but I said this was a difficult question to answer. We began to speak about their expectations about the birth. They spoke about their ante-natal preparation and their wish to stay home so they could manage, just the two of them, for as long as possible. Amanda said that she is generally afraid of pain but that she complains less since she had been married. She explained that when she has to undergo a painful procedure, she copes by not thinking about it and by focusing on something else. Doug said that he wanted to "be supportive to the best of my ability." I remarked that Doug would probably be able to teach Amanda how to detach, seeing that he becomes detached when hypnotised and she would need to be able to do this in order to cope with the

pain. Amanda reminded us that she wanted the birth to be natural and that she wanted to be in control. She believed she could hypnotise herself during the contractions, using imagery. She also emphasised the importance of the birth coach saying that she needed to have Doug with her and that she felt hypnosis could make it easier for him to help her. Doug remarked that he found it strange that their ante-natal teacher did not train the coach more.

Since both Amanda and Doug wanted to experience hypnosis, I decided to hypnotise them both. In order to punctuate what was about to happen as hypnosis, I set up two chairs for the event and began to speak softly to them . I asked them who they thought would go under first and they both thought the other would. I explained to them that before we began properly, we would need to see how they would be most likely to go into a trance. I asked them to hold their hands out in front of them and to see how they began to move. While Amanda's hands began to move together, Doug's moved downwards. They were fascinated by this as it now seemed that perhaps Doug's initial feelings that hypnosis took a long time to learn were being called into question. Amanda then asked why Doug also needed to be hypnotised. I explained that this was an aspect of the experience they could share and it would give Doug an understanding of Amanda's experience. Amanda closed her eyes, according to socially accepted norms and Doug followed her example. I instructed Doug to listen to what I was saying to Amanda but to also feel free to find his own way into a trance. I was going to work more directly with Amanda. I asked her to focus on her breathing and to notice any differences. She began to relax and I pointed out the tiny movements her hands were making as well as the way her head was moving. At this point, Doug's head dropped suddenly while Amanda's head moved slowly

downwards. Remembering her need to be in control, I allowed Amanda to take her time. Once her head came to rest, I asked her to notice the details of how it felt to be in that space. After allowing them to remain in their trances for a while, I asked them to become aware of their chairs again. I then asked them to slowly lift their heads and open their eyes and focus on a point in front of them. Having delineated a point at which they had come out of the hypnosis, I further qualified the experience as hypnotic by telling Doug not to move because he seemed to have been in a "deeper" trance. I asked them to remain seated for as long as they wanted to once I had left and then to discuss and compare their experiences with each other and with their previous experiences of hypnosis. I also asked them to notice if anything unusual happened during the week.

We made use of time at the beginning of the second session to discuss their experiences. Amanda said she had been very tired afterwards. Doug said that he had not really "gone under" but that Amanda had. He said he had felt very relaxed but a bit scared. It had been fine when he had allowed his head to move down under his control. Then, it had felt much deeper but he did not know how. I mentioned that it was probably because he had been ready for it. He said that he had felt self-conscious but that he was doing it for the baby. He had felt much more relaxed than in his previous experiences of hypnosis, probably because it was a different situation and he was doing it for a different reason. I reinforced the importance of the different situation. After all, they wanted to be at home for most of the labour and would need to be used to doing hypnosis in this situation. Doug continued to talk about initially going with it but then being unable to let go. I explained that there was a paradox between his absolute susceptibility - his head fell immediately - and his anxiety about

going under. At first, Doug didn't agree with this but I suggested that it was part of the way he became hypnotised and was idiosyncratic to him. Amanda agreed with this and then Doug remembered about another time he had been hypnotised in this way, thus broadening his domain of acceptable hypnotic behaviours and giving my explanation credence. He remembered that his body had felt warm and then wanted to know why he also needed to be hypnotised. I explained that it could be a way for him to access the inner voice he had spoken about previously. He could use this information to relate to Amanda on an unconscious level (he had used this term himself) by becoming more tuned into her needs. Doug said he was not sure how this would work practically. Neither was I but I left it vague and suggested that we would find out when the time was right. However, I suggested that it might have something to do with helping him be a better birth coach which he had mentioned as being important to him, during the first session. I also reminded them that Amanda had said she only wanted to use the hypnosis during labour and not during the delivery, so they could use the hypnosis during labour together to get in touch with each other. Capitalising on their status as psychology students, I then spent some time explaining that, theoretically, there were two possible choices as to how hypnosis could be used. The first was to directly suggest hypnotic analgesia and I referred to an article that I would bring for them the next session. However, Amanda did not want to do this as she wanted to experience actively coping with the pain. The second method involved focusing on positive and negative emotions and feelings so that Amanda would be able to use pain as a positive sensation. We would use visualisation techniques and Doug could help by accessing his inner voice. I mentioned that it would be important for him to remember his past hypnotic experiences in order to access this ability

readily. The inner voice would provide them with information about their subtle interactions and this could be used during labour. Both Amanda and Doug seemed captured by this idea and were excited at being able to play a part with me in deciding how to use hypnosis. We also all felt that this was a feasible choice in light of the fact that they did not have much time to practise and we could capitalise on skills they already had. I then told Amanda that I would only hypnotise her today although Doug would probably hypnotise himself because that was what he did naturally. I suggested that while he was in the trance he would listen to his inner voices, as well as visualising himself and Amanda together, in order to understand her needs. I suggested that they not try too hard, but just see what happened. This allowed us to create a situation in which a wide range of behaviours could be qualified as hypnotic. Doug wanted to know whether hypnosis was similar to falling asleep because he felt that if it was, then he could be susceptible. As had become the norm for him, he then recounted other experiences where this had been the case. I then turned to Amanda and asked her to sit in the other chair, as before. She giggled and I mentioned that people often did so before going into a trance. I then asked her to relax herself from her feet upwards. Once she was perfectly relaxed, I asked her to imagine a colour and then to allow the colour to frame an inner picture. She seemed to be struggling with something and with her eyes still closed and in a heavy voice, she eventually said that she could not do it. She told me that she was experiencing a horrible sensation, that something felt as if it was pressing on her hands and on her face and that she was finding it difficult to breathe. She said that she knew this feeling but that she had never felt it so strongly before. I asked her if she had a name for it and she said she could call it "thickness". I then asked Amanda to lift her hands slowly towards herself

and to push the thickness away. She followed my suggestions in a sleepy manner, slowly pushing her hands away from herself. At once she looked more relaxed. At this point, I asked her to turn her hands inwards and pull something pleasant towards herself. She pulled her hands closer until they were covering her face. She visibly relaxed and when she moved her hands away, there was a smile on her face. I asked her to give the pleasant sensation a name but not to tell me what it was. I turned to look at Doug who had initially been watching us but by this stage, seemed to be in a deep sleep. I asked Amanda to slowly lift her head and open her eyes in order to come out of the trance. When she opened her eyes, she remained silent for a time and when she did finally talk, she said that she felt like crying. I told her that it was fine if she wanted to. She did not cry, but began to talk very softly and with a lot of emotion about the experience, saying how intense the feeling had been and that she had felt an incredible sense of understanding and connection from me. I explained that this was the type of connection that I felt she and Doug would be able to discover about their relationship through the hypnosis. I suggested that Amanda had now had this experience and that she could access it whenever she wanted to. I explained that she would be able to push or pull the positive and negative experiences as she felt pain or other sensations. Suddenly, Amanda turned to me and said, "I know exactly how it's going to work." I suggested that she notice if anything was different in the coming week and that if the feeling of thickness came to her, she could push it away. I also said that she would be able to cry if necessary. I finished the session by saying that she should just allow things to happen naturally, not to force it but just to trust the process. I asked her to discuss her experience with Doug.

At the start of this session, I asked Amanda and Doug about the previous session and Doug said that he had been in a very deep trance. He had started off just relaxing but then "was gone". Doug then spent some time explaining to us how he knew he had been in a trance, especially because he had felt out of touch and that it had been different to sleep because he never wakes up from a sleep feeling so disoriented. He had also consciously decided to go into a trance. A fairly light-hearted discussion followed and then they mentioned that they had not had much time to practice nor time for Doug to listen to his inner voices. They wanted to try now. Amanda had discussed the last session with Doug and she said that it had been "very special". She mentioned that she had experienced the pleasant feeling again and that she could call it up by name without going into a trance. She had not used her hands to bring it closer though. I said that using her hands would probably prove to be a stronger cue. We then decided to work with Doug in order to use the time to allow his subconscious to speak to him. Doug chose not to sit in the original chair, preferring to stay seated on the couch. I suggested that he swap couches so that both Amanda and I could see him. In line with his previously expressed understanding of hypnosis as relaxing, we placed a cushion under his left hand. I then suggested that both Amanda and I would hypnotise Doug together. I explained to Amanda that she should watch Doug very carefully for any changes and we would talk to each other about this. This is a powerful method of hypnotic induction as it allows more than the designated subject and hypnotist to be involved in qualifying the context as hypnotic. According to Fourie and Lifschitz (1985), this is "typical of a hypnotic situation, that is onlookers seldom talk directly to the subject, they talk in a hushed tone among themselves *about* (italics in original) the subject's behaviour" (p. 79). I asked Doug to indicate to us

when he was ready to start. He said that he felt apprehensive and wondered what would happen if it did not work. I told him not to try to make it work but just to let it happen. I explained that it would be different now because we were going to hypnotise him whereas before he had hypnotised himself. I suggested that he notice how the chair felt and concentrate on his body against the chair and not on being hypnotised. I asked Amanda which part of Doug's body she thought would indicate to us that he was ready to go into a trance. Amanda said that she though his eyes would close and they began to close as we spoke about it. Doug's breathing also began to get deeper. Amanda and I discussed how hypnosis was a strange feeling and that it was difficult to believe it was happening to one, so much so that it was difficult to let go and allow it to happen. I reminded Amanda that last time she had shown this by giggling but that she had gotten over that stage. At this point, Doug smiled and his head dropped and Amanda and I agreed that he was in a trance. Amanda suggested that going into hypnosis was like being on the edge of a diving board. She said that when she had gone into her first trance with me she had been scared to let her head drop. I thought that on hearing this, it would make it easier for Doug to let go and go over the edge. His head began to drop even further. Amanda and I then began to speak about some of our personal experiences of hypnosis. During this time, the focus was removed from Doug and he was able to do his own thing, even though we had said we would hypnotise him - that is, it accommodated to his needs. I then mentioned that I wondered whether Doug could still hear us. If not, I was sure his inner voices were talking to him so that he would later be able to access information about their relationship. I then asked Amanda what she though Doug was experiencing. I explained that it was important for Amanda to do this because it

reinforced the connection between them in the nonverbal parts of their relationship. I said that it was impossible for me to do this for them and that only she would be able to imagine what Doug was experiencing. Amanda thought that Doug's hands might start to lift. However, he remained very still. I explained to Amanda that this was because Doug was probably in a very deep trance - so deep that he could not move and that what we said to him and what he said to himself would have no influence because what he was really listening to was his inner voice. I then suggested that we remain quiet while Doug's subconscious voice spoke to him. I mentioned that he would probably not remember what the inner voice had said but that it might come back to him slowly during the week as he interacted with Amanda or that if he did remember, he would not talk about it but would just be able to notice the differences in his relationship with Amanda and he would then be able to use this information during Amanda's labour to help her. I asked Doug to give us a sign when he was ready to come out of the trance. After a time, I turned to Amanda and said to her that it looked like Doug was struggling to come out of the trance. I asked Doug to focus on his body again and to notice how things he was touching felt more real again. I then suggested that he should climb a flight of stairs and while he did this, his head lifted slowly. Once at the top of the stairs, I asked Doug to open the door and as he did this his eyes opened very slowly. He found it difficult to focus on Amanda and myself and I mentioned that he must have been in a very deep trance. Doug then said that he had been able to hear us most of the time except for when he had been "really deep" in the trance. He said that he still felt quite removed and asked if this was because of the trance. I said that it could be his way of experiencing a trance and he said that he thought he was more of a deep kind of person. Doug said that he had

related to Amanda's explanation of the diving board and that at one stage, his whole body had felt "now, just jump". He said that there were times when he could have just opened his eyes but had not wanted to. I said that it would be helpful if Doug could find a time to practise and we all then started joking about using hypnosis to put the baby in a trance after the birth so that they could sleep. Once again, I asked them to see how things would be different in the week. I asked Doug to specially focus on his relationship with Amanda. I pointed out that Amanda's diving board description had been so relevant for Doug and that just as this had helped him in his trance, so their interchange of ideas about hypnosis would help each other. The process would go both ways and after all, it was to be an experience for both of them, not just for Amanda. Doug said that he was feeling funny and that his limbs felt weak. He felt as if he had lost the sense of his body and that he needed time to get in touch again. Once again, I emphasised the process between the two of them and suggested that they continue with this before the next session or the birth, whichever came first. We agreed that we did not have to have any more sessions if the baby was born soon but that they would continue getting in touch with the process between them.

