THE SCOPE FOR HYPNOSIS IN GENERAL PRACTICE

BY

A. FRY, M.R.C.S., L.R.C.P., D.M.R.

General Practitioner, London, S.E.

The aim of this paper is to show what uses can be made of medical hypnosis in general practice; the types of cases which may and those which will not benefit from it; and its clinical effects.

Technique

If hypnosis is to be of use in general practice the technique must be simple and the sessions not too lengthy. It is surprising how good the results can be with very short sessions of 5 to 10 minutes each in cases of dysmenorrhoea, asthma in children, and insomnia. The psychoneurotic and psychosomatic cases require much longer sessions.

For the induction of hypnosis, the method using fixed gazing and verbal suggestion was found the most successful; this, however, had to be modified occasionally according to the individual case. No drugs were used to facilitate the induction. In most of the cases treated, the hypnoidal and light trance states were found sufficient to obtain satisfactory results. Deeper states, however, were required in obsessional and anxiety cases.

The degree of hypnosis of the cases was: unsuccessful, 14%; hypnoidal and light trance states, 63%; medium trance, 9%; deep trance, 14%. These figures compare with those given by Weitzenhoffer (1953): unsuccessful, 14.70%; hypnoidal and light trance, 40.34%; medium trance, 24.92%; deep trance, 20.04%.

Before treating a patient with hypnosis very careful history-taking and clinical examination are essential; any possible organic causes must be fully investigated and treated on conventional lines.

The first interview is very important, since the method of approach to the patient may influence the effect of the treatment. He should be given a full explanation, in as simple language as possible, of his condition, the form of the treatment to be carried out, and how it may help to overcome his difficulties and remove his symptoms. Most people view hypnosis with scepticism and apprehension: it is only human, after all, to regard with a certain fear anything that is mysterious and imperfectly understood. The patient must be reassured and convinced, so far as is possible, that he cannot be harmed by it, even though it may not help him. At the outset it is advisable not to mention the word "hypnosis," but to use another term to describe the proposed treatment—for example, "suggestive relaxation." Usually the patient loses his scepticism and apprehension after the first or second session.

In cases with no deeply rooted causes or conflicts, direct suggestion in a light hypnotic state is sufficient to remove the patient's symptoms. In the neurotics and psychosomatics it is necessary to probe deeper to find the causes of the trouble, or the "crucial incident." In such cases the deeper states are required. Neurotic cases which are treated only superficially with suggestion of symptom disappearance usually relapse and develop substitution symptoms. If, however, the root of their trouble is discovered and brought up from the subcon-

scious to the conscious level of their mind, such relapses can be avoided.

At first, the patient is seen once or twice a week. The intervals between the sessions can then be lengthened gradually according to the progress of the case. In some obsessional and anxiety cases, maintenance therapy may be necessary, and patients may have to be seen once a month or once in two or three months.

It is advisable to bring the patient out gradually from the hypnotic state. Sudden waking may cause headache, drowsiness, or numbness in the limbs; these, however, do not last very long. No difficulty has been experienced in arousing the patient from the hypnotic state.

Results

Hypnosis was used in the treatment of 120 unselected cases over a period of nearly two years. Some of the cases have been followed up for two to three years. The following are the diseases and conditions in which hypnosis was used; the aims of the treatment are noted in each group.

Anxiety Neuroses (20%).—Lessening tension, discovering the cause of the conflict, and instilling confidence and reassurance.

Obsessional Neuroses (11.7%).—Discovering the underlying cause, dealing with the phobias and obsessions, inducing relaxation, giving hope of recovery, and encouraging the resumption of full activity.

Cardiovascular (10%).—Lessening anxiety, promoting general relaxation, and removing distressing symptoms such as dyspnoea, insomnia, and depression.

Heavy Smoking (9.1%).—Lessening general tension, fostering a distaste for smoking, and giving a picture of better health in the future with the loss of most of the distressing symptoms.

Bronchial Asthma (7.5%).—Attempting to discover the primary cause, reducing anxiety and general tension, training the patients in autohypnosis and relaxation, thus enabling them to overcome their attacks themselves, and arousing in them the hope of finally mastering their disability.

Skin Cases (7.5%).—Inducing anaesthesia, relieving anxiety and tension, discovering the underlying factors, and instilling hope of recovery.

Dysmenorrhoea (4.2%).—Inducing analgesia, lessening tension; training in self-relaxation.

