HYPNOTISM AND THE ANAESTHETIST

BY

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INTRODUCTION

Now that there is a renaissance of hypnotism in this brave new world of psychology it has become the habit to regard it as a weapon wielded solely by the psychologist. In its previous incarnation it was used mainly in the art of surgery, and as a means of avoiding the awful ordeal of pain attendant on the early surgical procedures. In other words it was the sole property of one who would now be called the anaesthetist, and since the main feature of hypnosis is “putting the patient to sleep” in order to avoid pain, who has a better claim to its use? Yet now, in modern times, it receives scant attention from the members of our faculty and, save in the matter of dental extractions, the subject is, in the main, ignored.

Hypnotism has always been regarded by the members of our profession generally as a somewhat exotic and slightly disreputable method of therapy, and those practising the art as mere “stunters”. The anaesthetists, in company with the rest, can console themselves somewhat for this lack of interest. Hypnotism in its induction and practice does indeed appear to be somewhat exotic, and the impression of those viewing the phenomena for the first time is that the whole thing is just a clever trick. For this very reason stage representations are still so popular.

Du Maurier served hypnotism ill when he suggested to the public, in the novel Trilby, the Svengali-Trilby set-up of the master-mind over the simple weak will. This entirely false aspect of hypnosis is still believed by the general public, and by many members of our profession.

Many justifiable objections can be taken by the anaesthetist in hospital practice to hypnotism, and the methods used for its induction. By ordinary methods, it takes anything from half to one hour to induce hypnosis in the average patient, especially surrounded as he is by the somewhat macabre and frightening bustle of the average hospital ward. Add to this the lack of co-operation, if not open hostility of the staff, and the use of hypnosis grows less and less attractive.

HYPNOSIS IN RELATION TO THE ANAESTHETIST

What use can the anaesthetist make of hypnosis? The rapid strides made in the past century in anaesthesia are well known; it was the discovery of ether and nitrous oxide that sounded the death knell of hypnosis. For this reason then, as now, it was considered that narcotics producing anaesthesia were much simpler to administer, easier to control, and more certain in their effects. The administration of the present-day anaesthetic is a simple, if not
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a delightful experience for the patient. It is not necessary to have him gazing at bright lights, or to monotonously stroke his forehead; just a slight prick of a needle and he awakes in bed with his operation over.

HYPNOSIS versus NARCOTICS

Though far inferior to anaesthesia in everyday use hypnosis can be used for general anaesthesia, for it can abolish the feeling of pain and relax the muscles. It does not prevent physical shock which is likely to appear as profound collapse after the patient has returned to his bed, when a timely injection of morphia may be required to ward off a disaster. So much then for the shortcomings of hypnosis: what of its virtues?

VIRTUES OF HYPNOSIS

Pain, its origin, varieties, intensities, and its thresholds, is ever in front of the anaesthetist, demanding his attention and study. We know that psychic tension plays a major role in the matter, lowering the threshold of pain appreciation. A comparatively minor toothache, unnoticed by the busy well-balanced man, can become a hell torture to the anxiety-ridden neurasthenic. Psychic tension is notoriously inconvenient to the anaesthetist, apart from the patient. A frightened, tensed, pre-operative patient needs more premedication, more anaesthetic narcotic, and is therefore a more restless postoperative case, necessitating increased postoperative sedation. It is true that pre-operative medication, and the use of thiopentone intravenously, does much to surmount these difficulties, but not altogether, for the more the psychic tension, the higher the metabolic rate and the operative risk.

RELIEF OF PRE- AND POSTOPERATIVE TENSION

We, intimately living, as we do, in a world of surgery, are prone to forget that we are seeing the prospective operation patient, only a day or two before the event, which, to him, is a dread psychological experience. Except in the mentally well-equipped, the event has been turned around and about in his subconscious mind probably for weeks. It has been considered and rationalized as to its inevitableness, until there is a large measure of resignation produced; but still, in the background, there will lurk the fear of death. Children, fortunately, are immune from this type of thinking, but nevertheless they do talk amongst themselves, and often are the horrific details of “what they do to you” in hospital told and retold by his siblings or school friends, who have themselves been in hospital; add to this the separation from the mother, the strange surroundings and faces, and you have an average pre-operative child. Using hypnosis as long as possible before the expected operation does a lot to dissipate these fears, and lower the psychic tension.