As it turned out, there was no time for another session before the baby was born. Amanda told me the story of what had happened, prefaced by her amazement at the whole event. They had gone to a party the night before and Amanda thought that her dancing had induced her labour. She had been woken up by contractions and for the first few hours, they had been about 20 minutes apart and about 35 seconds long. She had started to use her breathing techniques and had rested deeply in between. Initially, Amanda had woken Doug but had told him to go back to sleep. Doug said that he had gone back to sleep "quite easily". Amanda had relaxed by lying down and

breathing. The contractions had then become quite severe and in her back, coming about every 5 minutes. I mentioned that she seemed to have been very competent on her own. She responded that she had kept trying to use the technique and did manage to evoke the pleasant feeling in between contractions. She said that she had known that she needed to rest in between the contractions and had been moving around during each contraction but had used the hypnosis to rest in between. She had not tried to push away the pain but had used imagery which had definitely helped. Amanda explained that she had not wanted to use the pushing away technique as she had been saving it for later. She told me that she had felt very much in control and that she had not had to wake Doug. The imagery had helped her to relax. She explained to me that she had not used the imagery from the first session but had used the positive image that we had used in order to push away the feeling of thickness. She referred to the "time you said I must call up an image and then push away the image." At this point, Doug asked what the image was and Amanda said it had been "love". Continuing with her story, Amanda said she had got into a bath and had then woken Doug when the contractions had become more severe. At this point, the breathing was not really helping with the pain. However, all the time she was at home, she felt very much in control. Her waters had broken at about 07:30 and she and Doug then got into the car. At this point, Amanda said that she lost control, although at one stage she had made a conscious effort to use her mind to regain some control. Once at the hospital, someone else had taken control. Doug then intervened, saying that he had pretty much the same story to relate but from the perspective of the driver. He said it had been a frightening and stressful experience as he had tried to negotiate the morning traffic. He said he had coped by remaining optimistic, not

talking to Amanda, keeping his hand on the hooter and just driving. He then said, "The experience I had which is relevant to the contact we've had with you was in the labour room itself. ... it actually just occurred to me now that what we did, had some bearing on my experience then - because it wasn't a conscious thing of us communicating and being in tune with each other but at some point during the labour that kind of mutual understanding that we focused on was very present ... ja, I felt very connected to Amanda." Doug explained that he had been confident that Amanda was in control and this was the importance of the communication between them. He explained that it had been easy for him to go back to sleep initially because he had intuitively understood, without Amanda having to tell him, that she needed him to sleep then, so she could rely on him later. When they were in the car, they had also been able to do what each of them had had to do, on their own but together in this. Amanda then began to speak about the connection between them, reinforcing what Doug had said. Doug then said, " What I feel has been brought about by the contact we've had with you has been ... it's always left us once you've left, with a good feeling. It's always left us feeling positive about the way we relate to each other and there was a feeling of positivity." I asked if this was something that carried on and Doug said, "Ja, not just the labour - after you left one day, we were able to sit and really chat for a long time. There was a feeling of positivity. Not connected necessarily - maybe the hypnosis enabled us to get in touch." I mentioned that this sounded like a bigger process than just the birth. It wasn't just about a baby had being born but also about what the baby meant for their future relationship with each other. Amanda agreed, saying that she felt they now had an "unbelievable communication." Referring to one of the articles I had given them, Amanda said that self-hypnosis

"wouldn't work for me" and that she wouldn't have chosen that approach. I pointed out that through the process, she had found her own way to use the hypnosis. I also put forward the idea that having been exposed to hypnosis may have shortened her labour because she was relaxed, in control and confident. Amanda felt that this was very possible and agreed that she had felt confident. She ended our discussion by saying that it would be useful to teach people to use hypnosis to deal with the pain afterwards as well.

Metaperspective

This explanation will focus on the major therapeutic hypotheses guiding this case. In the initial session, one of the first issues discussed was why Amanda and Doug wanted to use hypnosis. Out of this discussion, we were able to discover that Amanda did not want to remove the pain, but wanted to find a way of coping with it. She also thought that hypnotic imagery might be useful. In addition, both Amanda and Doug were personally curious about the experience of hypnosis and it was clear that they wanted to share in the experience of hypnosis. When we began to talk about Amanda's feelings about pain, she pointed out that she complained less about pain since being married. She felt that in some way, the hypnosis could make it easier for Doug to help her and this tied in with the feelings Doug had about the importance of the birth coach. Thus, from our initial discussion, we were able to develop a workable problem definition, namely, that hypnosis could somehow help Doug help Amanda cope with the pain and she could also use imagery. In order to achieve this, it seemed as if it would be useful to enhance the feeling of connection between Doug and

Amanda, especially in light of the fact that Amanda had said she coped better with pain since being married. One way to go about this was to hypnotise them together so that they could share in the experience. Amanda had also mentioned that she thought the hypnosis could help Doug know how to support her. Doug had told us that in previous hypnotic experiences, he had been given valuable information from his subconscious. Thus, in the second session, we made use of these ideas by hypnotising Doug so that he could access his "inner voices" in order to gain information about his relationship with Amanda. This process was repeated in the third session and even elaborated in the way in which he was hypnotised. This time, Amanda was seen as being the only one, because of her privileged position in relation to Doug, who would have information about what Doug was experiencing in his trance. Thus, the induction method was not only used because of its power, but also because it fitted with the broader hypothesis of connecting. After each session, Doug and Amanda were asked to spend time sharing their experiences with one another. Later, during the feedback session, Doug referred to one of these times as proving to have been very meaningful for him. This is a clear instance of how hypnosis is not used because it has intrinsic power but the experience of hypnosis becomes a powerful confirmer of a therapeutic reframe. In this case, it confirmed Doug and Amanda's feeling of closeness which was seen as away of dis-solving (Anderson & Goolishian, 1988) the problem of pain being more difficult to handle when alone.

Another therapeutic principle is clearly demonstrated in this case, namely Keeney and Ross' (1992) principle of meaningful noise. They explain that

> all adaptive change requires some source of the 'new' from which alternative behaviours, choices, structures, patterns may be drawn. Although Ashby and Bateson referred to this source of the new as 'random', it is important to realize that not all sources of randomness or noise are effective in therapy. Clients, as well as therapists, must believe that there is some communication that not only is new to them but has meaning. We therefore prefer to speak of this communication as "meaningful noise" (p. 37).

When we first began to work together, Amanda and Doug kept asking how the hypnosis was actually going to work and they were met with vague replies. Each of them, in fact, seemed to have their own ideas as to how it could *possibly* work. In Amanda's case, she thought imagery would play a role although she was not quite sure how. However, after the powerful experience in the second session, Amanda proclaimed, "I know exactly how it's going to work." In some way, the experience was the "meaningful noise" she needed in order to understand how the process would work. Only later, during the feedback session, when Amanda revealed that the image she was using was one of love, did it become clear how her individual process connected with the bigger process between the two of them in that the theme of the closeness of their relationship seemed to play a role here too.

Kate (27 yrs) and Graeme (30 yrs)

Kate telephoned me in response to an announcement made by her ante-natal teacher with whom I had spoken about this research. Kate and I spoke for a while

before she agreed to participate in the study. Her two major concerns were whether we would be using self-hypnosis and if it would totally eradicate the need for an epidural.

During our first session, Kate told me that she had been a teacher but was no longer teaching. Graeme then proceeded to dominate the session with his stories. He pronounced a strong belief in "you do your part and then G-d[2] will do His part" and gave many examples in story form of G-d's intervention in his life. At the beginning of the session, I had explained that we would first need to spend some time talking in order to discover what would work for them. I now explained that there were different ways of using hypnosis in obstetrics as an extra tool. Graeme then asked if I would be present at the birth. I said that it was unlikely, but he seemed to want me at the birth because he asked again a little while later. As Graeme continued to tell his life stories, his life philosophy became clear - trust in G-d, wait and see what life offered, and then believe in the power of G-d. I pointed out that Graeme must have a very special connection with G-d and he agreed. I noticed that Graeme's stories seemed quite hypnotic and made a mental note that he could possibly use this to hypnotise Kate. I asked them what role G-d played in their relationship and Graeme said He played a big part, being unclear about the specifics but reverting to anecdotes about G-d's role in the conception of the baby and the idea that "we do what we can but can't control everything". It seemed as if Graeme had a strong influence on Kate's beliefs - when he had told her to stop worrying about falling pregnant, she had. The theme of "trust and taking it easy" was clear again. Kate admitted that these ideas came more easily to Graeme but she could follow his lead. I pointed out that there

seemed to be a chain in which Kate trusted Graeme who trusted G-d. In addition, Kate seemed more connected to the physical while Graeme was connected to the spiritual - he had told me that G-d talked to him in his dreams. Kate then changed the subject of the discussion, telling me that she did not want to have an epidural and that she wanted as many skills to help her with this as possible, which is why she wanted to try hypnosis. Her doctor was aware that they were using hypnosis and respected Kate's wishes to use it. Kate then told me that although she did not want an epidural, if it came to that, it would also be all right and she would not feel guilty about it. In fact, she believed that the guilt idea was other people's assumptions. Graeme felt that Kate might think he would be unhappy if she needed an epidural. Kate disagreed but Graeme cut her off saying, "She'll be okay, she's a good person, whatever happens will be okay." Graeme carried on saying that he felt if one believed in G-d, then G-d would make it easy. He could not explain how he knew this, but believed it had to do with his past experiences. He also said that he was not expecting Kate to have to do anything because he would do the believing in G-d. Kate said that she didn't see things quite as clearly. She was praying for everything to go well but was aware that the reality may be different. She felt that she needed to prepare emotionally for what might go wrong as opposed to Graeme's spiritual preparation. She said that she could never live with the blind faith that Graeme lived with, but that she respected it. Kate said that for her, birth involved a fear of the unknown but she was excited about motherhood. Graeme then interrupted with another of his anecdotes about being at the dentist and how trust had allowed him to relax and cope with the pain. Kate was not sure how this was related to labour but Graeme

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[2] For religious reasons, it is forbidden to write this word out in full; a hyphen replaces the 'o'.

explained it with an analogy of the brain as a traffic light, controlling things. If Kate's traffic light was not able to function, Graeme said he would be her traffic light. With that, the session ended.