Enuresis (3.4%).—Relieving anxiety in patient and parents, instilling hope of losing the disability, and suggesting the gradual recovery of full bladder control.

Duodenal Ulcer (2.5%).—Removing anxiety and tension, analgesia, giving up smoking.

Malignancy (2.5%).—Analgesia suggesting a peaceful state of mind and the hope of recovery, if pre-operatively.

Petit Mal (2.5%).—Removing anxiety in patient and relatives, directly suggesting a gradual diminution of the number of the attacks and their final disappearance.

Small numbers in each of the following conditions were also treated: insomnia, migraine, anxiety hysteria, psychosis, pregnancy, stammering, ulcerative colitis, examination "jitters," behaviour problems in children, "dentist" phobias.

The predominance of the psychoneurotic and psychosomatic cases conforms to the usual pattern met with in general practice. The results of hypnotherapy in those cases were as follows:

Fourteen patients stopped attending after one or two sessions. This may have been due to their dislike of the treatment or to other psychological causes. Twenty-three cases were resistant to hypnosis. However, if more prolonged attempts had been made some of them would have eventually responded. Twenty-six cases partially improved. These did not entirely lose their symptoms and anxieties, but they ceased worrying about them, became more relaxed, were able to resume or continue their normal work, and felt generally much better. Fifty-seven cases fully improved and had no relapses, in some cases for two or three years. These included 20 patients who had not responded well to other methods of treatment but were able to resume full work after being treated with hypnosis.

The obsessional cases were the most difficult to treat, and most of the failures were encountered in this group. The border-line psychotics previously treated in hospitals did not improve. Patients over 60 were particularly difficult, but children responded very well.

Twenty-four patients were able to stop or to reduce drastically the taking of hypnotic and analgesic drugs.

The various post-hypnotic effects manifested in the treated cases were marked relaxation, diminished depression, sounder and more natural sleep, increased self-confidence, improved appetite, marked physical improvement (especially in cardiac cases), antipruritic action, analgesia, greater feeling of contentment, and lessened anxiety.

The following case histories will illustrate the reactions to hypnotherapy, the clinical progress, and the results.

Case 1

Man aged 46. Anxiety neurosis for 10 years. Persistent pain in the head caused by worry, to which he was inclined. Slight stammer. Paraesthesia in left temporal region. Very erratic at work owing to poor concentration. Attacks of depression with feeling of inferiority. Six years ago he had a "nervous breakdown" and was absent from work for 11 months. He slept badly, and had to stay away from work very often. He had attended a psychiatric out-patient department five times a year ago, but did not improve. A history of unhappy childhood was obtained. After treatment twice a week for three weeks he lost his depression, and said that his head felt clear for the first time for 10 years. He took his wife to a show for the first time for many years. His employer became satisfied with his efficiency. He was treated for three months and finally lost all his symptoms. He was also able to give up smoking after indulging in it for 31 years. Two years later he remained well and was working regularly.

Case 2

Woman aged 36. Company secretary. Long-standing obsessional case with superimposed depression. Her recent attack started in the summer six months previously, and she attributed it to a heatstroke. She had had pain on the top of her head ever since. She complained of depression, palpitation, inability to concentrate, cancerphobia and various other fears, insomnia, and fear of being left on her own. She was very worried about herself, and had been away from work more than six months. She had had empyema at the age of 5, at which time her mother died; her father had died when she was 12. She had been brought up in a "home" and had had a very unhappy childhood.

She did not respond to sedation (amphetamine, chlorpromazine, etc.). She was referred to the psychiatric department of the local hospital, where she was given E.C.T. She had three treatments and became much worse. Her depression increased and she felt that she was going mad. She described with horror her experience with E.C.T., and the scene on coming round after the treatment; she refused to have any further treatment at the hospital. She was a good subject for hypnosis, and was able to recall under it the origin of her recent attack. She developed her pains in the head after exposure to the sun and too much sea-bathing, and felt dizzy. Her friends at work told her that she was probably undergoing the menopause, and as her mother died from cancer when she was 40, and she herself was nearing this age, she thought that her symptoms were probably those of cancer.

Her fears and all the other symptoms gradually resolved with hypnosis, and she became very much more relaxed. It was explained to her that the lack of security and the loss of her parents when she was a child had a good deal to do with her present state. She was able to resume part-time work after the sixth session, three weeks after the beginning of hypnosis. She became interested in her work and gradually came to like it more and more. Her fear of travelling on buses disappeared. She regained interest in her housework and began to have more social contacts, which she

had been avoiding before. Eventually she resumed full-time work and had no relapse. The intervals between the hypnotic sessions were gradually increased from twice a week to once a month. She has remained well ever since.