HYPNOSIS IN CHILDBIRTH

Nowhere is hypnosis seen to better advantage than in childbirth. Here, pain is greatly influenced by the heightened emotions. It has been well established that unstriped and, to a lesser degree, striped muscle is also influenced by this factor. The uterus in particular shares this with the rest of the body musculature.
So too does the levator ani. Anything causing disfunction of these important muscles of parturition, any factor altering the rhythm or causing spasm when they should be relaxing, will produce pain and eventually delay the course of the labour. The training of relaxation, given by competent teachers to the expectant mother, has proved very well worth while.

Similar instructions under hypnosis, and control under that influence at the actual time of labour, carries this method of muscle and psychic relaxation a step further, and allows the hypnotist to regulate the actions, at least of the levator ani and abdominals. In this way a perfectly painless labour is possible, the perineum is safeguarded and seldom is there delay in that most dangerous phase, the second stage. The above relates to normal cases, with no anatomical obstruction. Even in these, where there is mild disproportion of the pelvis and a "trial of labour" in the Walcher position is advised, relaxation under hypnosis is very helpful. This type of pain relief in childbirth is getting very popular, and women are demanding the services of a hypnotist. It is a pity this is invariably a physician and not an anaesthetist.

METHODS

The use of thiopentone and the art of venepuncture in general is the daily practice of the anaesthetist. I chose this method for that reason. It is handy in its administration, produces all the stages of hypnosis from mild relaxation to somnambulism, and the anaesthetist is in control all the time, regulating lightness or depth at will. Another reason is that it is the speediest method of producing the phenomenon, an important factor in a busy hospital. Moreover, it is a simpler method and has no apparent "hoodoo" trappings, no passes or prolonged eye fixation, or continuous monotonous suggestions of sleep. It is positive in its action, and it works in 100 per cent of cases, all important factors in hospitals. It is easy, also, to continue the injection to complete anaesthesia if there is a question of operative procedure.

USE OF THIOPENTONE IN HYPNOSIS

For the anaesthetist really interested in hypnosis, it is recommended that he consult some of the leading works on the subject. He should then see the actual condition produced by an expert, medically qualified. Stage representations are of no scientific value whatever, and are, if anything, misleading to the inquirer. Having seen the phenomenon, he should himself experience the state of hypnosis. Then he is ready to practise, by ordinary methods, the induction of the state, either on patients or lay subjects. Having made himself proficient on these lines, he should concentrate on the method of hypnosis using thiopentone.

THE HYPNOTIC STAGE OF GENERAL ANAESTHESIA

It is worth while considering in detail this method of narco-hypnosis using thiopentone. All textbooks on anaesthesia describe a state seen in the early part of stage one of anaesthesia. It is a point when the patient lapses from the alert awake state to the slight dreamy, somewhat confused, condition which has been described in many anaesthetic books as sleep; the
breathing is slow and regular, if somewhat deep, reflexes are also slow, and sometimes absent. The patient is capable of responding to questions, replies are slow, but on the whole intelligent. Sleep this condition may be, but it is also light hypnosis. The stages are for all practical purposes identical. Natural sleep can, in good subjects, be turned into hypnosis by suggestion, without awakening the subject. This is an easy matter in the majority of children.

PRELIMINARY INSTRUCTIONS

Taking advantage of this hypnotic state, the patient is told by the anaesthetist that he is going to put him into a light state of sleep, when he will hear every word spoken by him, and will obey all instructions and suggestions given. This will be in no way a matter of forcing the condition, but the anaesthetist will be merely acting as his guide, and assisting him to reach this stage. He will tell him that he will be giving him a slight prick of a needle in his arm, which he will hardly feel. A signal is then given; any signal will do, such as “Then I will count three, and at the third number you will fall asleep” or “I will look at you and whistle”. It must be a definite signal. I generally count with adults, or press my thumb on the bregma. With children I say, “I will blow on your face and then you will fall asleep.” It is well to do this, as afterwards, if it is necessary to give an anaesthetic, blowing with nitrous oxide in a Boyle’s serves just as well where it is impossible to venepuncture.

The patient, now understanding the procedure of induction, is instructed as to his awakening. “I will tap three times on your forehead, when you will awake feeling refreshed and well” or, if he is to have an operation, “You will awake from your operation in your own bed and feel well and free from pain”. It is even possible to control excessive vomiting. These factors help considerably the nursing of the case.