The second session began with a discussion about Kate and Graeme's ideas about hypnosis. Kate said that she believed it could be beneficial in that it would make her more aware and in control. She said all she knew about hypnosis was from television when people were taken to past lives on hypnosis shows. Graeme said that he had never seen a live show, but had seen hypnosis used in movies. Kate felt that hypnosis helped one to overcome barriers because it lessened one's defenses. She said it was a deep state of relaxation and mentioned that she had used imagery, breathing and colour in her work with other people but not for herself. She wanted to know what the difference was between hypnosis and deep relaxation. I asked her what she believed the difference to be and she said hypnosis was more focused. Graeme then said to us that goals were like Kate's focus and that one could achieve goals through belief in G-d. Talking to oneself about goals was the same as hypnotic focus. I interrupted Graeme and asked them if hypnosis was different to what they had been doing in the ante-natal class. They felt it used the same kind of breathing techniques and also worked with the pain, keeping relaxed with one's mind focused on the goal, taking one step at a time. However, they felt that hypnosis was a deeper state in terms of all of the above. However, the hypnosis was definitely linked to the ante-natal techniques. I asked where they saw the role of G-d in all of this and whether it was connected or not. Graeme said that all he had to do was trust in G-d and worry about the practical things, but Kate said that although she understood this intellectually, she was not as emotionally close to the idea. She saw no conflict in her belief in G-d and

hypnosis. However, she didn't see them as directly related. Graeme felt hypnosis could be a tool for focusing on G-d and it was part of G-d's plan that I was working with them. He then told one of his stories to illustrate this point. In summary, I said that we could see the fact that G-d had sent me to them as a framework and then within this, Kate could work with hypnotic imagery. In this way, Graeme's spirituality could create a framework for Kate's emotional and pragmatic needs in a combined approach. I then asked Kate about the impact of Graeme's stories on her and Kate admitted that they irritated her if they weren't told in the right context. However, if they were told at the right time, then they were wonderful. I pointed out that it seemed as if Graeme had a lot of the right stories for certain situations. I then suggested that we get down to business and asked Kate to sit on a chair in front of Graeme and me. Kate asked what was going to happen. I said that we needed to see what happened to her when she was hypnotised and that later we would connect it to the bigger picture I had just described. I told Kate that I would talk and that she should just go with the strange feelings. I asked her to focus on her breathing and then to imagine colours around her. I then asked her to imagine a peaceful, relaxing place. Kate began to laugh nervously and I told her that before hypnosis, people often feel uncomfortable. I than asked her to focus on the parts of her body that were touching the chair and to notice how this felt. She asked me if she could close her eyes and I told her to do whatever came naturally to her and that in this way, her body would lead her into a trance. I told her that once she had taken the first step, then it would be easier but that she should take her own time. At this point, Graeme left the room. I carried on talking to Kate, pointing out that her breathing seemed to be getting deeper. I asked her to notice the relationship between her breathing and the

fluttering of her eyes. I then asked her to notice how sounds outside were different, pointing out the water running in the pool, the buzzing in the air and how a bird's chirp might sound louder or softer or just different. I then pointed out to her the way her head was moving on its own and asked her to continue to allow it to do its own thing. I also showed her that her fingers seemed to have a life of their own and asked her to focus on the way her head and fingers wanted to move and how this was different to the rest of her body which was very still. I then asked Kate to focus on what it was like to be in this state. At this point, Graeme came back into the room. I asked Kate to continue focusing on the feeling while I talked to Graeme. I told Kate that she may or may not hear us but that it did not really matter. Instead, I wanted her to focus on the feeling and then to find a name for the feeling. I told her not to think of the name but just to let it come on its own. I then turned to Graeme and told him what had been happening. I explained that Kate would be able to use this feeling when she was in labour and that after she had found a name for it, we would build the name into an image. I referred Graeme back to the story he had told about the dentist, saying that if Kate could focus on other parts of her body, the labour pains would be less. Kate murmured as an indication that she had found the name for the feeling. I told Graeme that it was important for him to understand what was happening because he would be there to help Kate focus. I said we would work on this during the next few weeks and see how best Graeme could help Kate. I then turned back to Kate and asked her to come slowly out of the trance. I asked her to remember the name so she would be able to evoke the trance feeling in her body, her head and her hands. I asked Kate to become more aware of the chair and the floor and the things she was touching and to notice how the sounds around her were becoming more normal. I asked her to

become aware of her body and that when she was ready, she could open her eyes. Kate eventually opened her eyes. She told me that she felt heavy; that her head and everything felt very heavy. I said that she should remember the name for the feeling and keep it. Kate then said that she had heard me talking to Graeme but had felt very relaxed and removed from the sounds. She said our voices had sounded different and she had felt very still. I then said that she could use her trance experience to focus more strongly on the ante-natal techniques and that Graeme could help as we had discussed. As he had done in the previous session, Graeme then asked me if I was going to be there. I explained to him that we would work so that I wouldn't have to be there as it might not be practical at the time. Kate then asked at which stage of labour she should use the hypnosis and I told her that she should decide when to use it so she would have control over it. The session ended and as I was leaving, Kate said to me that she hadn't thought she was in a trance but the more she thought about it afterwards, the more she realised that she had been hypnotised.

At the start of the third session, Kate told me that she had been very emotional during the week. I wondered if it had anything to do with the hypnosis because I had asked her to be more in touch with the way she was feeling. Kate told me that it had been difficult for her to talk to Graeme about the way she was feeling and she had felt quite separated from him. She had spoken to a psychologist friend who had managed to help Kate sort out her feelings. However, Kate had also been able to use the name she had found during the hypnosis the week before to help her go to a special place and relax. Graeme then admitted that it had been difficult for him to share in Kate's pregnancy at times. He said that he felt they had been divided through the week over "stupid issues". Kate became quite emotional at this point and had tears in her eyes. I

commented on this and said that it was quite important at this stage to reconnect Graeme's spiritual framework with Kate's physical and emotional experiences. In response, Kate mentioned that she had felt very spiritual during the week. She had been told that her obstetrician might be away at the time of the birth and she had accepted it in the way Graeme always accepted G-d's will. She said that Graeme's guidance had been strong through this and that they were both feeling a strong connection to G-d. I then said that it was also important to combine their individual styles of being. Where Kate liked to work with relaxation and imagery, Graeme preferred to tell stories and often had the perfect story at specific times. I reminded Kate that she had said that the stories worked for her when it was the right time and place so it was up to us to make this the right time and place by using Graeme's ability to help induce a trance in Kate. I suggested that we try and do this now. I asked Kate if she could start hypnotising herself by using the name while Graeme and I talked to each other. I asked Kate to listen to us with one part of herself. Kate's eyes closed quickly and I pointed out how much quicker they had closed this time. I then asked Graeme if he had any stories about the last few weeks, the hypnosis and G-d's providence. True to style, Graeme quickly found a relevant story to tell about trust in G-d but at the same time, having confidence in one's own abilities. At this stage, I pointed out the relationship between one's own thoughts and confidence. I said that Kate had seemed to go deeper into a trance and that it was important for her to know that her thoughts could control her body and that she could have confidence in this. Graeme then mentioned that he wasn't entirely happy about the way the baby was impacting on their relationship. However, he said in the light of this, they had to have a lot of trust. I pointed out the role hypnosis could play in building this trust and

showed them that it already had helped Kate trust Graeme's spiritual connection when it came to accepting the fact that her obstetrician might be away. We then spoke about the way in which Graeme's trust in G-d had helped them to conceive and then Graeme pointed out that part of G-d's blessing was that they needed to have a good relationship between them because G-d wouldn't come to a place where there was no peace. Thus, we realised that the overarching theme of conception, the birth and trance was to relax and leave it up to G-d within a context of closeness between Kate and Graeme. I then suggested that this could also apply to Graeme's stories, namely, that Kate should learn to go with them instead of being cut off from them. Graeme could then tell Kate stories to put her into a trance I then asked Graeme what he thought Kate's special place was and if he could tell a story about it. He thought it was Mauritius, where they had gone on honeymoon and he then went on to describe the sound of the sea. He described this as a very relaxed time and told of how they had spoken about their future life plans together. I said that it sounded like a place where they had been alone without intrusions and I wondered how this had changed with the approach of the birth of the baby. Graeme replied that things would change with children but that they had built shared trust in their relationship. He remarked that there had also been disappointments but that Kate had trusted him and seen that his decisions could be trusted. He told me that he usually makes decisions in the shower and I remarked that that was quite a relaxing place. It was interesting that it seemed as if the right ideas came to him in a state of relaxation, which was similar to hypnosis. Thus, if Kate became relaxed, the right things would happen. It seemed as if the mind became so focused that the body automatically knew what to do and in this way, things were actually left up to G-d. Graeme agreed that in his experience,

when it was left up to G-d, results could be achieved. At this point, I turned back to Kate and asked her to start coming out of her trance in her own way. As Kate was doing this, Graeme said that he felt Kate needed something physical in order to trust in the spiritual because she could believe in the physical. I said that perhaps the hypnotic experience would be the physical experience that would then help her to believe in G-d. I told Graeme that I felt he was the link for Kate to G-d and that he and Kate worked on different levels in a complementary way. Graeme said that he still felt it took Kate time to believe in G-d. I pointed out though, that Kate didn't need to believe directly because Graeme did it for her. At this point, Kate opened her eyes. Before leaving them, I asked them to find the themes connecting Graeme's stories and Kate's hypnotic experience.

Kate started the fourth session by telling me that it had been a better week because she had been much less emotional. Graeme agreed. Kate said that Graeme had been much more present and more supportive. I noted that he had also been more present in the previous session. I asked them what themes they had discovered from the last session and Kate mentioned the theme of trusting Graeme to do what he said he would do, building dreams together and have a greater sense of confidence in him. They had spent time discussing these themes together. While we were talking, it seemed as if Graeme wasn't participating much and I mentioned that it seemed as if he didn't want to be working with us. Before we had begun, he had taken his time in coming to sit with us, saying that he was busy doing things to fix up the baby's room. Kate asked him directly if he did not think it was more important for him to be with us now. Before Graeme could answer, I pointed out that it seemed as if the balance between them had shifted. Graeme now seemed to be concentrating on physical, external

things while Kate seemed more in touch with emotional and spiritual matters. However, they were still balanced as a whole partnership. Kate said that she liked this idea and that she found it useful that the whole could remain stable even if they shifted individual focus. I then asked Graeme what other things he thought he might feel like doing while Kate was in labour. He looked surprised at my question but Kate did not. At first, Graeme did not answer but then he shared a fantasy with us, that when Kate went into labour, he somehow would not be able to be found. I remarked that this would save him from having to go through the whole ordeal. Graeme then changed his mind, saying that he wouldn't like this if it happened because he had to be there for "my baby - the big one" - his father had even told him to be there "like a horse with blinkers". This image prompted me to move to the theme of 'focus'. Kate said that she saw the issue of focus as linked to the issue of trust because she had trust in Graeme's sense of purpose and focus. She said that now, she was having more of an experience of Graeme's original themes being part of the hypnosis than before. She began to ask me how and when she should use the hypnosis - the whole way through labour or only for the contractions but then realised, "I know what I'm going to do for myself but Graeme's stories help because it helps to know he's there." I then asked Kate how she wanted to use Graeme during the labour. Graeme said that he could help Kate with the breathing without the hypnosis and during the hypnosis, tell her about difficult things they had been through before and speak about their future with the baby. When I paraphrased this as him telling her stories, he said that he thought this would be difficult because his mind would be focusing on wanting the baby to be born. Kate was troubled by this, saying she needed Graeme to help but he pushed this aside, saying G-d would help. Kate and Graeme then confronted one

another over this issue. Finally, Graeme said that he would be too busy being involved in the excitement about what sex the baby was. I then said that this was exactly the kind of thing he needed to be telling Kate stories about because this tied in to Kate's 'future dreams' theme to which Graeme responded, "No problem." Kate, however, still wanted Graeme to help her focus. I explained that the way we had been working till this point was to do what fitted easiest with both of them. Thus, although focusing was an important theme, perhaps the content of the focus was less important. So, Kate could try to get in touch with Graeme's process of focusing through his focus on telling stories and use it in her own way. Graeme said this idea sounded "like music" and Kate agreed to try it as another tool. I then asked them work out a practical plan for using the hypnosis. Kate said that when she was ready, she would tell Graeme and it was agreed that Graeme would follow Kate's lead. In fact, he would trust Kate to know what was best and he then launched into a story to illustrate this point. I responded to his story by saying that it seemed as if they had agreed that because it was Kate's experience, she would know better than Graeme what to do at each point. Graeme responded to this with yet another story after which Kate said that she was sure on the day, she and Graeme would be in it together. I then suggested that they use the rest of the session to practice what they had just been discussing and to practise twice more in the next few days, but no more than this.