Case 3

Housewife aged 39. An obsessional type with severe agoraphobia. Her symptoms began 13 years ago following an unfortunate incident when a soldier made an attempt to assault her while she was waiting for a train. At the same time her first husband suddenly left her and she found herself alone, as her relatives had been evacuated to the country. She married again a few years later, had two children, and was quite happy, but the intense fear made it impossible for her to go out. Even when she used to ride with her husband in the car, she became panic-stricken if she went too far from home, and had to return. She had never been away with her children on holiday, had not been to a theatre or cinema for over five years, and she was very unhappy.

She had had two courses of treatment by psychiatrists. One was in 1943, for 12 months, at the rate of two or three sessions a week; the other in 1946 for eight months, at two sessions a week. She did not improve. She was again seen three years ago in consultation with another psychiatrist. In his opinion it was notoriously difficult to do much with such cases. He suggested that the patient should take amylobarbitone sodium and methylamphetamine half an hour before going out. If this should fail, he advised a trial of E.C.T. The prescribed drugs had no effect on her condition. It was then decided to give hypnotherapy a chance. The patient was a very good hypnotic subject and was able to reach a fairly deep state. She was abreacted under hypnosis; her problems were explained to her and she gradually improved. After the fifth session she was able to go to a theatre without experiencing any fear. She had two sessions a week during the first three months and one a week after that. She has not lost her phobia completely, but she is now able to lead a more normal life, and is no longer a "prisoner." She can go out anywhere, and has been to the seaside several times, which she had been unable to do since her illness started. All this made a remarkable impression on the patient's mental attitude. She is now able to enjoy life nearly as much as any normal person.

On one occasion the patient developed an attack of migraine with severe headache and vomiting. It came at a very inconvenient time, as she was busy with her son's birthday party. The symptoms completely disappeared after she was hypnotized, and she was able to carry on with her work within a very short time without the slightest trace of headache, nausea, or vomiting.

Case 4

Housewife aged 48. A severe obsessional, with a strong family history of mental ill-health. Very depressed, with a fear of insanity. Very tense and unable to relax. She used to get violent hysterical attacks, which were difficult to control. She had two courses of E.C.T. as an in-patient, but was no better. Several unsuccessful attempts were made to induce hypnosis. She had to be admitted later into a mental hospital, and after 12 months' treatment there she was still in the same state.

Case 5

Man aged 54. Senior fire officer. An obsessional type with depression and hypochondriasis. There was a five-years history of dyspnoea, generalized pruritus, poor concentration, depression, nosophobia (especially cancer), lack of self-confidence, and fear of making mistakes while carrying out his duties. He had been fully investigated in hospital. Psychiatrist advised E.C.T. and he had seven treatments. He improved for three weeks and then relapsed. With superficial analysis under hypnosis some past incidents were discovered, which gave him a feeling of guilt. This was

dealt with and he soon began to improve. The hypnotic suggestions and analysis gradually disposed of some of his symptoms. He was able to resume full duties five months later, having previously been on part-time duties for eight months before treatment. He is still occasionally depressed and has feelings of guilt, but has been able to continue full duties without a break. He has been followed up for 2½ years.

Case 6

Housewife aged 46. A severe obsessional, with three years' history. She had suffered from migraine all her life, and had hysterectomy for fibroids two years ago. She developed "creepy" feelings all over, cancerophobia, severe depression, insomnia, and some agoraphobia. She had been an in-patient in a psychiatric teaching hospital for three months, and had E.C.T. She was told on discharge by a psychiatrist that she would "always have her pains in the head, as she was born with them."

She only slightly improved with hypnotherapy. She remained resistant and was not able to reach a deep state of hypnosis. The attempts were given up after two months' trial. For the last two years she has been attending a psychiatric out-patient department of a hospital and remains unchanged.

Case 7

A general practitioner aged 62. Angina of effort for 10 years. No history of coronary occlusion. He consulted a cardiologist five years ago, the electrocardiogram was negative, and a diagnosis was made of some left ventricular failure. The symptoms were precordial discomfort on exertion and after meals, with some mild pain. He had always been over-anxious and tense, and had "played hard and worked hard." He had been doing a good deal of communal work apart from his medical practice. Two of his brothers had coronary disease. He had been advised to take tab. "mycardol" four times a day and one tablet of trinitrin when required. His blood pressure was 180/110. When first seen he was unable to walk a few hundred yards without some discomfort in his chest.

