HYPNOSIS IN ANESTHESIOLOGY

AN INTERNATIONAL SYMPOSIUM

HELD AT THE FIRST EUROPEAN CONGRESS OF ANESTHESIOLOGY
OF THE
WORLD FEDERATION OF SOCIETIES OF ANESTHESIOLOGISTS

VIENNA / AUSTRIA, SEPTEMBER 5, 1962

CHAIRMAN AND EDITOR

JEAN LASSNER, M. D.
PARIS, FRANCE

SPRINGER-VERLAG
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Preface

During the First European Congress of Anesthesiology, held in Vienna, Austria, in September, 1962, panel discussions on nineteen different subjects were held, each lasting approximately three hours. One, concerning Controversial Aspects of Resuscitation, was later edited by its chairman, PETER SAFAR, and published in 1963. At the request of the publisher, the discussion on hypnosis has been edited in a similar manner.

The participants in the discussion on Hypnosis in Anesthesiology had agreed, prior to the meeting, on a list of questions to be debated, and Dr. STOKVIS' introductory statement on the nature of hypnosis was circulated among them in appropriate translations in order to give the debate a starting point.

It had also been agreed that no formal papers should be read after this introduction, and that the participants should use at will the German, English or French language. Following each contribution it was the chairman's task to give a brief summary in the two other languages. Discussion was therefore somewhat slowed down and occasionally rendered difficult by misunderstandings or the omission of details.

Drs. GUÉGUEN, MOSCONI, and VÖLGYESI, who were not able to attend, had sent written contributions which the chairman presented briefly during the discussion.

The present text has been worked out of the tape recording of the discussion and the chairman's correspondence with the panelists some time after the meeting. Whenever the original contributions were in French or German, the English translation has been the chairman's.

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JEAN LASSNER

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	Language used
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* Dr. Stokvis died suddenly on September 8th, 1963.

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Introduction

Chairman: When the executive committee of this First European Congress of Anesthesiology decided to schedule a panel discussion on hypnosis it must have been under the influence of forces operative nowhere else but in this city of Vienna. As far as I am aware, this topic has never before been on the agenda of a meeting of anesthetists. At the request of the executive committee, it became my task to invite participants and structure the debate of this panel. Under these circumstances, it seems appropriate that I should make an initial statement of intent.

Hypnosis has been a highly controversial subject ever since it made its entrance into modern medicine at the end of the 18th century in this city. The esteem in which it was held as a therapeutic tool and the prevailing opinion concerning its practice have known successively great peaks and depressions. There has been a renewed interest in hypnosis in the English-speaking countries during the last few years. At the same time, a psychological method for pain relief during childbirth, developed in Russia as an offspring of hypnotic analgesia, has been widely acclaimed in France and Italy. Here and there, anesthetists have become interested in this matter, but their experiences are few and isolated. Obviously, there is a tremendous gap between the usual field of activity anesthetists are accustomed to the world over and hypnosis.

Our first aim has therefore been to assume an approach to the subject under discussion. At the same time, a common basis was to be found for our debate. Since there are various and opposing views on hypnosis, this latter endeavour seemed to be of prime importance in order to avoid spurious arguments. It is our privilege to have among the members of this panel Dr. B. Stokvis, whose wide knowledge in this field is universally esteemed. He has been good enough to prepare a statement on

the nature of hypnosis on which we have agreed to base our discussion.

The first topic to be debated will then be the question of how the use of hypnosis by an anesthetist will influence his way of practising our speciality and, more specifically, how this will modify the patient-doctor relationship in this field.

Nobody would use any particular form of therapy in every case. So this brings up the question of when to use hypnosis. Once agreed on how to determine when hypnosis would be indicated, another problem arises. It is well known that one cannot induce hypnosis in everyone. To choose appropriate cases comes therefore to mean also such cases where hypnosis may succeed. Eventually this will lead to the question of how to ensure success in a given case. This will bring up the matter of induction methods and the ability of the anesthetist to practise hypnosis.

Here I would like to add a word to prevent erroneous expectations. It is not our purpose to teach such methods here.

We will then come to speak of hypnosis in its application to the various fields of surgery, obstetrics and dentistry. Several motion pictures will be shown illustrating these possibilities.

Afterwards we will discuss the difficulties and resistances encountered when using hypnosis, and finally the dangers and complications possibly resulting from its use.

I am quite aware that this is a very ambitious programme for a rather short meeting. Many questions will have to be summarily treated for reasons of time. So let us begin by asking Dr. Stokvis for his conception of the nature of hypnosis.

The nature of hypnosis

Stokvis: Hypnosis can be understood only from a psychosomatic point of view. It encompasses all the manifestations of the human being and is induced through affective influences which appear in the individual's experience and in his body. It is therefore part of the emotional life.