Their baby boy was born about two and a half weeks later and about two weeks after this, we held a feedback session. Kate was the one who started telling me about the events leading up to the birth. On the Tuesday, she had had a false alarm. However, by the Wednesday afternoon, she had begun to have back contractions. She had used her breathing exercises as well as the hypnosis the whole of Thursday. By

Thursday night, she and Graeme went to the nursing home to discover that she was hardly dilated and the baby had turned around. By 02:00, she was only 3 cm dilated. All this time, she had been using her breathing exercises and then they decided that Graeme should put her into a trance. They were not quite sure what time it had been but thought it was about 23:00 on Thursday night. She was in the trance till about 02:30 on Friday morning. Kate said that she had found it very relaxing and that the pain from the contractions had definitely subsided. However, because the baby had turned around, the obstetrician gave her an epidural at about 02:00 in order to speed up her dilation. At this point, Kate stressed that she was coping with the pain under hypnosis and that she had not needed the epidural for the pain. I asked Graeme how he was feeling at that stage and he said he was feeling fine. At 08:00 on Friday morning, Kate was only 5 cm dilated and a foetal monitor was attached to her. At one point, it seemed as if the foetal heart beat was being lost but later it turned out that this was because the monitor had come loose. Graeme had meanwhile spent some time sleeping and he woke up when Kate was about 7 cm dilated. At this point, it was not possible to increase the epidural because the baby was in distress. Graeme had begun to tell Kate stories about what the nurses were doing. The obstetrician then came in and because it seemed as if the baby's heart had stopped, he decided to deliver by caesarian section. Kate had been given a spinal block and although she was awake, she said she felt "out of it" and that in retrospect, it seemed like a dream. Graeme said that it seemed more like a nightmare. Kate explained to me that they had made use of the hypnosis right from the beginning. While at home, it had constantly been part of her coping repertoire which had also included listening to music, breathing and using imagery. Later, with Graeme's help in the nursing home, she had been able to

maintain the trance for much longer and she said that at this stage, she had felt no pain. She explained that she had mainly used imagery and that her biggest problem had been that she had begun to feel very tired. I asked Kate how the hypnosis had actually worked. Graeme started to answer me, saying that when Kate's mother had left, he had suggested that they use the hypnosis. He explained that he had put Kate in a chair and that her head had begun to get heavy and in this way, "I put her into hypnosis." The minute Kate had come out of hypnosis, she had felt the contractions again. Kate then took up the explanation, saying that the hypnosis had helped with her mental attitude. It had also been especially valuable afterwards in helping her to accept that the birth had not been natural. She had been able to maintain a positive attitude because of the discussion we had had about things not always being in one's own hands. I asked about her specific use of imagery. She said that it had given her an ability to distance herself and not focus on the pain as pain. I asked what her special word had been and she told me it was 'heavy'. I asked what specific image she had used. Kate explained that it was the image of a wave coming up and washing the pain away. Her experience had been that every time the wave went out, the pain had gone out too. She said it was difficult to explain exactly how everything had helped but that she had felt mentally strong and thus able to cope with the length of the labour. I asked Graeme if it had helped him knowing that he could do something for Kate. He said that it had, but that he hadn't really used story-telling. Instead, he had read to her from psalms and that this had seemed to help in the same way. He explained that he had first put Kate into a trance by telling her to relax, breathe and find her picture and word, and then he had read from psalms while she was in the trance. Kate said that she had made use of the hypnosis in the nursing home after the

birth as well, when the baby had developed jaundice. She said that on the Tuesday, she had been very upset and she had used imagery and music to calm herself. In this way, the hypnosis had been a way of coping. Kate said that she still used the hypnosis while feeding because it helped her to relax. She also used the breathing exercises for this purpose. I asked Kate whether she thought she would use the hypnosis in the future. She thought she would, saying that she had been in touch with relaxation before which she used and that the hypnosis was just more focused. Kate's description of the whole experience was that had been very positive and she was glad she had done it because it had given her an extra tool. She was not sure how she would have been able to handle such a long labour without this tool. It had given her a positive mental attitude which had also helped afterwards in accepting the caesar that she hadn't wanted. She said that she did not feel the need to ask questions about why it hadn't gone as planned. I mentioned that this seemed to have a lot to do with what we had spoken about, namely, doing one's bit and then accepting whatever happened. Kate said that the sessions had helped her get in touch with that kind of thinking because she would never have sat down and thought about it on her own.

Metaperspective

One of the most noticeable processes in the sessions with Kate and Graeme was the manner in which Graeme's stories deflected attention away from the issue of Kate's pain. This became evident after realising that the logical connections both within the stories and to the topic at hand were spurious at best (for example, the story about the traffic light in the first session); but the stories themselves were told in an intensely

captivating manner. Furthermore, it seemed as if Graeme's relationship with G-d played a similar role in that it allowed him to use a socially acceptable concept as a coping mechanism in a way that made him look competent. At times, he also used his faith declarations to deflect attention away from conflict. Graeme's illogical explanations of his faith made it difficult for Kate to understand them and thus, difficult for her to emulate. Thus, because Graeme created the rules in a manner that couldn't be challenged, he could play the game better than she could and thus, seem to be the most competent one. It was also evident, from his description of his relationship with G-d ("if one believed in G-d, then G-d would make it easy"), that Graeme's style was not to put much effort into things. In summary, then, it seemed as if Graeme used his talking about G-d as well as his stories, as a way of fulfilling his responsibilities without appearing obviously incompetent - he knew he wanted to help Kate but did not know how to do it. Haley (1976) explains that "it is possible to describe symptoms as communicative acts that have a function within an interpersonal network" (p. 99). As a result of the above considerations, Graeme's need to tell stories and to rely on G-d can be understood as a 'symptom' within his relationship with Kate and the need in that relationship for him to prove his competence. Thus, the hypnotic intervention needed to take account of this. Because his stories seemed to serve the function well and because he was unlikely to work hard at something new, it seemed that it would be best to use his story-telling abilities during the hypnosis. Telling long, monotonous stories also conformed with a socially acceptable hypnotic induction ritual. During the second session, we spent some time discussing their expectations of hypnosis in order to establish a consensual domain (Maturana & Varela, 1987) and it became evident that it would be useful to incorporate colours in

Kate's experience as this fitted with her conceptions of the hypnotic experience. Here, one can see the principle that "there are only conceptions (underlined in original) of hypnosis, and no misconceptions" (Fourie, 1989, p 21), in operation. Furthermore, as soon as the context was defined as hypnotic, Kate's behaviours, such as her nervous laugh, could all be qualified as hypnotic (Fourie & Lifschitz, 1989). At the end of this session, the importance of continuing to qualify the experience as hypnotic even after the event, became evident, when Kate volunteered her remark that the more she thought about it, the more she knew she was hypnotised. During the feedback at the beginning of the third session, some interesting confirmations of the systemic hypothesis were evident. According to the hypothesis, Graeme's stories helped him to cope with his responsibilities but also distanced him from Kate. At this point, Kate declared that after her hypnotic experience, she felt more distanced from Graeme. In addition, the hypnosis allowed her to experience her feelings of being alone more intensely as she felt she could not turn to Graeme for help but preferred speaking to a psychologist. She also used her special place, discovered under hypnosis, as a comfort, which had the effect of distancing her even more from Graeme. With Kate's separateness so overt, Graeme was able to speak about his feelings of separation from Kate which had intensified during her pregnancy. With this background, hypnosis could now be used as a tool to bring Kate and Graeme closer to each other in a manner that was safe for both of them. Thus, hypnosis was framed as a physical experience that Kate had been through that could help her believe in G-d, thus connecting her to Graeme's belief. In fact, Kate reported an increased feeling of spirituality. Throughout this session, the theme of connection was emphasised through the choice of language, such as "combine their individual

styles of being", "connect Graeme's spiritual and Kate's physical and emotional". Furthermore, the entire idea was formalised in the creation of the theme of trust in G-d as a framework that encompassed the closeness between Kate and Graeme. In the last session, the impact of the perturbations became clearer. There seemed to be more overt acknowledgement of relationship issues and direct confrontation which could then lead to some degree of resolution. Graeme overtly spoke about his fantasy to avoid the birth and his use of stories to induce a trance in Kate could be seen as allowing him to be present and avoidant at the same time, while helping Kate in his manner of avoidance. Kate and Graeme were also able to directly confront each other on the issue of G-d's help and find some resolution in Graeme's discovery that his stories could show Kate that he was supporting her. In this session, Kate also realised for herself, how the hypnosis would work for her. This became clear in her description during the feedback session, of how she had used the image of a wave. The feedback session also served to highlight the systemic hypothesis once again. Graeme had chosen to use the hypnosis only once Kate's mother had left. It seemed as if she acted as a coping buffer for him while she was there, but he needed to rely on the hypnosis once he was left alone. Finally, Graeme's decision to recite psalms instead of telling stories seems to have been an ingenious way of linking the issue of trust in G-d with his need to avoid direct coping.

Sue (28 yrs) and Craig (32 yrs)

As with Kate and Graeme, Sue and Craig heard about the study through their ante-natal coach. Sue then contacted me and we made an appointment. On introducing

ourselves, I learned that Sue was a secretary and that she was also studying by correspondence while Craig was an attorney who worked a lot with psychologists and social workers on child cases. Sue initiated the conversation. She said that she had not spoken to her obstetrician but that she did not think he would have a problem with them using hypnosis. And anyway, if he did, it was her choice. She wanted to have a natural birth experience without an epidural. She said that she was not scared of labour pain but that she did become scared of things that she was not in control of. Control could be gained through information, such as from the ante-natal classes. I asked them how they felt hypnosis could help them. Sue said that it would help her to relax and then she would not feel as much pain because she would be focusing on something else. She had always had an interest in hypnosis, not in the stage shows, but in hypnosis as an aid as she had seen in the movies where it was sometimes used to help people recall memories. Craig saw hypnosis as a tool to help the mind control the body. He thought that this could be similar to what Sue was saying about focusing. He suggested that it might help her focus on the ante-natal techniques. It could also be used to focus on an object and think positive, goal-directed thoughts about having the baby. Craig said that he also thought it worked by suggestion. Sue said this suggestion could work, for example, at the dentist where she could be given a suggestion that she would only need one injection instead of two or three. Previously, Sue had successfully used hypnosis tapes to help her diet but Craig said he had never been hypnotised before. I asked him if he was sure about this and then he thought that perhaps certain memory techniques he had used had an aspect of hypnosis because they involved the use of imagery to trigger what had been learned. He said that because the image served to control the mental process, it was possibly similar to

hypnosis. He also remembered using hypnosis for sport. He would imagine reaching a goal and in this way, could overcome physical obstacles. I then asked Sue how she would know when she was hypnotised, how would it feel. She said she was not sure but she didn't want it to feel as if she was not there and what did I have in mind. I asked her what she had in mind and she said that she wanted to be able to control the pain so that she could feel the experience. She then mentioned that she would not want to be under someone else's control in case she could not get back in control. So, she would not want to go too deep. She felt that there were different levels of hypnosis like there were different levels of awareness. She thought hypnosis could be like falling asleep but she wanted to feel more awake than that. She thought that if her eyes were closed, she would need to be very aware of what was going on. The conversation then shifted and Sue explained that her whole experience of being pregnant had been a very spiritual one. I asked her what she meant by 'spiritual' and she said that she felt a lot closer to G-d in her mind. She explained that she did not feel more religious but that she felt protected by G-d because of the pregnancy. She explained that it was not a physical protection because she felt quite vulnerable physically but there was a strong emotional connection with the baby. Craig murmured his agreement and I wondered if the pregnancy had changed his life at all. He said that he felt more responsibility which he saw as a natural, positive process and something that he wanted to do. He explained that in their relationship, he and Sue did not maintain the traditional roles although they were not fanatical about it and did accept practical differences. He felt that their relationship was close because they shared their feelings with each other. Sue mentioned that Craig had been very supportive practically and that when she had had bad moods, he had handled it well.