TECHNIQUE OF THIOPENTONE INDUCTION

Placed on a comfortable couch or, if it is necessary, on a theatre trolley which is not so comfortable, the patient should be put in the quietest room in the hospital. There must be no tearing about of nurses with or without messages, no clattering of instruments or loud conversation, in fact just the atmosphere of monastic quiet which should but, alas, does not exist in the normal anaesthetist’s annexe to the theatre. Distraction of this kind makes the induction of hypnosis impossible.

TECHNIQUE OF INJECTION

The thiopentone is now prepared and drawn into a 20-ml syringe. Unless it is intended to produce complete anaesthesia after induction of hypnosis, 0.5 g of the narcotic is sufficient, made up to a 2.5 per cent solution. Since the minutest amount of thiopentone is necessary to obtain the state, this dilution is easier to control. Choosing a small size sharp hypodermic needle, all is now ready. The needle is inserted into a vein and the patient instructed to keep his eyes open. Inject just enough to produce that slight drowsiness already described. The pupils will dilate slightly and at the signal the eyes will close. Talk the patient down into hypnosis. “You are feeling comfortable and warm.” “You are feeling a little
sleepy.” Now give your signal: “You are now asleep but can hear my voice, your arm is rising above your head.” He will raise his arm; but should he fail to do so raise it for him. “Now it is stiff like an iron rod, and you cannot put it to your side.” These tests being positive, the patient will be in hypnosis and ready for the suggestions of the anaesthetist hypnotist.

**SUBSEQUENT INDUCTION AT A GIVEN SIGNAL**

It will not be necessary to inject thiopentone at the next sitting, for before awakening your patient you will give him the signal, and command that the next time you say it, he will fall asleep without the prick of the needle. This posthypnotic command will be obeyed. The art in the technique is to be able to estimate the minimum of the drug to produce the effect. Too much will, of course, spoil the effect by the patient passing into anaesthesia. One should remember, too, the variation in each individual of the exact circulation time. It is a good method to place the patient’s arm, stiff in catalepsy, above his head at the early onset of hypnosis: if and when his arm falls flaccidly to the side, he has then passed from hypnosis into anaesthesia. A dainty estimation of dosage is particularly needed in dealing with the child.

**HYPNO-NARCOSIS IN CHILDREN**

A different method of approach may be necessary in dealing with children. In cases where it is impossible to do a venepuncture, it can be quite satisfactory to blow on nitrous oxide with the tube concealed in the palm of the hand. “I am a magician and I can blow you to sleep by blowing on your face” puts the relation of the hypnotist and patient on an immediate working basis, well understood by the mind of a child. “I am blowing on your face, and you feel as if you were in your own little bed and you are going to sleep.” This method is also quite good in the ordinary induction of ethyl chloride for anaesthesia, where the narcotic is placed in a Boyle’s and blown on with oxygen. Using this means when venepuncture is possible, the child is told that he will have a slight prick of a needle, but it will not hurt him, for before doing this you will rub in some magic ointment. A little nupercaine rubbed in with a lot of suggestion will accomplish this. The needle is then inserted and the procedure is the same as for an adult. The metabolic rate must be allowed for in judging the necessary dosage. With children a running “question and answer” technique gives a clue to the state, with its slightly slurring speech, which is a feature of the ordinary state of hypnosis.

**RESULTS**

Combining, as I do, general practice with my anaesthetic specialty, I have ample opportunity to test out the efficiency of this method of inducing hypnosis. Hypnosis does produce dramatic cessation of symptoms which may or may not be permanent. In the main, an analysis of the deep subconscious roots of the disease cannot, and indeed should not, be omitted. Hypnosis should be regarded as a convenient channel for the easy flow of the contents of the subconscious. I do confess that most of my failures, and I
have had many, have been due, not so much to the failure of hypnosis, but the neglect or the lack of opportunity to accomplish this.

I have mainly studied the following diseases, so most of my case histories concern these. Epilepsy, auto-erotism, somnambulism, and nocturnal enuresis. Many of these cases have been seen by me in hospital undergoing operation for other diseases, and I have been able to test out the use of hypnosis at a given signal.

Some cases are cited demonstrating methods using thiopentone, and others induced by the ordinary methods. A case of laparotomy using hypnosis is also given.

Epileptics, in general, dread the onset of unconsciousness. No patient with this disease enjoys the sensation of oncoming oblivion. They are, therefore, almost impossible to induce by the ordinary methods of hypnosis induction. Thiopentone induction very successful. Strong suggestions were given that the fits would take place at night, and would grow less and less in numbers and severity. Monthly visits, when hypnosis was produced at a given signal. After two years she has now very few fits, one or two yearly where they are severe enough for her to bite her tongue. She married and was much better during the gestation period of her child, having no attacks. Under hypnotism it was suggested she would have no pain whatever during her labour. She was taught to relax, and has now been delivered and has had no pain.