Neither the psychological nor the physiological theories of hypnosis are appropriate. Hypnosis is an alteration of the

psychosomatic unity produced by affective resonance. It entails a modification of consciousness, frequently giving the hypnotized person the appearance of being asleep. How consciousness is modified depends mainly on autosuggestive influences. Each person produces his own type of hypnosis. There is no one sign constantly present in hypnotized people. That is probably why BABINSKY considered hypnosis a fraud. Studies on how hypnosis is experienced have shown that it entails a certain regression in personality structure as well as in bodily functions. This regression may reactivate emotional reactions of the Oedipus situation. Hypnosis is an archaic state which can be accompanied by modifications in the autonomic and endocrine functions, probably induced by the hypothalamus.

Scientific approach can be made to hypnosis through: 1) experimental medico-psychological study; 2) psychodiagnostic methods; 3) studies in clinical psychology; 4) studies in physiopsychology.

Our medico-psychological studies have been conducted along phenomenological and psychoanalytic lines. The world of the hypnotized seems to be like the world of a child whom an adult has taken by the hand. Occasionally the world of the hypnotized seems to be quite similar to the one experienced by a hysteric. Our psychoanalytical studies have demonstrated that the behaviour of the hypnotized depends not only on his constitution and autosuggestive imagination but is determined also by the doctor-patient relationship. The latter constitutes a transference relationship. Both positive and negative effects can be demonstrated. The form and the effects taken by hypnosis are therefore determined to a great extent by the patient's infantile conditionment. The operator can constitute for the patient a father as well as a mother image, for in deep hypnosis the Oedipus situation, or even a fear of castration, can be reactivated. The patient's behaviour is also determined by the urge to pleasurable self-abandonment. These hetero- or homo-erotic feelings help the hypnotized to identify himself with the operator and to introject the latter's orders. Each patient attributes some magic capacities to the physician, and through identification he takes part in the magic power. That is how the regression into the magic world is achieved, and that is why

such extensive effects can be obtained through suggestion in hypnosis. In psychoanalytical terminology, it is through the hypnotizer's penis that the hypnotized achieves great power.

A word about our psychodiagnostic studies. A battery of tests systematically performed have shown regressive phenomena affecting, in hypnosis, the whole personality: modifications have been shown to affect the intelligence, motor expression, affectivity, character and temperament. Our graphological studies have shown that reality testing is lost very rarely; it is an essential feature of hypnosis that the suggested situation is actively experienced while a more or less clear notion of reality is maintained. This means that the hypnotized is frequently aware that he is playing a role. This induces disagreeable feelings in the observer.

As reported in our clinical-psychological studies, there is no specific sign of hypnosis to be observed in the hypnotized. This holds true also for catalepsy, which can be missing even in deep hypnosis. Theoretically, every modification induced by emotions could be produced through hypnosis. In fact, resistances frequently come into play.

We have been able to complete our physio-psychological studies these last years with the use of an electronic polygraph. We have been able to show that through hypnotic suggestion every physiological function can be modified. Obviously suggestibility is increased in hypnosis. This does not mean that hypnosis can be induced only in suggestible persons.

Chairman: Dr. STOKVIS' introduction was circulated among the members of this panel prior to the present meeting. Several dissenting opinions have been voiced, as was to be expected. Supporters of one or the other of the theories of hypnosis, be it the naturalistic approach with its two main variants, the Pavlovian and the behaviouristic, or the anthropological approach, have contested some of the statements just made. The psychoanalytical interpretations derived from FERENCZI's work have been strongly criticized. But in order to reach the real subject matter of today's meeting, we have agreed nevertheless not to open a discussion on theory.

To modify emotions and physiological function, or to prevent the latter's deterioration, is a matter of great interest to

anesthetists. Let us take this as a starting point for a discussion of the first question which comes up: what could the role of hypnosis be in anesthesia, and how does its practice affect the relationship between the anesthetist and his patient? May I ask Dr. STOKVIS to continue.

Hypnosis and the doctor-patient relationship in anesthesiology

Stokvis: Hypnosis has been used in anesthesiology to achieve pre-operative sedation. It has occasionally been used as the sole means of achieving anesthesia, or it has been combined with chemical anesthesia. It has been shown to facilitate post-operative recovery. Hypnosis can abolish sensitivity and reduce or eliminate the anxiety frequently linked to the experience of pain. This effect has been compared to the one obtained by prefrontal leucotomy. The dissociation of pain experience from suffering can also be of help in chronic pain conditions.

In anesthesiology hypnosis is therefore mainly useful to achieve psychosomatic changes.

Whether hypnosis should be used depends on the personality of the patient, the personality of the physician, the symptoms present, and on the social and economic set-up. The symptoms should not be considered alone. In hypnosis, as in other forms of psychotherapy, it is not so much the method of treatment as the doctor who helps the patient.