This too had helped them become emotionally closer. Thus, she saw the baby as facilitating a stronger bond between them because in relation to the baby, they had been doing everything together. I suggested that it would be useful to be able to carry this togetherness through the hypnosis to the birth and possibly even into the future beyond that. Sue said that she believed that after the baby was born, they would still share all sorts of responsibilities because their relationship had survived stress in the past. They used to argue a lot but they had been together for over ten years, although they had only been married for three. Craig said that they did experience conflict at times but if it was an important issue, one of them would realise they were wrong and compromise. He believed their relationship was strong through a process of learning through trial and error. Again, I mentioned that it would be nice if the hypnosis could get them closer still and I suggested that they could both use the hypnosis so it would become part of the relationship. Before leaving, I asked them to spend some time discussing how it could become part of their relationship after the birth.

At the start of the next session Sue said that she had spoken to her obstetrician who didn't have a problem with the hypnosis. He saw it as a form of self-motivation and that Sue wasn't going to be unaware or in a trance but would just know more about herself. I then explained to Sue and Craig that I thought the best way for us to work would be for them to do most of the work, using Craig's experiences. Craig said that he was happy with that as he was used to working with self-motivation. I then asked them if they had discussed how to use the hypnosis after the birth. Sue said that they had spent time discussing the birth. Since Craig was not going to be the one in pain, the hypnosis would not be for him at this stage. He thought he needed to know more about hypnosis in order to assist Sue. I asked them if they could find a special chair

with arms for Sue to sit in while we hypnotised her. Craig went to fetch it and I arranged the seating so both he and I could watch Sue. I then asked Craig to try to hypnotise Sue, drawing on his past experiences and doing whatever he thought would work. I said that I would watch and guide him if necessary. He did not know where to begin so I suggested that he ask Sue what she needed. Sue then turned to me, asking what I wanted. I told her I wanted her to have a hypnotic experience. I suggested that it was up to them to negotiate exactly what that would be. Sue decided that what she needed was to relax. Craig, taking his role very seriously, asked her how and Sue responded by giggling and than said that she needed not to think of anything specific. I wondered if she meant she needed to think of nothing and she agreed but said she also needed to think of specific things but not of an actual image. Craig suggested that she progressively relax her body and I suggested that in order to achieve this, she should close her eyes - in fact, I pointed out that they were already closing. Sue said that she would focus on an object and breath deeply because this had previously helped her when her leg was cramping. However, she pointed out that this suggestion of hers was problematic because in order to focus on the object, her eyes needed to be open. I suggested that we should just wait and see how this problem spontaneously resolved itself. I asked her to spend some time thinking about it while I spoke to Craig. I suggested to her that if she felt something we were saying influenced her in any way, she should just go with it. I then began to speak to Craig about the dilemma Sue was having about her eyes being open or closed, her need to focus her mind, breathing and focusing on one part of her body. Craig felt that she should close her eyes and focus on an image in her mind. Sue interrupted, saying that she was worried about this because she needed her eyes to be open during labour.

However, it was easier to relax with her eyes closed. I suggested that she close her eyes now at first and then open them later. Sue agreed and I suggested that we wait and see when her eye decided to close. In the first session, Craig had described hypnosis as self-motivation or self-talk, so I asked him to say out loud what he thought Sue should be saying to herself. In a soft voice, he began to suggest that she was feeling relaxed and peaceful. He began describing natural images and repeating the words "quiet and gentle". At the same time, I began to suggest that Sue's eyes seemed ready to close and that this was a sign of her going deeper into a trance. I suggested that she let go and that she would be able to hear both Craig and myself as she breathed and entered a deep state of relaxation. I then told her that as she entered the next stage, she would be able to carry on with her own thoughts. I mentioned to Craig that Sue's body was twitching in some parts and that he should watch carefully as this was a sign of her muscles relaxing. Sue seemed to be experiencing a deep heaviness and her head began to move down to the left. I pointed this out and suggested that as it carried on dropping, she would move into a deeper trance. Her head continued to move very slowly and I continued to describe her relaxed state. I suggested that she enjoy the heavy, sinking feeling of her head and perhaps the heaviness would extend to the entire left hand side of her body. In contrast, I asked Sue to notice how the right hand side of her body felt and pointed out that the fingers of her right hand were twitching. I suggested that as the right hand side continued to become more alive and lighter, the left side would become heavier. I also asked Craig to continue to watch Sue's hands and to notice the difference between the hands. He pointed out to me that it seemed as if her right thumb was getting lighter and I continued in this vein, until her right hand had completely levitated. As her right hand

moved upwards and brushed against her shirt, her left hand began to slip downwards. Craig, sensing a need to create safety for Sue, said "nothing can hurt you." I instructed Sue to listen to Craig's voice while she allowed her hand to continue moving upwards, following its lead and becoming more confident in its ability to move quickly upwards. As her hand began to move upwards more rapidly, picking up on Craig's theme, I told her not to be afraid of this. I also asked her to notice how it felt and then, when she was focused enough and felt ready, I asked her to open her eyes and watch her hand continue to move upwards. At first, she seemed reluctant to open her eyes but then they opened slightly and I reinforced this. At this point, Craig began to focus on maintaining Sue's breathing and I followed his lead by suggesting that the breathing would maintain the hand levitation. After a while, I suggested that when Sue had seen enough, she could close her eyes again and bring her hand down under her own control. I then asked Craig to bring Sue out of the trance and following his suggestions not to force it, Sue slowly opened her eyes in her own time. Once her eyes were open, I asked her to talk to us when she felt ready. She sighed heavily and then smiled. saying that at first, she was not sure if she'd been hypnotised. Then, she'd had a nice feeling and felt as if her hand were very light. She mentioned that she had been very aware of how it had felt against her shirt and she had been unsure what exactly her hand had brushed against. The experience had been different to what she had expected but it had been very unusual. I said this was a good thing because we wanted her to feel unusual, different sensations, not pain. She went on to say that when she had opened her eyes, she knew she was still in a trance because sometimes she could see and sometimes she could not and she had had difficulty focusing. She was pleased that she had felt in control of when she could open her eyes. Craig asked

her about the relaxation and she said that she had taken the lead from him to relax when she had felt that it was the right thing to do. At other times she had done her own thing. However, it had helped her to focus. Sue mentioned how amazed she was that when I had said her hand would feel light it had felt light. Craig asked her if the other side had felt heavier and Sue said that it had but it had not been so heavy or uncomfortable that she would not have been able to move if she had wanted to. Craig wanted to know if she had felt in control. Sue replied that at times when she was relaxing and when she had brought her hand back down, she had, but not when her hand was lifting - her hand had been doing that on its own. Craig then asked her if she had noticed the outside noises; had they not been an interruption. Sue said that she had known what was happening around her but it had not been a disturbance. I pointed out that this was very useful because she was going to need to know what was going on around her while in a trance in labour. Sue said that she had been aware of this exact thought during the trance when the dog had jumped on her lap. Craig also agreed that this was a good thing. Sue then expressed a doubt about carrying this type of experience into the end of labour and through to the delivery because it would be a more extreme situation. Perhaps the hypnosis would only be useful in the beginning stages of labour. Craig said that even so, she would still be able to deal with the later stages with less stress. Sue then said that she had come out of the trance only because we had told her to but that she felt that she would have been able to remain focused for much longer, even with the outside distractions. With that, I left them, asking them to practise and experiment.

The third session was spent discussing the problems Craig and Sue had encountered while practising since the last session. It transpired that by discussing

their experiences with one another, they had learned from some of their errors and were eventually able to achieve an arm levitation. Sue said that it had been a good experience and they had spoken about this afterwards. I commented that it seemed as if there was a fair amount of pressure on Craig to put Sue in the same kind of trance that we had initially achieved and I wondered if Sue could try to find ways to help him. I emphasised how unusual it was to achieve as much as we had during that session and I also pointed out that during labour, Craig was going to need to take breaks and he needed to be realistic about this. Sue, however, mentioned that the second time they had practised, it had been as deep as it had been with me. She said that she had been able, once again, to maintain the trance with her eyes open. Sue then began to ask me lots of questions, such as which stage of labour to use the hypnosis, how to maintain the trance and how to get into the trance more quickly. It seemed to me that the best way to find answers to these questions was for Craig and Sue to learn how to read and use the feedback from their experiences. There was not much point in me hypnotising Sue again because it was more important for Craig to try to establish his own way of doing it. I wondered again what Sue could do to help Craig achieve this. I pointed out to them that one thing we could learn from the practising was that Sue should only use Craig's suggestions if they were pertinent; otherwise, she should ignore them. However, Sue said that she found it difficult to ignore him. I then pointed out that it seemed as if Sue kept focusing on the "I can'ts" and I wondered what the complementary "I cans" were. Sue said that she found Craig's voice to be very relaxing, irrespective of what he was saying. She thought that she could choose to use the sound of his voice, rather than the actual suggestions. Sue then said that sometimes she did not know whether she was doing something

because of the trance or because she had become conditioned. I suggested that perhaps it did not really matter. What mattered was that she experienced hypnosis both because her body did something, such as her head dropping or her arm lifting and she did these things because she was in a trance. In fact, it seemed to work both ways. Because of this, I suggested that we could use some of her body movements to trigger her going into a trance more quickly. Sue wanted to know how to do this and I said that it would be best to see how it would work, through practising. Craig, however, was concerned because there was not much time left to practise and hearing his concern, I said that I expected that the more they practised, the quicker they would become. Craig admitted that he had already found that they had become better at it. At this point, I felt that it was important for me to allow Sue and Craig to experiment with hypnosis and also to encourage them to practise as much as possible so that Craig could get better at sensing what Sue needed. I made a few suggestions to help Sue get into a trance. I suggested that she try counting in order to reach a certain depth of trance. I then suggested that counting could become a trigger for going into a trance. Craig mentioned that when they had practised, Sue's arm had only reached a certain height and he had then instructed her to move it sideways. He said that he had become concerned that her arm would not go higher but I pointed out that it was impressive that he seemed to have such suggestive powers over Sue that made her hand move sideways. In any case, all that was important was that the highest point Sue's arm reached at any time was indicative of her deepest state of trance. Sue, however, said that she had been worried that the trance wasn't deep enough. In response, I suggested that it was possible that she had reached such a deep state that her arm could not move anymore and that it was just as important for her to listen to

the feedback from her body as it was for her to use the feedback between herself and Craig. Sue then mentioned that she had a specific concern about the pain. I suggested that they should then try to experiment with pain while she was in a trance. I wondered *how* she would experience pain, what it would actually feel like. Perhaps it would feel different because she had previously mentioned that her body had felt different while she was in a trance. I thought it might feel more like discomfort or it would be too much trouble for her to notice the pain. Craig suggested that it would be good if Sue cold transform the pain into something else. I also suggested that Sue should see if she could make pain worse because then she would be able to conceptualise the pain as similar to the dimmer on a light switch - if she could make it worse, she could also make it better. Craig joined me in thinking of different images we could relate this experience to, such as counting, words, colours and touch. Sue said that she thought she could relate best to counting downwards, the dimmer and climbing down stairs. She felt these were the most tangible images and they were also connected to her previous experiences with hypnosis. I said that she should then try to visualise the actions of turning the dimmer, walking up and down stairs, etc while she was in the trance. I said that they would have to spend time experimenting with the ways in which the body triggers, these depth images and pain interacted. Sue said that she felt they should also experiment with talking and breathing in case she needed to do either of these while in the trance. Craig said that it seemed as if they needed lots of practice working with feedback from each other and I pointed out that it was important for them to recognise the nonverbal as well as the verbal feedback. I suggested they practise reading each other's nonverbal feedback in non-hypnosis situations and then acknowledge when the other person had got it right. This would

serve to increase their confidence in each other. Sue then took some time to reflect on the whole process. She mentioned that the first time I had hypnotised her, she hadn't been in a position to predict what problems they might encounter. However, now, having tried it themselves, she was pleased that they had come across difficulties because they had learned about how to incorporate this feedback into what they were doing. She said that it had been a very useful process and had shown them how wide the possibilities were. I ended the session by telling them how well they seemed to be doing without me, allowing them space to experiment on their own.