The aim of hypnosis in this case was relaxation and reassurance. He felt much better after the first session, having no more discomfort after meals. After the third session he said that he could walk slowly for 2½ miles without any chest discomfort. He had seven sessions during 3½ months. As a result he said that he had more confidence in himself, and felt very much better generally. He no longer had to take trinitrin tablets, and when seen last he had discontinued taking the mycardol tablets as well. His blood-pressure reading remained the same, but subjectively he was very much better.

Case 8

A business man aged 48. In March, 1954, he had right-sided heart failure, auricular fibrillation with an incalculable ventricular rate, and inversion of the T-wave in chest leads V2-4. In 1949 he had been treated in hospital for ?endocarditis. In March, 1954, he was an in-patient in a teaching hospital for three weeks with heart failure. When first seen, six months later, he was very dyspnoeic and orthopnoeic, with considerable oedema of his feet and ankles. He had not had any proper sleep for over 12 months, because he was unable to lie down, and was having heroin injections for his sleeplessness. He was also a very tense and worrying type. He had already tried hypnotic treatment for six sessions, but did not benefit from it.

After a prolonged first interview he was hypnotized with a very good response. That same night he was able to go to bed properly, to lie down, and to sleep with a few small interruptions until 7 a.m. without heroin. He said that he felt fine the following morning. The oedema of the feet and ankles subsided after two days. He received treatment twice a week in the beginning, and after six weeks this was reduced to one. The consultant cardiologist saw the patient two weeks after hypnotherapy had begun, and was amazed with the result. According to him, there was

no more oedema of his ankles or engorgement of the veins in the neck, and the liver was no longer palpable. When he saw the patient again after three months he was well satisfied, and remarked that the electrocardiogram was "the best ever." The patient continued to keep well, except for some slight dyspnoea due to his excessive weight, which was very difficult to reduce. He was able to attend to his business regularly and to lead a fairly active life, including masonic duties. Eighteen months later he still remained well.

The consultant's final opinion was that "the patient, who became virtually resistant to any form of conventional treatment, would have died some months ago if he had not been treated in the way he was."

Case 9

A woman factory worker aged 20 had begun to smoke when 7 years old, and had smoked 10 to 20 cigarettes a day since the age of 13. When seen first she was smoking up to 80 cigarettes a day and spending nearly £4 a week on them. She had a craving for cigarettes which she could not control. She wanted to be able to break this habit, as it was ruining her financially. After only two sessions she was able to stop smoking entirely. When she was offered a cigarette subsequently, she refused it. When seen three months later she had not smoked a cigarette since she was treated.

Case 10

A builder's foreman aged 52. He had been a heavy smoker for 38 years, consuming on the average 40 to 50 cigarettes a day. He had chronic bronchitis, was emphysematous, and was a rather heavy beer-drinker. He expressed a wish to give up smoking. He was a very tense subject and found it difficult to relax; even light hypnosis could not be induced. No satisfactory results could be obtained after six sessions, as he proved very resistant. He was, however, able to cut down the number of cigarettes to 20 a day, but could not get any further. No other attempts at hypnosis were made.

Case 11

A very anxious girl aged 13. She had had bronchial asthma since the age of 18 months, and eczema in childhood. The onset of the asthma coincided with an accident, when she was scalded by an overturned teapot. The attacks sometimes lasted three to four days, and used to occur when she exerted herself or was emotionally upset. She was a good hypnotic subject. At the first session suggestions were given to her not to worry about the attacks, and to relax well. She was trained in autorelaxation by mild hypnosis, and told to use this when an attack occurred. It proved to be quite effective. When she had an attack of asthma she was able to relax, counting slowly up to ten and using autosuggestion, with the result that the spasm was very soon relieved. She was seen only three times. Six months later she was free from any attacks. This could be explained by her conviction that she had an effective remedy in her hands, and was able to make use of it when necessary.

Case 12

A garage proprietor aged 33 had had bronchial asthma since 2 years of age, which interfered with his schooling. He was the only child. His father died some years ago, and he was managing the business with his mother, who was a domineering type, and treated her grown-up son like a child. He had been using an inhaler for over 17 years. He had been in several hospitals, had undergone a sinus operation, and had had allergy tests, which were all negative. He was unmarried, was very shy, and did not have many friends. He was a very tense subject, difficult to relax. Several attempts were made to get him into a state of deep hypnosis, but without success. Any further attempts to alter his tension, the mother-son relationship, and his outlook had to be given up. He was treated altogether over a period of six weeks.