There are many cases in anesthesiology where hypnosis is unnecessary, and some where it should not be used. When the preliminary interview leads to suppose that hypnosis might produce unpleasant effects by way of autosuggestion, one should proceed with great caution. If the patient refuses hypnosis, one should certainly not use it. One should probably abstain also when the interview reveals a hysterical personality. In impending psychosis, hypnosis is to be avoided except in involutional depression.

Chairman: While for a long time interest among anesthetists has been focussed primarily on pharmacology and physiology,

there have been many contributions in recent years aiming at a better understanding of the patient's psychological situation. Still, there is a long way from the position of a critical observer to the assumption of an articulate psychotherapeutic management. The latter no doubt requires a major change in the actual practice, at least as far as the relationship between the anesthetist and his patient is concerned. I would like to ask Dr. RAGINSKY to give us his opinion in this matter.

Raginsky: Inter-personal relationships in hypnosis are much deeper and more meaningful than at non-hypnotic levels. In other words, any mishandling of the normal relationship with a patient is greatly magnified when it occurs in connection with a hypnotized patient. As compared to chemo-anesthesia, hypnosis, whether it be used to achieve a state of painlessness or any other hypnotic effect, implies a much greater involvement of both patient and doctor. It also usually requires more time from the latter. Aside from technical skill in the use of hypnosis, he must also have a keen awareness of the patient's emotional needs. He must be able to recognize whether a particular patient should have a passive induction or an authoritarian one. Thus the physician must be flexible and resourceful in meeting the patient's requirements if the subsequent patient-physician relationship is to remain constructive.

Nothing should be told the patient in the hypnotic state that the doctor would not tell him in the waking state. If sufficient care is taken in the course of induction to obtain the patient's cooperation, he will come out of the experience with a somewhat stronger ego than before. Alternatively, if the patient has been bullied into submission, there may be posthypnotic hostility. To maintain a good patient-physician relationship, it is essential not to disturb a patient's image of himself.

The patient-physician relationship following hypnoanesthesia is usually better than in most other hypnotic situations. This is so because the objectives are simple and direct, and do not usually interfere with the patient's emotional equilibrium.

Chairman: It will be of interest to hear how the use of hypnosis has affected the anesthetist's daily routine.

Semelka: At least in North America, the relationship between the anesthetist and the patient is often superficial. The

anesthetist is considered as a rather impersonal agent, an efficient technician, not a person.

By the act of inducing hypnosis, the anesthetist demonstrates his special interest in the patient, who in turn shows that he accepts him by going into hypnosis. Therefore hypnosis adds a new dimension to the patient-anesthetist relationship, deepening their mutual appreciation. To what degree depends on the purpose of the hypnosis and the circumstances under which it is administered. Hypnoid suggestions often go unnoticed when used to make the induction of anesthesia by injection or inhalation more acceptable. Group hypnosis, as in maternity classes, makes a fairly deep impression on the patients. Hypnosis used in the treatment of pain unrelieved by other means or in terminal disease states knits a close tie between the anesthetist and his patient.

Völgyesi: Since I started my private hypnotherapeutic practice in 1918, I have been called upon a great number of times by colleagues in the surgical field for various reasons. Certain patients show extreme anxiety, and in this case many surgeons feel that the operation is fraught with danger. In this circumstance, as well as with highly neurotic patients who cope badly with the stress of hospitalization and the sickness itself, hypnosis offers a tremendous help. On the other hand, there are a good number of patients with severe heart disease or other conditions that make general anesthesia difficult or dangerous, some also have allergies or sensitivities to various drugs. Hypnoanesthesia is then the method of choice. I have been able to demonstrate this very vividly at a meeting, held in Budapest on July 1, 1922, of the Hungarian society of dentists. The patient, a dentist himself, had phobic fear of dental care, he was suffering from advanced rheumatic heart disease, and was allergic to novocaine. As a result, his denture had been severely neglected. Under hypnosis, three teeth were extracted at the meeting without any reaction on the part of the patient.

Chairman: Hypnosis certainly increases the therapeutic possibilities of the anesthetist. It therefore heightens, so to speak, his professional status, and modifies his relations with both patients and other doctors. It is our privilege to have among us a surgeon who has also been practising anesthesia and hypnosis.

To terminate our discussion of this point I would like to ask Professor ZWICKER to give us his opinion on the relationship between anesthetist and patient when hypnosis is used.

Zwicker: The development of highly technical means of investigation and of operative techniques of increasing complexity have led to a practice of surgery in which the personal contact between the patient and the surgeon has been very much reduced. The great work load in hospitals also explains why surgeons are chronically short of time. These changed conditions have not modified the patient's need for assistance in the stress-filled situation created by the impending operation. We can only to a certain extent replace confidence in the individual surgeon by belief in surgery anonymously practised. The present conditions in surgical hospitals therefore increase the need for psychotherapy. It does not matter whether this psychotherapy is given by the surgeon or the anesthetist, but the latter seems to be in a better position to accomplish it.