About two and a half weeks after the baby was born, Craig and Sue told me their story. Sue had gone into labour at about 03:00 and about three hours later, they decided to start using the hypnosis to help Sue relax. I asked them what they had done and Craig said that he did the relaxation, which "took her about halfway under" and then Sue had done "the rest myself" by telling herself, "This isn't really sore, there's no pain". Sue said that "it really helped, it was amazing actually. I mean the pain really really diminished a lot." I mentioned that we had discussed methods they might use such as counting, or switching a light down. Sue said that they had practiced a few times beforehand, but the baby had arrived sooner than expected. At the time, they decided to use Sue's head as a sign of how deeply she was hypnotised and that when her head was at a certain level, she would be able to talk to Craig. This had worked well and giggling, she assured us that she had indeed been in a trance but that she was able to talk to Craig. She then explained that when they had come to examine her, every half an hour, she had to get onto a bed but that she wanted to be able to stay in a bit of a trance for the internal examination so as to be able to control the pain then. Craig explained that in this way, she was able to go back into the trance

very quickly and he was able to relax while she kept on talking to herself. Sue then remarked again, "It's amazing how much it took the pain away, it really did; in a way, more than the breathing. The breathing helped to calm me down when I was out of hypnosis - the hypnosis took the pain away more. The breathing just helped to control me from screaming." Craig reminded Sue that the breathing had helped her to focus and she admitted that she would not have been able to cope without the breathing. She had, in fact, used both together. At times, she explained that she had been "pulled out" of the trance by some of the internal examinations but had been able to go back into the trance again. In fact, she said it wasn't so bad because it helped her feel "that it was going very quickly." Continuing with their story, Sue said that at about 07:30, her obstetrician had told her that she was still only slightly dilated and still in pre-labour. They had offered her an epidural in order to speed things up. Sue decided to wait until he came back the next time, which was at about 10:00 at which stage she did have the epidural. She used the hypnosis while they were giving her the epidural and thinks that that might be why it did not feel as painful as they said it would be. She managed to rest until about 17:00, at which time her waters broke but when the doctor saw her about two hours later, she was only 2cm dilated and the pain had started coming back through the epidural. At this stage, Sue said that she became a bit panicky and cannot remember actually going into a trance properly again but she started repeating the phrase "there's no pain". I asked Craig what he was doing at this stage and Sue said that he was talking to her, trying to calm her down the whole time, calling him "really brilliant". She then said, "I'm so glad we did this hypnosis because it helped Craig to be able to talk to me in a certain way to help me relax." At this point in the labour, Sue said that the pain had become very severe and she had

gone into a type of delirium, feeling disconnected from her body and becoming disoriented. Afterwards, the doctors said that it was the result of an atypical response to the epidural. During this time, Craig was "really brilliant" in using the hypnosis to keep her "not calm, but sane". At this point, he had held her hand and spoken to her in the tone he had used for hypnosis which really helped to calm her down. Craig explained that it also helped her to focus on all the things that were fine such as her blood pressure and the baby's heart beat. Sue explained that this had helped her to realise that she and the baby were still alive. In response to a question, Sue said that she had been concentrating both on Craig's tone of voice and on what he had been saying. Sue spoke quite a lot more, describing how frightening the experience was, concluding with, " I was very thankful that we had done the hypnosis and that Craig was there because I think that's what helped me through this. We then discussed how the hypnosis had given Craig "a background or a basis from which I could work and talk to Sue and she would know from where I was coming." Sue's doctor finally decided to do a caesar because the baby's head had become stuck. The labour had started at 09:00 the previous day and Sue was in labour for about 23 hours in total. She was given a spinal block which completely removed all pain and was able to focus and open her eyes in order to watch the baby being born. Sue concluded by saying how thankful she was that she had done all the preparation ie. ante-natal classes and hypnosis. Again, she said that Craig was "really, really brilliant." He explained that he thought it was important to stay calm. He was able to do this because he is a calm person, he knew what was going on and he had tools such as the hypnosis and the breathing at his disposal. Sue said that the hypnosis had also helped when she had had to go to the toilet and had to cope with her contractions in there on

her own. Laughing, she admitted to having used the hypnosis on the baby when she had been screaming once in the nursing home. Sue had spoken to her in the hypnotic tone of voice, telling her she was calm and that her eyes were becoming heavy and it had worked. Both Sue and Craig said they would use hypnosis again "with conviction."

Metaperspective

In viewing this case from a metaperspective, it seems as if one of the most useful concepts for understanding the processes at work is the social constructionist idea of constructed realities. In her article, "Constructing realities: An art of lenses", Lynn Hoffman (1990) explains how the social constructionist movement grew out of constructivism. As explained in Chapter 3, Maturana and Varela (1987) showed how the nervous system is in fact closed to external, instructive interactions. Thus, the perceived world or perceived reality is constructed internal to the nervous system and according to Hoffman (1990), the idea of an objective, knowable world is banished. This must necessarily include the banishment of any objective conceptualisation of pain. For Hoffman, this extreme constructivist view allows for no communication between people (because there are no instructive interactions) and is in disagreement with the social constructionist views of Gergen (in Hoffman, 1990) that "we build up our ideas about (the world) in conversation with other people" (p. 3), that is, in response to some type of instructive interaction. Thus, social constructionism posits that (our experience of) reality - including (our experience of) pain - is filtered through an evolving set of meanings.

Fourie (1992) explains that the therapist's task is to join with the client's consensual domain and then from within this space, to perturb ideas and behaviours so that they evolve into more positive or useful ideas and behaviours. The therapist has no linear effect on the client system, so any intervention merely acts as a catalyst for change. In this light, hypnosis is viewed as a technique or vehicle which carries creative possibilities for change. When these ideas are understood from within the context of social constructionism, hypnosis can be seen as a tool imbued with the potential to provoke new (experiences of) realities. All the time, however, it is important to remember that these realities are constructed within a social community and are thus co-constructed.

From out initial conversations, it seemed as if the consensual domain within which we were situated adhered to the following ideas: hypnosis could help with relaxation, it could provide a different focus, it allowed the mind to control the body, it could help Sue focus on the ante-natal techniques, it could work through suggestion, it could work through imagery, and it could help one reach a goal by overcoming obstacles. One of the other main issues to come up was that of control. Sue, and later Craig, also picked up on the concept of hypnotic depth, believing that the deeper one went, the more powerful the hypnosis would be. From the beginning, Sue was quite clear that she did not want the hypnosis to remove the pain, but to somehow change the pain experience into something with which she could cope. Another useful idea mentioned, was that the pregnancy experience had brought Craig and Sue closer together in their sharing relationship and that perhaps the hypnosis could further this process. During the second session, when Craig hypnotised Sue, many of these ideas were used and experimented with. The whole issue of whether Sue's eyes should be

open or closed, connected with the control issue and eventually, through suggestions and modifications of suggestions arising from an understanding of the verbal and non-verbal feedback, a situation was co-constructed in which Sue had enough control to feel safe but gave up enough control to feel hypnotised. During this session, the idea of different depths of hypnosis was used and this was later linked to certain physical experiences which could then 'trigger' the desired hypnotic depth. In this way, we used concepts already within the consensual domain, but adapted them to suit our purposes. Finally, when Sue commented that the hypnosis had made her feel unusual, this opportunity was used to link with her desire for pain when under hypnosis to feel different - or unusual - and in this way, for her to be able to cope with it. The third and feedback sessions were perhaps the times when the process of the co-construction of a more useful reality was clearest. During the third session, the use of feedback took prominence and made it very clear that what we were doing was truly co-constructing a useful hypnotic reality. One instance of this was when Craig became worried that Sue's arm might not rise high enough. In this case, the co-constructed reality came about through the acceptance by all involved, that whatever its highest point, this was indicative of deep hypnosis. Another instance of a changed reality was Sue's discovery that she could use Craig's tone of voice rather than the content, to hypnotise her. One more instance was when Craig noticed that they were "already getting better" at the hypnosis after I had commented that the more they practised, the better they would find they became. In effect, Craig's comment served to confirm that he had accepted my new description of the situation. The idea that hypnotic imagery may be useful was capitalised on in order for Sue to dim the pain sensations and in this way, a different, more useful reality was co-created from within the

consensual domain. Perhaps the clearest indication that the process of co-constructed realities was the "mechanism" at work, was during the feedback session when Sue described how she had used self-talk to "diminish the pain a lot", how Craig had helped her to relax by hypnotising her and how she had been able to focus better. Finally, Sue's statement that "I was very thankful that we had done the hypnosis ... because that's what helped me through this," shows how she attributed the experience of this reality to the use of hypnosis.

Belinda (27 yrs) and Stan (31 yrs)

Belinda and Stan heard about the study through a friend who had been going to ante-natal classes with the ante-natal teacher with whom I had been in contact. Our first session together took the guise of an introductory talk as Stan and Belinda had not yet decided whether or not they wanted to participate in the study. I asked them about themselves and learned that Stan was an electrical engineer and Belinda was planning to go into the interior decorating business, specialising in babies' rooms, after the baby was born. Although Belinda acknowledged that I couldn't tell her everything because we would have to see as we went along, she wanted to know what we would be doing. Stan wanted to know if it would involve self-hypnosis. I outlined the general format of the sessions as they had developed with the other cases and explained that there were many options, including self-hypnosis, but I stressed that our ideas would develop into a way of working that was unique for them. Stan wanted to know what my qualifications were and after explaining my position, Belinda said "So, you've been trained." They then asked about some of the other

cases. I said that I had had some interesting experiences with other couples but that each experience had been very different. Belinda asked about the reactions of the obstetricians, as she had not told hers yet. I said that he would probably want to know more about what we were doing and that it was important to work with his concerns too. Stan asked how much time would be involved and I said that I had found we usually needed three to four sessions of about an hour each. Belinda wanted to know if they would have to practise alone and I said that that depended on how we decided to work. I told them it was quite likely that I would give them homework between sessions but this might not necessarily be practising, it could be to discuss certain topics, to be aware of certain feelings, etc. I explained that it was important for us to develop a way of working that would fit into their lives and not disrupt it. I then said that I understood that it was often difficult for people to agree to participate at first because I needed to be vague about the process in order not to close off possibilities. Stan said that this was not a new thing for him because he had a friend who did hypnosis. I said that even so, it would probably be a new way of working with hypnosis. Belinda said that a friend of hers had tried hypnosis for the births of her children but that it had not worked and that she had been upset about this. I responded to this concern by saying that one of the benefits of my way of working was that I concentrated on developing a unique way of working with each individual so that it fitted with him or her and thus, there was more chance of it working. Belinda then told me that she had been hypnotised or relaxed - she was not sure which - by her plastic surgeon once and I said that was really useful because we would be able to build on that experience. Stan wanted to know if anybody could be hypnotised because he had seen a show once where some people had been hypnotised. Before I

Belinda pointed out to him that this would be different to a hypnosis show. She now told us that she had decided she would like to participate in my study but Stan said he still wanted to think about it. I suggested that they speak to their obstetrician in the mean time. Stan then asked if the hypnosis was about switching off the pain but Belinda said she felt it was more about controlling it. I said that we would have to first discuss all of their ideas and only then could we decide how to use them. I then ended the discussion and asked them to let me know what they decided to do.

