Hypnosis in Treatment

SIR,—Your correspondent Dr. K. M. Hay (September 17, p. 653) has expressed some misgivings about the therapeutic dangers of hypnosis on the basis of the theory described in his letter. I hasten to reply that those of us who employ hypnotherapy are not fully agreed that the dissociation theory can explain adequately the true nature of hypnosis. Dissociation does occur during hypnosis and is often facilitated by it, but this does not logically imply that hypnosis is merely a form of dissociation. For example, the variability and autonomy of the so-called dissociated symptoms seen during hypnosis cannot be accounted for by this theory any more than can the active and purposive participation of such symptoms in the total behaviour of the subject.

Changes in personality, as demonstrated by the Rorschach test, have been reported by various investigators. T. R. Sarbin (*Amer. J. Orthopsychiat.*, 1939, 9, 315) stated that there was an increase of "organizing energy" and the externally imposed *Aufgaben* circumscribed the response pattern to a greater extent than the self-imposed *Aufgaben*. Other personality changes have been reported when different moods have been produced under hypnosis, when anxiety is made to develop, or the subject is regressed. Such phenomena are not, as is suggested by Dr. Hay, indicative of a weakened personality but are merely changes of personality whilst in the hypnotic state. No evidence exists to suggest that these changes tend to become permanent.

Dr. Hay's conception of hypnosis as a mental assault by the hypnotist upon the subject is a false one cultivated by stage performers and charlatans. The true role of the operator in hypnotherapy is rather to introduce and guide the subject through the hypnotic experience, when the method becomes a truly valuable aid to the diagnosis and cure of mental illness. —I am, etc.,

London, W.14.

NEVILLE MURRAY.

SIR,—Dr. K. M. Hay (September 17, p. 653) in discussing hypnosis as a form of treatment states that a hypnotized person is "depersonalized," that his intellectual faculties are suppressed, and then his mind is influenced on the feeling level by the hypnotist. In other words, the hypnotic subject is a passive automaton blindly responsive to the suggestions of the hypnotist. The hypnotized subject, as any medical man who practises this science will tell you, is by no means an automaton; a suggestion takes effect only if it is consistent with the balance of forces of the individual's strivings, and his understanding and elaboration of a suggestion are likewise determined by his own personality structure. The suggestion is really autosuggestion, just as there is no education but auto-education, since it does not matter how much an individual is taught if he does not learn anything.

About a year ago I saw a girl with a cardiospasm that she had had for four years. The history revealed that it dated from the day her mother died. Under hypnosis she was told that she could not swallow the fact . . . that her mother died—that the mere thought of it stuck in her throat. It was through her intellectual faculties that understanding came and through the hypnotic power of suggestion that she was able to swallow.—I am, etc.,

London, W.1.

A. P. MAGONET.

Distinction Awards

SIR,—Would any advantage be gained if we were to take a hand and grade administrators, superintendents, and the like? The waste of medical man-power might be reduced in this way. Although an advantage, it is not always essential for a superintendent to be a medical man. From time to time I have worked under three unqualified men who managed to unify the various requirements of the different hospital committees economically and with satisfaction to all concerned. One sees medical men in their prime superintending and inspecting hospitals, planning, etc., when they could be better employed working at medicine or surgery, in which subjects they have long been trained. The extra cost to the country must be

considerable. Administrative work could well be left to older members. From long experience of the manner of it they might be glad to have a less strenuous and more regular and complacent mode of life during their declining years than they had when practising their profession.—I am, etc.,

London, W.1.

G. H. COLT.

A New Neonatal Syndrome

SIR,—It was with much interest that we read the article of Mr. W. G. Mills on a new neonatal syndrome (August 27, p. 464), and we would like to record the following case seen recently and which appears to be identical with the eight cases in his article:

Male child, born June 9, 1949, by caesarean section on account of placenta praevia. At birth there was some respiratory distress, and nikethamide was injected into the umbilical cord.

On June 10 "bruising" of the left buttock and perineum was noticed.

On June 13, on the left buttock there was a network of small superficial vessels and some large deep ones. The movements of the left leg were weak, and there was slight oedema of the left foot, which was not being moved spontaneously.

On June 17 the condition of the buttock was subsiding, and it appeared as if thrombosis was taking place. There was still considerable weakness of extension of the left knee and dorsiflexion of the ankle. The general condition was always excellent, and the buttock became normal. At the time of writing the left leg is much improved following orthopaedic treatment in a plaster.

The condition of the buttock was almost identical in size and shape with that shown in Mr. Mills's photograph.

There was in this case the common factor of an umbilical cord injection, and it appears to us that the postulation of intra-arterial injection of a drug leading to thrombosis is the probable aetiological factor. A puzzling feature of the condition is that it has only recently been described although many thousands of injections into the cord must have been given, with the risk of intra-arterial injection. It would be interesting to know if the condition has occurred with lobeline alone. If nikethamide is the only drug concerned, has its chemical formula been changed recently?—We are, etc.,

CRYSTAL BATES.

A. P. M. PAGE.

Nottingham.

Transfusion in Domiciliary Midwifery

SIR,—I have read with interest the controversy arising out of the letter of Dr. C. T. H. Whiteside (June 4, p. 1005) on the use of dried plasma in retained placenta. The following questions arise: (1) What is the maximum time during which a placenta may be left in the womb? (2) In a case of retained placenta with profound shock, what would be the ideal procedure to adopt—remove the placenta and then treat the patient for shock, or the reverse? (3) Which is the ideal fluid for intra-venous transfusion in such cases—whole blood, blood plasma, gelatin solution, or saline with glucose? (4) What is the best anaesthetic to use for removing an adherent placenta?

I am in agreement with the opening sentence of Dr. H. A. Logan's letter (July 23, p. 232) that "in these days of synthetic medicine, diplomas, etc., it is refreshing to read some of the facts of life as expressed by those capable of using their powers of observation and confirming them with experience." Having done 22 years of midwifery as domiciliary practice, and not possessing anything better to transfuse than normal saline with glucose for an emergency, my working procedure in cases of retained placenta has been as follows. If I am on the spot when the second stage of labour is over and the placenta does not deliver itself in one hour, I remove it under soluble thiopentone. If, however, the retention is attended with more bleeding than I feel happy about, the period of waiting is less, depending on the amount of blood lost and the contractility of the uterus.

The difficult problem is the woman about whom a call is sent after the placenta has failed to deliver, and who is therefore seen in varying degrees of shock or collapse. I can look back on eight such