Case 13

A housewife aged 52 had pruritus ani and vulvae for five years, had a perineal repair four years ago, local x-ray treatment to the perineal region three years ago, and hysterectomy for severe metrorrhagia two years ago. The pruritus had resisted all treatments so far, and was worse when she became warm. She was very "nervy," tense, depressed, and anxious owing to her complaint. She could not sleep, because the itching was so intense. She could not take part in any social activities, and when she was talking to anybody she had to run off suddenly to relieve her itching by scratching. It was also upsetting her family life. There was no history of any possible psychological cause, and her urine was normal.

She was very sceptical when I first explained the proposed treatment to her. The first session was not very successful, but she began to feel better after the second treatment. The pruritus round the anus ceased completely, and there was only slight itching in the vulvar region. After the third session she was able to sleep throughout the night. The perianal skin, which was at first macerated and raw, gradually became darker and drier. After six sessions she had no more pruritus, felt remarkably better, was very happy, and was enjoying life fully. She could not believe that she was so relaxed. She ceased using any local applications, and stopped taking the sedatives and hypnotics, which she had done for the last five years. When followed up a few months later she remained symptom-free.

Case 14

A housewife aged 43. Ten years' history of cheilosis. There were deep cracks at both angles of her mouth, which were always moist and very sore. She had tried various treatments, including vitamins. Direct suggestion under hypnosis in two sessions cleared up her condition completely, and there was no recurrence. When seen six weeks later, she stated that she never felt so well. She stopped using any local applications. Six months later she remained free from cheilosis.

Case 15

A typist aged 25, with dysmenorrhoea for 11 years. The intense pain and incapacity usually lasted four to five days, and was interfering with her work. She had been treated on general lines with anti-spasmodics and analgesics, with poor response. She was referred in March, 1950, to a gynaecological department. The gynaecologist suggested trying tab. stilboestrol, 1 mg., at night and "synapoidin" injections. These had no effect. Her name was then put down for operative treatment. She had a D. & C. performed, after waiting two and a half years for the operation. The first subsequent menstruation was just as painful and incapacitating as the one before. Hypnotherapy was suggested to her, and she decided to give it a chance. She was treated with direct suggestions of analgesia and relaxation. When she came for the first treatment she was in agony; half an hour later she walked out free from pain. When seen again on the following day, she said that she was able to stop the pain by self-relaxation in the way she was taught at the first session. She said that as soon as she closed her eyes she imagined seeing the object which she was looking at when she was hypnotized, and her pain then soon disappeared. During her next menstruation she was seen three times, and during the following one twice only. She has had no further treatment since, and stopped taking any drugs for the relief of pain. Two years later she was still free from dysmenorrhoea.

Case 16

A boy aged 12 had a 12-months history of enuresis since he changed schools. At one time he was a sleep-walker and had nightmares. Amphetamine, etc., were tried without success, and no psychological cause could be found. Direct suggestion, under hypnosis, to stop worrying, and of

improved control of the bladder was very effective. He had a completely dry week after the first session, and stopped taking amphetamine after the third session. He was seen six times, and has since remained free from enuresis.

Case 17

An engineer aged 43 had had chronic duodenal ulcer since 1938. He had medical treatment in hospital for six weeks in 1939, and two further courses in 1942 and 1943. In 1944 he had a partial gastrectomy. He made a good recovery, and was told on discharge that he would have no further worry, would require no more special treatment or diet, except smaller and more frequent meals. He remained well for 12 months, and then the pain, nausea, and the rest of the symptoms recurred. The pain used to wake him up five to six times during the night, and he could not do his work regularly. Alkalis, belladonna, and anticholinergics had very little effect. A barium meal showed a constant fleck in the duodenal region, probably due to an ulcer. He was a worrying type, and this aggravated his condition. However, he agreed to try hypnosis, and was a very good subject. After the first session he said that he felt more relaxed than he had been for years. He slept well that night and was free from pain. He stopped his heavy smoking as a result of suggestion given to him during the first session. He had some slight pain the following night. After the second session he had his first real breakfast for years. Altogether, he was seen four times. He now stopped taking mixtures, tablets, etc., and was on a liberal diet. When seen three months later his weight had increased by over three stones (19 kg.). He remained free from pain, slept well, did not smoke, and felt fine. Three months later he said that he had never been so well for years. A year later he remained symptom-free and did not smoke.