Belinda had phoned me to say that they had decided to participate in the study so I began this session by asking them why they had decided to participate. Stan explained that he thought it could help with stress. Belinda said she was usually open-minded about natural interventions, such as homeopathy and alternative medical practices and although she would know the epidural was there if she needed it, it would also help to have control over the situation. She thought it may prove useful for Stan's headaches and also, that it would be nice to be able to do this together for the birth. Stan said that he had never been hypnotised before so he would like to watch Belinda first. She had been hypnotised before at the plastic surgeon so it would not be new for her. Also while at university Belinda had used meditation which she described as "a type of not hypnosis but relaxation." Stan then said that he had also been involved in alternative healing and had tried alpha waves, white noise and subliminal suggestions on de-stressing tapes but he was nervous of hypnosis because it meant giving up control. I pointed out to Stan that it seemed as if we had a problem and I wondered how he would bridge the gap between wanting to be hypnotised but being too nervous to try the first time. He said that it helped that he was in his own home and that he trusted me. I then asked Belinda how meditation was different to

being in a normal state of alertness. She explained that it was a different level of consciousness in which one became very aware of sounds and flashes of light, even though one's eyes were closed and one could almost see inside oneself and in this way, one experienced a different aspect of oneself. I said that I saw hypnosis as being a similar way of getting in touch with oneself and in this case, finding out what one's pain coping mechanisms were. Belinda said that meditation was a very relaxing, dream state while being awake. She thought that hypnosis could be similar - being relaxed while being very aware of what was going on. Stan, however, said that although one knew what was going on, one was not in control. I wondered whether knowing what was going on could rather lead to increased control and asked Stan if he would feel safe up to a certain level of hypnosis. I made reference to him having used tapes to stop smoking, saying that it probably would not have worked had he not wanted it to. In the same way, a person would still feel pain under hypnosis unless they did not want to. Hypnosis could thus be the tool to help accomplish what one already wanted. Belinda said that she felt hypnosis would take the edge off the pain and help her to focus on something other than the pain. I said that her desire not to feel pain was the motivation which hypnosis could then help to accomplish. Stan pointed out that hypnosis could make smoke taste bad, so it had a physical effect and I said it seemed as if what he was saying was that hypnosis could actually change a physical reality, including pain. I wondered if they could now tell me what hypnosis actually was. Stan said that it was a type of control - self-control - over the mind and body. He said that he was including the body because of what we had just discussed - he said that he felt there was a link between the mind and body. Belinda agreed. So, I wondered how they thought hypnosis worked. Belinda said that she thought it

worked because the mind thought there was no pain and the body believed this. I then asked her how she would know that she was hypnotised, because she was unsure whether she had actually been hypnotised at the plastic surgeon. She said that she was not sure but that she had certainly felt relaxed afterwards. She remembered feeling distant and that although she could hear noises, she could not repeat exactly what had been said at the time. I asked her if that meant that she knew she had been hypnotised by the way she had felt afterwards, namely, detached and if she could thus become detached from pain. I then asked Stan how he would know if Belinda was hypnotised. He jokingly said she would stop talking and then more seriously said he didn't know. Eventually, he said that because they had known each other for a long time, he would know if something was different but he was slightly confused about what he was trying to say and he did not really know. He thought that perhaps he would also only know afterwards if he had been hypnotised. I then pointed out that I had noticed that Belinda and Stan did not interrupt each other when the other was speaking. It seemed to me that they gave each other space and supported the other's needs for space in this regard. Belinda then mentioned that she had not spoken to her obstetrician yet but she felt it was not really necessary because he would only be there at the end. I then asked what their exact plans were for the labour period. Stan reacted by saying that he did not want to talk about it as it made him nervous. He said that the ideal scenario would be for the baby to just arrive without having to go through the whole labour process. He was anxious and worried about the labour and when pushed to explain this, he said that apart from the idea of it, he experienced his worry as an uncomfortable feeling in his body, specifically his chest, neck and shoulders. So, the emotions of anxiety and worry were experienced as a mind and body experience. However, he wanted to make

it as quick and easy for Belinda as possible. He was not worried that they would not cope although he wished she did not have to go through it. Belinda, however, said she was worried about the pain and did not know if Stan would really be able to help. She was worried that he would do what he thought would help but because they had not really discussed it, it might not help. I then said that it seemed to me that they did agree that hypnosis could be a tool that could help. I suggested that it could possibly be a way of helping them communicate their needs during the labour process. I pointed out that we had already seen that hypnosis could be a way of helping them get in touch with themselves and their needs and that this would also help them communicate their needs to each other. As Stan had initially seemed concerned about the amount of time he would have to give up, I ended the session without giving them any specific homework except to see if our discussion made any difference to them in the next few days.

I initiated the next session by saying that I wanted to try something quite special. Since Stan wanted to experience hypnosis, but wanted Belinda to go first, I thought we should try to get Belinda to somehow hypnotise him from within her experience of hypnosis. I said that I imagined it would be almost like a flow of energy or electricity between them. I suggested that once this was achieved, this process could be reversed while Belinda was in labour and that some of the energy of her pain would be able to flow out through Stan, via the link they had established. I asked them to sit close to each other, but so that they could still see each other and I sat opposite them. I asked them to make sure they were comfortable and to ensure that one part of their body was touching. They chose to touch their feet. I then asked Stan to watch Belinda as I hypnotised her and to look for a sign from her which I probably would not be able to

notice, at which stage he would also start to go into a trance. I said that he would probably go into the trance in the same way she did, only much quicker. I told him that after the experience he would remember what the sign was although he probably would be unable to explain it. The purpose of the sign was that it would induce a trance in Stan. Once he received the sign, I explained that it would be like flicking on a switch and he would feel as if the channels between them had opened and the energy or hypnotic current would flow into him. I stressed that there would probably be less resistance in Stan because the channels would be opened. I then turned to Belinda and asked her to focus on me. I asked her to become aware of her body and to notice how her eyes were blinking rapidly. While we waited to see what happened, I asked her to notice how her body felt different, to concentrate on her breathing and to allow her eyes to close when they wanted to. I stressed that she should focus on how this felt and on the energy that was allowing this to happen and on how it would transfer, when it was ready, to Stan. I noticed that she seemed to be relaxed and heavy. Her head began to drop and I spoke to her about how heavy it was feeling as it moved slowly downwards. As her head continued to move downwards, I asked her to focus her attention on the points of connection between parts of her body and between her foot against Stan's foot. I glanced over to Stan and noticed that his eyes had closed and that his head was also moving downwards. I began to speak to him, asking him to also notice the connection between the two feet. I allowed them to remain in this state for a while and then asked them to feel how the connection between them allowed them to come out of the trance together. Immediately on opening her eyes, Belinda said that she could still feel the connection quite strongly. She then admitted that she had kept doubting herself and that she had only started to feel different once she knew

she was going under. She said that although she could not see Stan she had known he was there. Stan, however, said he was skeptical. He had known what was going on and had been wondering if it was actually hypnosis. He had been waiting for some kind of electron exchange but it had not happened. I asked him what, then, had made his eyes close. He said that they had just become heavy. Belinda then said that she had thought she would be able to open her eyes but when she had tried, she had found that she actually could not. At first, she said, her head had not been heavy but then it had become heavy. I said that although they did not consciously know what the sign was, they did not need to think about it because Stan had spontaneously closed his eyes and somehow known that he had received the sign, although he could not identify it now. Belinda then said that she thought Stan intellectualised too much. He interrupted, saying that he thought he could do this kind of thing himself much more easily when he was relaxing in bed. I pointed out, however, that it seemed as if it was very easy for him just to have allowed his eyes to close without knowing why. He wanted to know how they could actually use this experience to cope with pain. I asked him what he thought and he said he thought it would work by helping them not to focus. I said that I thought perhaps Belinda would be able to transfer the pain away from herself to Stan, in the same way as the hypnosis had been transferred from her to him and then Stan would be able to do something different with the pain because, after all, he had had a different experience to Belinda when he was in the trance - for one thing, his head had not been as heavy as hers. Stan said that in fact, his arms had been heavy while Belinda said that hers had felt very light, even though she wasn't able to move them when she had tried. She said she had felt very floaty except for those parts of her that I had said were heavy. Again, I pointed out that they seemed to

have a connection through the trance but that they did different things in the trance. This was why they would be able to do different things with the pain. Stan wanted to know how to get to this point. I explained that through practicing, they would be able to discover different points of connection between them and it was up to them to find the most effective connection. Stan thought it could be a mental connection. I said that because of the type of relationship they had, it seemed that they gave each other space but they were also able to sense each others needs on an unconscious level and that this type of connection could be strengthened. I referred back to the time when Stan had said he would just know when Belinda was in a trance because that connection was there. Stan then said that he felt he could go into a deeper trance on his own by breathing deeply. He had never realised before that this was hypnosis. I said that he should practice different ways of going into a trance as well as the different kinds of connections with Belinda. Belinda was still concerned about how to communicate her needs to Stan during labour. I said that I was sure she would find more of a flow between them every day and that she should notice how, as they practised more, the connection strengthened even when they were not hypnotised. I said that it would probably be difficult to verbalise this difference, but that she should just notice it. Belinda mentioned that after the last session, she had felt a different type of connection which she couldn't explain and we all agreed that this connection seemed to be occurring on a non-verbal level so it was probably not necessary to try to find words for it. Before ending the session, I repeated that it was important for them to experiment with how they felt under hypnosis and I reminded them to notice how their connection had an effect on their relationship with each other outside of the trance.

Belinda and Stan had spent time since the third session experimenting with different trance experiences. Stan said that he had been able to become hypnotised by using breathing and deep relaxation. However, he said that he felt very isolated in the trance and tended to forget that Belinda was there. Belinda said that she found staring at something put her into a trance but it did not feel any different to meditation - calm and relaxing and floaty - and perhaps hypnosis and meditation were the same thing. She said that it was better for her if Stan became hypnotised after her. The best connection had been established through their hands, if they linked fingers. Both of them had felt floaty and we spent a few moments exploring what this felt like for each of them. Stan said that he had been doing this kind of thing for a long time but did not know it was actually hypnosis. Belinda said that it felt more like day-dreaming. After hearing about their experiences, I suggested they show me what they had been doing. They both sat on the couch and I suggested that Belinda start by staring into the middle of the plant that was on the coffee table. I asked Stan to go slowly so that Belinda could go into the trance first. Belinda said that the plant was making her eyes tired and she could not focus. I asked her to carry on until the plant made her close her eyes. At the same time, I pointed out to them that through their connection, their breathing was in time with each other. I continued to emphasise this connection throughout. I then pointed out to Belinda that her body seemed to be getting lighter with each breath and that her head was becoming loose and floaty. I asked her to notice how this floaty feeling moved around her body to her hand, legs and head. I told her that it felt as if she were in a bubble of air and to concentrate on how her body felt in this. As she continued to float, I told her to concentrate on the space between her hand and the chair and to notice how the space became bigger and how the air

pushed her hand gently upwards until it floated. I asked her not to concentrate too hard on this but just to allow the air to push her hand up and instead, to concentrate on the connection between herself and Stan so she would know when she was ready to pass a signal on to him. At the same time, I asked Stan to concentrate on how the floaty feeling was being transferred to him, especially to his thumb which seemed to be moving. I pointed out how both of them seemed to be floating and how the connection between them seemed to be very strong, although they both also remained in their own space. I then spoke to them about the way this connection made it easier for them to understand each other and to know what the other was thinking and also how it would enable Stan to take away some of Belinda's pain. I then asked Stan to consciously begin to lower his hand and I asked Belinda to focus on this as it would bring her out of her trance. I asked them both to become more aware of their bodies and to regain control of them and finally, for them both to touch the couch with their hands that had been lifted. I then asked them to open their eyes, stressing that the connection that had been established would not be lost. Belinda began to speak first, saying that it had been a strange feeling when her hand had started to lift. She said that it had actually felt as if her whole arm were lifting and although it began to get tired, she had to keep it there. Both she and Stan said that they had wanted to laugh but did not and had found that they could control this urge. However, she said that she was still concerned about how to use the hypnosis in labour. Stan said that she should use it in order to relax and thought it would be better if Belinda didn't hypnotise herself but that he would talk her through it. I pointed out that in this way, they could use their strong connection even if Stan wasn't actually hypnotised. Stan wanted to tell us about his experience. He said that at first he had listened to me

talking but then blocked me out. However, when I mentioned his name, he found himself having to do what I said. I said that it seemed as if their names were very powerful in controlling their trances. Stan wanted to know if it was the same for Belinda and she said it was. It seemed to us all as if the physical connection they had used worked better than before. For homework, I asked them to practise every day but to alternate going into a trance together and Stan hypnotising Belinda without him going into a trance. I asked them to continue to focus on how the connection between them strengthened and existed outside of the trance but to just allow this to happen without actively creating it.