The central problem of this therapy should be, in my opinion, the pre-operative fear of the patient, which stems from uncertainty about the outcome of illness and operation, and from the feeling of being abandoned. The pre-operative visit of the anesthetist offers a possibility to help the patient by a detailed discussion of these matters. Should this be insufficient, suggestions in the waking state or hypnosis can be very useful psychotherapeutic tools. In this way, the first steps are taken to prepare the patient actively for the post-operative recovery. Thanks to hypnosis, this period can become much more pleasant, and many of its features positively influenced—postanesthetic vomiting, micturition, bowel movements and appetite and, last but not least, post-operative pain.

I have been able to perform a number of operations under hypnosis, or under hypnosis combined with local anesthesia. The main value of hypnotic analgesia is to demonstrate the effectiveness of hypnosis through the relief of pain. In the modern practice of anesthesia there will seldom if ever be a need of hypnosis to achieve anesthesia. No doubt the chemical methods are simpler and require much less time. But for the pre- and post-operative treatment, psychotherapeutic methods are undoubtedly superior to the chemical ones.

Chairman: It seems that we agree on the added possibilities given the anesthetist by including psychotherapy and hypnosis in his professional radius. Obviously this does not mean that every patient undergoing surgery or anesthesia needs psychotherapy or hypnosis. This brings up the question of when to use hypnosis.

The indications for hypnosis in anesthesiology

Marmer: The choice of a suitable case is patient-determined, as is everything else in hypnosis. In order to know when and when not to use hypnosis, the patient must be seen by the anesthesiologist pre-operatively. If the patient appears to be relaxed and easy-going, without façade, confident and emotionally stable, if the patient already has the proper "psychological set" for the anticipated surgery and anesthesia, and if the patient offers physiological evidence of the validity of this impression, such as a warm, dry skin, a normal, regular pulse rate, and a normal blood pressure, then this patient should be left alone with reference to hypnosis. The anesthesiologist should have a pleasant visit with such a patient and not upset him in any way.

On the other hand, if the patient appears to be apprehensive and agitated, and asks a thousand and one questions, relevant and irrelevant, he needs more attention. When the agitation is accompanied by a cold, clammy skin, tachycardia and elevated blood pressure, occasionally even hyperventilation, you have all the corroborative evidence of a nervous, fearful, tense patient. This patient needs hypnosis, especially if he tells you, "Doctor, I am afraid I am going to die." Do not ever shrug such a statement off. Do not ever take it as a joke. Such patients may die, and need all the emotional support you are capable of giving them.

When I first started experimenting with hypnosis, I used it in every case. I had not yet developed any criteria for its use. As I gained more experience, I developed not only personal confidence, but a sixth sense which enabled me to actually choose the right patients for the use of hypnosis. There are situations where the use of hypnosis becomes more mandatory, such as in

traumatic procedures where the patient has a full stomach and in very poor risk patients. Recently I was called upon to attempt hypnosis on a child who was burned very severely in an accident. The accident had taken place one month prior to my seeing the patient. I attempted hypnosis but it was of no avail. This was like closing the barn door after the horse had been stolen. In order to use hypnosis successfully in these cases, it must be used from the very beginning of therapy.

Chairman: As Dr. MARMER just pointed out, once hypnosis has been deemed indicated, attempts to achieve it can succeed or fail. In the case of the burned child, Dr. MARMER felt that the failure was due to the fact that the child had lost confidence in doctors. This shows that the patient's situation influences the outcome of the attempt, but could also be interpreted to mean that the method of induction was not appropriate for the given case. Instead of looking for subjects who are easily hypnotized, as is the case in experimental hypnosis, the object of medical hypnosis is to succeed in inducing it in a given patient. It seems therefore appropriate that we now discuss the methods of induction available to the anesthetist.

The induction of hypnosis

Stokvis: Whatever technique of induction is to be used, it has to be adapted to the individual patient. This means first of all that the patient must be prepared in a preliminary interview. At the same time the interview is needed to obtain information about the patient. The patient's cooperation must be ensured, whether we choose to inform him or not that hypnosis will be used.

As in other fields of medical practice, the physician may feel more at ease with certain techniques than with others. To adapt himself to the patient's needs he has to be proficient with several. Nevertheless, success is likely to be achieved most often with the doctor's preferred method. Our own preference consists in having the patient look fixedly at a card showing two contrasting colours. This method was first described by MAX LEVY-SUHL in 1908. While the patient looks at the grey interval between the two coloured strips, one yellow, the other blue, the