Case 18

A man aged 78 had a partial oesophago-gastrectomy for carcinoma of the lower end of the oesophagus. He developed a secondary growth six months later in the left sternoclavicular region, and was deteriorating rapidly. He was taking methadone hydrochloride for the relief of his pain. Hypnosis was tried in order to make him more comfortable. He had three sessions, which were partially successful. He remained free from pain, did not need any more methadone, and felt much better generally. He died three weeks later. His relatives stated that he felt much better after hypnosis, and remained in a much more peaceful state of mind until his end.

Case 19

A housewife aged 21 had had petit mal since the age of 12. The attacks were aggravated by any emotional upset and by menstruation, and occurred mostly in the mornings. For about two hours she would look vacant, but was able to continue work and converse. She had four major attacks when pregnant, and one during labour. She was a tense and very excitable type. Her relatives were very anxious about her condition, which did not help matters.

She had been under continuous treatment since the attacks began, and had been fully investigated in different hospitals. Anticonvulsants and sedatives had little effect, except to make her feel drowsy. Lately she had been taking epanutin-and-phenobarbitone capsules. Her anxiety was increased by the fact that she had a young baby to look after. Her mother used to come early every morning to take care of the housework, as the attacks made it impossible for her daughter to do so.

She was a good hypnotic subject. Direct suggestions were used to lessen her anxiety and tension, and to control the number of the attacks. She felt much brighter after the first session; the attacks decreased from 40 to about 10 a day, and she said that she did not worry so much about them. She was more cheerful and hopeful, seeing a form of treatment that might help her. Until then, no one had encouraged her to believe she would ever lose the

attacks. Treatment was continued at intervals of two to three weeks, as she was living some distance away. Altogether she had nine sessions in five months. The attacks were finally reduced to only two or three a day, but on most days she was free from them. They used to be more frequent during menstruation, but towards the end even this did not affect them. She had also been suffering from dysmenorrhoea, which was treated with hypnosis at the same time, and after three months she was having completely painless menstruation. It is possible that the pain may have been responsible for the increased number of attacks. When seen a year later, she stated that she was feeling fine, and had hardly any attacks. She also reduced the number of the capsules she had been taking.

Case 20

A factory worker aged 19 with a history of nightmares and sleep-walking since childhood. Her mother was a very neurotic type. The patient had been treated in 1949 for 12 months as an out-patient in a psychiatric hospital. She improved for three years and then relapsed. When first seen, the mother stated that her screaming at night disturbed the other members of the household, as well as the neighbours. The girl was very tense. During the week following her first hypnotic session she had only one disturbed night, and she felt less tense. She was seen altogether five times at weekly intervals. As a result she was sleeping normally, and had no more disturbing dreams. When followed up two years later she was still sleeping normally.

Case 21

A 3-para aged 27 had labour under hypnosis. She was first seen when three months pregnant. She had eight sessions. She was trained in autorelaxation and to reach a hypnotic state by slow count up to 10, in deep breathing, and in autosuggestion. She responded well to the training. She was 10 days overdue. At 2 a.m. she began to have slight pains, which lasted till 7.30 a.m. At 2 p.m. the pains started again. At 3 p.m. they became stronger, and the patient gently clenched her right hand—a prearranged signal. She then became fully relaxed and felt no more pain. She was fully co-operative, and at 5 p.m. a 9½-lb. (4.3-kg.) infant was born without difficulty. There was no need for pethidine or gas-and-air analgesia. She was not seen until after the third stage was completed. She felt fine, and said that she would not mind having a few more babies in the same way. She had no after-pains at all. The perineum remained intact.

Discussion

Hypnosis used carefully and sensibly can be of great help in general practice. It may achieve results in cases which have resisted more conventional methods of treatment.

It is not suggested that hypnosis is a panacea which will cure every disease or disability, but far more can be done with it than has been supposed. Many conditions can be controlled by hypnosis alone, and in most conditions the patient can be made far more comfortable and more able to carry out his normal duties. It is also possible (Lloyd, 1934) to enhance the effects of other forms of treatment by appropriate suggestion under hypnosis.

It is difficult to change completely an obsessional personality, but it is possible with hypnotherapy to enable sufferers to lead a reasonably happy life. If hypnosis will not help a psychoneurotic, at least it will not aggravate his condition. The Subcommittee of the Psychological Medicine Group Committee of the B.M.A. stated in a report (*British Medical Journal*, 1955), that they "had no clear evidence upon the extent of the danger or the quality of the danger to a patient which some psychiatrists claimed inevitably followed the induction of hypnosis."