We held our feedback session about two weeks after the baby was born. Belinda had been overdue and so her doctor had decided to induced her. After being induced, they had decided to go home and wait there. She said that she was not feeling proper labour pains but was experiencing burning sensations which came about 1 minute apart. Eventually, the midwife had come and confirmed that she was definitely in labour as they could see her stomach contracting. However, she still was not feeling the pain where she was supposed to be feeling it. Belinda explained that at this point, there were too many people around to do the hypnosis but the midwife calmed her down by talking to her. Belinda felt that the hypnosis probably helped her at this stage because as each contraction came, the midwife talked her through it which was similar to the way I had spoken during the hypnosis. Belinda finally went into the nursing home and initially refused an epidural because at that stage she felt she was coping. However, the next time she was asked, she decided to have the epidural. She explained that at this stage, the pain was coming at such short intervals that they could not use the hypnosis. Stan reminded her that they had tried a few times and she

agreed. I asked them what they had done. Stan said that he had told her to focus on the wall, but the next contraction kept coming and interrupting them. Belinda said that she had been disappointed because she had been looking forward to using the hypnosis. It took about an hour for the anaesthetist to arrive, by which stage, Belinda was in terrible pain. When she finally did have the epidural, Stan did not come with her and she felt that the hypnosis helped her at this point. She explained that she did not go into a proper trance but she was able to relax, close her eyes and focus on something else. She needed to be able to do this because every time they were about to give her the epidural, she would tense up from a contraction. When she focused, she could relax her body so they could give her the epidural. She explained the focus as a "shifting away from the pain". Belinda explained that the hypnosis had actually been most useful over the next few days, after the baby was born. She was in quite a lot of pain and the hypnosis had helped as a focus away from the pain, although she admitted to not having the patience to go into a proper trance. Laughing, Belinda said that the one time it really helped was the first time she went to the toilet. She had torn really badly and was able to refocus herself by doing exactly what we had done in practice sessions. She explained that she had heard my voice talking her through it until she had gone into a trance. Stan felt that Belinda did not have to even use the focusing technique, it was just the breathing that "kicked it in" - as it did for him. Belinda carried on her explanation, saying that in practicing, she had been able to put herself on a beach or somewhere peaceful and she had done so at this stage too. Stan then interjected, saying that he had been using the hypnosis when holding the baby. "I tend to try and feel her and just bring a calmness over me which I feel is passing on to her." Stan was convinced that it made a difference, saying, " I can sit with her for

two minutes and I concentrate and I just calm my whole body down. In two minutes she'll close her eyes." Belinda agreed that there was a big difference when Stan did this and a difference to the way the baby responded to him. Stan said that he did it all the time and it definitely worked because the calmness in him was transferred to her. Belinda then remembered that she had also used hypnosis the night before she had left the nursing home. The nurse had not been very helpful and Belinda had been quite upset. At this point, she used the hypnosis to relax and calm down emotionally. I then reminded them that Belinda had been worried that she might not be able to communicate her needs to Stan. In reply, she said Stan had been wonderful, helping her to breath and the connection was there. I asked Stan how he had known what to do. He said he had not used hypnosis but that he'd known that the contractions would only last for a few seconds and that he could talk to Belinda for that time. He then thought that maybe through the practicing and the breathing during our sessions, everything had come together. Belinda thought that this was definitely the case. Stan said that what he did know was that the whole time he was speaking Belinda through the contractions, he had the "hypnosis in the background" and when he had helped Belinda with her breathing, he had not been thinking of the breathing from the ante-natal classes, but of the hypnosis breathing. He reiterated that the thought of breathing for him had been related to the hypnosis sessions and then said "maybe it came through me". I reminded them that we had specifically worked at facilitating a connection between them so that if Belinda's coping skills failed then Stan would be able to take over. They agreed and Belinda began to speak about how the hypnotic relaxation had actually minimised the pain while they had been waiting for the epidural. Stan then pointed out that the hypnosis had been a vehicle for refocusing

attention away from the pain. He said that it had given them a lot of inner strength and "confidence that we knew that we had something." We began to wonder how the hypnosis had actually worked and thought that it may have been the experience of spending the time together and establishing a connection that helped. Belinda admitted that she had "felt a bit nervous about how Stan would be, but I think we worked through it together by doing the hypnosis beforehand which tuned him into me." Stan said that even now he felt they were more in tune with each other than in the past. Belinda said that the connection now was more special and that "it was something that just helped us bond a little bit more that helped the whole experience. The process was helpful, the practising and the talking about it ... and I think that was helpful in our relationship" during a very tense time.

Metaperspective

At first glance, this case seems to contain similar processes to both Kate and Graeme's case and to Amanda and Doug's case. In the first instance, there seemed to be a similar desire with both Graeme and Stan to provide support for their wives, while at the same time, feeling some inadequacy in the face of this expectation. For both men, the hypnosis sessions provided a solution to this problem by giving them a tool that was defined by all involved as useful. In the latter case, the similarity was that the supporting relationship was enhanced by the use of hypnosis. However, this case is unique in that it combined both processes in terms of an individualised content that could, by its very nature, only be useful for the specific people involved. Perhaps what is most important about this case is the manner in which it illustrates Fourie and

Lifschitz's (1988) concept of "fit" or "hypnotic responsiveness". They explain that the concept of hypnotic susceptibility is problematic because although it initially attempted to describe the individual differences in responsiveness to suggestion, it has become a causal explanation and as such, a reified concept with the implication that 'susceptibility' actually exists. As a result of the unfortunate evolution of this concept, it can no longer be used as a descriptive term and Fourie and Lifschitz suggest the term "hypnotic responsiveness" as a more useful replacement. They are careful to point out that the term "does not refer to the subject only... (but rather to) ... a consensus or fit of ideas to describe all the participants in the context" (Fourie & Lifschitz, 1988, p. 174). Thus, if one is to achieve maximum effect, it is no longer useful to adopt a 'cook-book' approach to hypnosis. Rather, one needs to use an approach that fits best with all involved. This is true both of the manner in which hypnosis is induced and the manner in which it is used as a hypnotherapeutic tool. The importance of fit in the hypnotic induction has been described above and will not be repeated here. What is clear from this case, however, is that the way in which the hypnosis was used therapeutically could only have fitted with this particular couple. Although the creation of a sense of support through togetherness featured strongly in other cases mentioned above, the manner in which the connection was established through the use of hypnosis in this case, was particular to it, namely, the use of the electrical metaphor which was pertinent to who Stan was. The feedback session brought out the relevance of this metaphor most clearly, especially Stan's conviction in his admission that he was using the technique on his baby daughter. Perhaps less clear, but equally important, was Belinda's statement that the hypnosis sessions had been useful in that they had "tuned (Stan) into me".

Conclusion

The above five cases represent a sample of what is possible in ecosystemic hypnosis. By this stage, it should be clear that almost anything is possible when working in this way and that what is important is that all participants are able to form a consensual domain in which the events are construed as hypnotic. What should also be clear is that what qualifies hypnosis as ecosystemic is not so much what is done, but the manner in which the doing is conceptualised as well as the manner in which the conceptualisation perturbs the problem for the significant system.

In the final chapter, some of these ideas will be elaborated and in line with new paradigm thinking, the value of the study, rather than its quantitative limitations, will be discussed.

CHAPTER 5

CONCLUSION

This study began by stating that a good deal of research into hypnosis is concerned with a search for the mechanisms responsible for hypnotic effects. In this specific study, the effect in question was analgesia. However, most research has approached this question from the old paradigm perspective, fraught with problems of reification. Studies from within this paradigm have tended to produce results which are unable to bridge the conflicting opinions of different theorists. Instead, the developmental process of this particular field has been one of escalating polemics and self-proving experiments and one begins to question how useful and relevant this process is.

At the outset, it was suggested that a more useful exercise might be to unravel an explanation of hypnosis in terms of the process involved, the thinking behind it and the epistemological guiding principles rather than by searching for an objective mechanism. This approach was justified in terms of new paradigm research principles. It was felt that such an understanding would allow for an escape from the escalating old paradigm process described above and open up alternatives both in terms of the practice of hypnotic analgesia and in terms of understanding.

The above intentions were actualised in the presentation of the five case studies. By giving detailed narratives, a grounded understanding, based on contact with the different experiences in each case, could be achieved by the reader and a general practical process could be deduced. In each case, the researcher spent some time

trying to understand the conceptualisations of hypnosis held by the participants. In this way, a consensual domain was formed in which actions could be qualified as hypnotic in the context of the stated understandings. Thus, in the case of Amanda and Doug, it was possible to qualify Doug's experience of being almost asleep as hypnotic, in terms of his expectations that hypnosis was similar to sleep but not quite the same thing. Once hypnosis had been experienced, the power that each system attributed to this experience was utilised so as to perturb their consensual domain around labour pain. In more than one case, this involved establishing a special connection between the husband and wife so as to increase the experience of support. The hypnosis was also often used as something tangible that the husband could do in order not to feel helpless. During the entire process, the individual experiences were incorporated into the therapeutic conceptualisation which allowed for modification of the therapeutic rationale through the use of feedback. Most importantly, the feedback sessions played a vital role in attributing analgesia to the use of hypnosis.

The feedback sessions were also important from the point of view of the principles of new paradigm research. According to this perspective, the value of research lies in the individual attributions made by each person who comes into contact with the research. Thus, the dialogues around trying to understand the processes involved in each case can be seen as an integral part of the research process, not in terms of the gathering of data, but in terms of creating space for meaning-making, which is continued by each person who comes into contact with this research. In this way, each individual determines the relevance of the experience (whether as participant or as reader) for him- or herself, rather than the relevance being predetermined by a set

of rigid research principles such as sample methods, controls, data collection methods variable manipulation, etcetera.

As explained above, according to new paradigm research principles, one useful way to judge the usefulness of research is to look at the extent to which the researcher has 're-searched' or been able to retrace the distinctions drawn during the process of discovery. In this study, an attempt was made to do this by explaining the therapeutic rationale in each case by way of a metaperspective as well as by clearly stating the epistemological premises upon which the research was carried out. However, it is once again up to the reader to determine whether or not this has been adequately achieved and to the extent that it was not achieved, this represents a shortcoming for that reader.

Finally, the choice to adhere to new paradigm thinking does not eliminate old paradigm research but rather adds a different perspective to the topic under investigation. It will be noted that many of the techniques used in traditional hypnosis were employed in the case studies, such as hand levitation, eye closure, and imagery. However, the thinking behind the use of these techniques represents the point of departure from traditional hypnosis. It is the examination of assumptions and the way one thinks about hypnosis that illustrates the difference between traditional hypnosis and ecosystemic hypnosis. Hopefully, this explanation opens up a way of languaging about hypnotic analgesia that can facilitate a useful journey into the unsaid in this field.

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