C. L., male, age at time of first consultation 10 years. Fits several times a week, especially at class time. Somewhat maladjusted and unable to settle. Weaned off phenobarbitals and put on small doses of epanutin. Successfully inducted by thiopentone. After four monthly visits fits occurred at night only, and were feeble in nature and less frequent. After two years, except for odd attacks, he is free from major symptoms.

Nocturnal Enuresis.

R. T., female, age at time of first consultation 11 years. Brought by her parents because she was found stealing from neighbours. She had a wet bed every night since infancy. Hypnosis, by using thiopentone, and put through a quick psychoanalysis. It emerged she heard voices ordering her to take the money. Suggested that these voices would cease, and she would hear only mine ordering her not to steal. Other family difficulties producing feelings of insecurity were righted. She is now, after two years, except for a very occasional lapse, symptom free and has not stolen since first consultation.

J. F., male, age 28, at first consultation. Enuresis since childhood. Is now married and is still afflicted. No physical cause found. Thiopentone induction successful. Symptom free for some months. He bought a business which entailed much worry and anxiety. Symptoms returned and in spite of numerous hypnotic sessions, is still wetting. Psychoanalysis and repeated suggestion of no avail.

Auto-Erotism.

J. D., female, age 25 at time of consultation. Masturbated several times a week. Avoids social male contacts and feels it is due to her habits. She proved
a very bad subject, and was uninfluenced by the ordinary methods of induction. She was put under thiopentone hypnosis. On subsequent visits she entered hypnosis at a sign. Analysis under the state bringing to the surface the cause of her perversion. Under hypnosis she was instructed in a more adult attitude to sex, and a sublimation of her impulses. There has been gradual improvement and now, after two years treatment, she is engaged to be married.

**Somnambulism.**

These cases need very little induction as they are “naturals”, but the following case is of interest.

C. C., female, age at time of first consultation 5 years. Found “walking” in the garden of her home on several occasions. I had an opportunity to induce hypnosis, as shortly after the initial interview she developed acute appendicitis. In hospital she was given a premedication of secobarbital 1/2 grain and atropine 1/100 grain, and induced under intravenous thiopentone. Taking the opportunity to suggest during the hypnotic stage that she would not leave her bed when asleep. This treatment was successful for six months when she had a relapse. Under hypnosis induced “at the sign” she has, after two years, no relapses.

**Laparotomy under Hypnosis.**

J. J., female, age 27. Was under treatment for anxiety neurosis. She proved a very good subject and was put under hypnosis using the ordinary methods. She sank into deep somnambulism at the given sign after the first induction. She developed signs of chronic appendicitis, which was confirmed by X-ray. Admitted to hospital and hypnotized the night before operation. She was ordered to have a deep sleep and awake the following morning refreshed. She was also told that an operation would be performed after she was put to sleep the next day, when she would feel no pain whatever and would awake after the operation well and free from pain.

Hypnosis was induced after preparation for her operation. No premedication was given. Blood pressure then 120/90. Temperature normal. Heart and lungs normal. No complaint from the surgeon as to undue muscle contracture on his incision. Patient grimaced slightly on opening the peritoneum, but otherwise remained in deep hypnosis. Blood pressure as above. Surgeon complaining of slight stiffness on stitching the peritoneum, but not sufficient to impede his work. Returned to the ward, her blood pressure fell steeply to 80 systolic and she was showing all the classical signs of shock. Morphia, 1/2 grain, given intravenously produced a rapid all-round improvement. No further sedation was found necessary and the patient slept peacefully until morning. Her recovery was uneventful and she states she did not know or feel anything after her induction for the operation.

**SUMMARY**

Anaesthetists, by their very calling, should not ignore the possibilities of hypnosis. It is as much their instrument as that of the psychologist. There are some unattractive aspects for those working in hospitals. Hypnosis has its uses in hospital. It is suggested that the most useful method for anaesthetists is that of hypno-narcosis using thiopentone. In cases of children, blowing on nitrous oxide or ethyl chloride can be used as an alternative.

**CONCLUSIONS**

Hypnosis has its place in surgery practice, and in midwifery, where it is seen at its best. It is ideal and safe as a pre-operative sedation. The use of thiopentone hypnosis is the method par excellence for the anaesthetist.