I did not encounter any deterioration in the patients' condition when treated with hypnosis. Kuhn and Russo (1947) make the following statement about any possible dangers of hypnosis: "Moral—there is no surrendering of the will,

there is only co-operation. Psychological—does not weaken the mind. Physical—there are none."

The possible use of hypnosis in alleviating pain in malignant conditions is worthy of study. Case 18 illustrates this well. Wolberg (1948) states that hypnosis can eliminate pain in incurable progressive fatal ailments and reduce or eliminate the necessity of analgesic drugs.

The value of hypnosis in skin affections is based on its effect on the emotional state of the patient. Bonjour (1929) maintains that the skin is a mirror of the mind. Some patients suffer from certain skin diseases which may be due to emotional disturbances—for example, erythroderma, hyperidrosis, urticaria, and eczema.

The removal of anxiety and other disturbing symptoms in psychosomatic cases by hypnotherapy offers great possibilities. The anxiety which follows a coronary occlusion or other cardiac affections is a particular example. Dr. Morgan Jones (1955) states that in cases recovering after a coronary occlusion there is often far more residual disability from fear than from myocardial damage. This fear can be dealt with by hypnosis.

The good results from hypnotherapy in cases of dysmenorrhoea, petit mal, migraine, and asthma should encourage its further use in such patients.

The possibility of helping heavy smokers, especially young people, to give up this habit through hypnosis may play an important part in the prevention of bronchial carcinoma.

The general practitioner is particularly well suited to use hypnosis, as he is usually familiar with the patient's background, and enjoys his confidence, which is so essential for successful hypnotherapy.

To enable patients who have been regarded as incurable to resume work, to regain their self-confidence, and to dispense with drugs for the relief of their symptoms is a worthy achievement, and should stimulate further application and research in the use of hypnosis.

It is hoped that this paper may stimulate research and interest in this branch of medicine, especially in its application to general practice, and it may help to overcome the prejudice and scepticism of some members of the medical profession.

Summary

A report is presented of 120 cases treated by hypnosis in general practice. The technique and clinical effects of hypnosis are briefly described. Twenty-three cases were resistant to hypnosis.

The largest group of cases were the psychosomatics and psychoneurotics: 57 cases fully improved and 26 only partially did so.

Most of the resistant cases were amongst the obsessionals and adult asthmatics.

Cases of asthma in children, dysmenorrhoea, duodenal ulcer, petit mal, cardiac anxiety following an organic lesion of the heart, anxiety neurosis, and skin affection gave the best results.

Twenty patients who had resisted other methods of treatment recovered and were able to resume work after treatment with hypnosis.

Twenty-four patients were able to stop taking hypnotic, analgesic, and anticholinergic drugs, or drastically reduce their use, as a result of hypnotherapy.

Hypnosis, used carefully and sensibly, can be of great help in general practice, achieving results in cases which resisted more conventional methods of treatment.

Hypnotherapy compares favourably with psycho-analytical and physical methods in the treatment of psychoneuroses.

None of the treated cases showed any deterioration of their original condition as a result of hypnotherapy.

There is no evidence that any danger may arise from the use of hypnosis in medical treatment.

There is no special "gift" required to induce hypnosis.

The general practitioner is particularly well suited to use hypnosis as a method of treatment, as he is usually familiar with the patient's background and has his confidence, which is important for successful hypnotherapy.

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FLUCTUATION OF ARTERIAL BLOOD PRESSURE IN ASTHMA

BY

KLAUS A. J. JÄRVINEN, M.D.

Lecturer in Medicine and Assistant Physician-in-Chief at
 the First Medical Clinic, University of Helsinki,
 Finland

If the arterial pressure is measured by the ordinary auscultatory method during an attack of bronchial asthma, a few beats, usually two or three, will be heard at a higher level of pressure than the others. If the cuff pressure is kept at this level for several respiratory cycles, it will be noticed that these two or three beats of higher pressure occur at the beginning of each expiration. Usually the cuff pressure has to be lowered 20–30 mm. Hg before the point is reached where all the beats are heard. These fluctuations in the systolic pressure in bronchial asthma have been studied by Gauchat and Katz (1924), Katz and Gauchat (1924), Tinel and Jacquelin (1931), Rackemann (1931), Osgood (1943), Osgood and Ehret (1943). The following is a further study.

Material

The material comprises 33 patients (19 women and 14 men) with bronchial asthma. The diagnosis was clinically certain in all cases. Patients with other concurrent disease, or in whom severe emphysema or cor pulmonale had developed, were excluded. The mean age of the women was 47.8 years, and of the men 41.7 years.

On the basis of the severity of the clinical symptoms the cases were divided into three groups: (1) *Mild bronchial asthma*:—Only a few sibilant rales in the lungs; subjectively, no real dyspnoea; physical activity unrestricted. (2) *Moderately severe bronchial asthma*:—Sibilant rales throughout both lungs; subjectively, definite although not severe dyspnoea; auxiliary respiratory muscles not much used; hard exercise impossible. (3) *Severe bronchial asthma (involving primarily an attack or status asthmaticus)*:—Wheezing heard without a stethoscope; numerous sibilant rales and noises; dyspnoea so severe that the patient had to sit upright or lean forward to secure maximum use of the accessory muscles of respiration; patient hardly able to move.

The fluctuations in arterial pressure were measured by the ordinary auscultatory method with a mercury sphygmomanometer. As the changes in systolic pressure proved much easier to detect than those in the diastolic it was decided to observe only the former in this part of the study. Measurement was effected by finding, in the usual

way, the maximum pressure at which the first beats began to be heard. As noted above, the one to three beats coinciding with the beginning of the expiration were heard, especially in cases of severe asthma, at a considerably higher pressure than the other beats. These few higher beats are easily overlooked unless each even-number pressure-reading near the maximum is observed long enough—for not less than two complete respiratory cycles. Subsequently the cuff pressure was lowered by 5 mm. Hg at a time until all the beats could be heard continuously irrespective of the phase of respiration; the difference in pressure between the few higher beats and this pressure was recorded. The lowest beats (two or three) were found at the end of expiration and/or at the beginning of inspiration. During the most severe attacks of asthma, however, it was sometimes impossible to obtain a reading at which all the beats could be heard continuously during the whole respiratory cycle: before the lowest beats at the end of expiration were heard the ones at the beginning of expiration had vanished. In these few cases the systolic pressures at the beginning and end of expiration were measured separately. However, this was much more inaccurate than the method of measuring described above.

Results

As can be seen from Table I, the fluctuation in systolic blood pressure due to respiration increased with the severity of the bronchial asthma. In cases where the fluctuations were

TABLE I.—*Fluctuation of Systolic Blood Pressure Due to Respiration in Patients with Bronchial Asthma, Measured With a Mercury Sphygmomanometer*

Severity of Bronchial Asthma	No. of Cases	Fluctuation of Systolic Blood Pressure Due to Respiration (mm. Hg)
Mild	19	4±0.6
Moderately severe ..	9	13±1.5
Severe	5	25±1.7

recorded while the asthmatic symptoms were being relieved by adrenaline, there was a clear correlation between the range of pressure fluctuation and the severity of the symptoms. In three patients with severe bronchial asthma the fluctuation in systolic pressure was 25 (E. V.), 20 (A. N.), and 20 mm. Hg (L. E.). The corresponding pressure readings after the relief of symptoms by adrenaline were: E. V., 15 mm. Hg (symptoms still moderately severe); A. N., 5 mm. Hg (symptoms mild); L. E., 5 mm. Hg (symptoms nearly subsided). In two moderately severe cases of bronchial asthma the fluctuation in systolic pressure was 10 mm. Hg. After adrenaline had produced a nearly complete disappearance of the asthmatic symptoms none of the cases showed any demonstrable pressure fluctuation.

To investigate further the connexion between these fluctuations in arterial pressure and the degree of respiratory obstruction present, clinically healthy persons were asked to breathe through glass tubes of various diameters. The ratio of the resistance to respiration produced in this way (taken as corresponding to that during an attack of bronchial asthma) to arterial pressure was studied.

To start with, the *intra-arterial pressure* of the femoral artery of the test subject was followed during "tube respiration." The pressure was recorded by Sandborn's electro-manometer. All the tubes through which respiration took place were 10 cm. long. The largest diameter was 10 mm.; the tubes then successively narrowed in diameter (see Table II). During respiration the nose was pinched and the tube, fitted with a special mouthpiece, was held between the lips. The results are shown in Table II, which gives only the variation occurring in the course of single respiratory cycles, as pressure recordings obtained over a longer period were not considered fully comparable; for when an ordinary sharp syringe needle is being used to record intra-arterial pressure a change in its position in relation to the arterial walls may affect the results.