ANXIETY REACTIONS IN HYPNOSIS

BY

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Many patients exhibit some minor degree of anxiety when the question of hypnosis is first put to them. This is a fairly normal reaction. It is of little consequence, and is ordinarily minimized by establishing good rapport with the patient before mentioning the idea of treatment by hypnosis.

At the Threat of Loss of Ego Control

A mild, transitory anxiety reaction in the early stages of induction is very common. This is associated with the relinquishing of voluntary control. The abandonment of volition is a threat to the ego. It would seem that, under these circumstances, anxiety functions as a warning that all is not well with the psyche. For example, when hypnosis is being induced by suggestions of relaxation, it often happens that the first few suggestions are accepted easily; the patient relaxes, the limbs become flaccid, the facial muscles lose their tone, and the lips tend to gape. At this stage, when the patient is just on the verge of abandoning ego control in favour of the therapist, there is an exacerbation of anxiety. It is manifested by a general increase in tension. The relaxation is not so complete; the naso-labial folds become more marked; there may be some degree of frowning of the brow and a slight tightening of the lips. If the anxiety is not recognized it may motivate the production of defences against hypnosis, particularly in the form of restlessness, which not only provides an outlet for the anxiety but also serves as an effective defence against hypnosis by relaxation. On the other hand, as soon as the anxiety shows itself the suggestions of relaxation can momentarily give way to suggestions of calm and ease and security. The patient becomes aware of the therapist's empathy; he is reassured; the affective relationship is intensified; and the anxiety is allayed.

This type of anxiety reaction occurs more frequently when rapport with the patient is inadequate. A satisfactory affective relationship with the patient prior to hypnosis makes it easier for him to introject the idealized figure of the therapist, and the abandonment of ego control becomes so much the smoother.

At the Sudden Awareness of Hypnosis

In other circumstances much more severe anxiety reactions may occur. Occasionally during the induction, patients experience a sudden violent paroxysm of anxiety. This is quite distinct from the mild anxiety described above. It occurs in patients who may have given verbal acquiescence to the idea of hypnosis, but who nevertheless really believed that they could not be hypnotized. The acute anxiety follows the patient's first awareness that he is in fact hypnotized and has lost voluntary control.

Some patients defend themselves against hypnosis by simulation. By consciously carrying out all the therapist's suggestions the patient feels that he obeys the suggestions voluntarily, and by so doing has avoided being hypnotized. Sometimes it is obvious that the defence is used in clear consciousness; at other times it would seem to be an unconscious mechanism. If the patient is allowed to persist with his defence he actually becomes hypnotized, but he is not aware of it until he is challenged. It is at this moment that acute anxiety may be precipitated. The reaction is accompanied by the physical signs of anxiety, pallor, tremor, sweating, dilatation of the pupils, and rapid shallow breathing. The pulse is rapid and may be thready or full and bounding. To this there may be added a certain degree of collapse. The suddenness with which the condition may

develop can be quite alarming. The natural impulse to terminate hypnosis and wake the patient must be resisted. Suggestions of relaxation, drowsiness, and eventually sleep are added. Provided the patient is kept hypnotized this episode is easily managed, but there is a tendency for the acute anxiety to bring the patient out of hypnosis. The anxiety comes on without warning, and develops very quickly. Accordingly, it is wise to deepen hypnosis immediately the first signs of anxiety are observed. It is obviously very important that the therapist does not communicate to the patient his own anxiety by any non-verbal or extra-verbal means.

A company director in his late forties sought relief from tension and depression. Two years previously he had been treated with narcoanalysis and E.C.T. without improvement. He was a hysteroid personality, and fancied himself as an amateur actor. On a verbal level he desired hypnosis. His first defence was by depreciation. He depreciated the whole situation. By non-verbal means he conveyed the idea that the whole thing was silly. Induction was made by arm levitation. On the first suggestion of lightness of his hands he immediately lifted his arms into the air. When movement was suggested he straightway waved his arms about. He was smiling all the time, and it was obvious that he was defending himself by simulation. Following suggestions, various antics were performed with his arms, and he was allowed to believe that the therapist thought him hypnotized. He was in no way challenged, and was dismissed without comment. The same procedure was repeated in the second session, and in the third session the patient was suddenly challenged to put his arms down. He was unable to do so, and immediately developed an acute anxiety reaction. The anxiety was controlled by a deepening of hypnosis, and by allowing the patient to lie down. Subsequent hypnosis was uneventful.

At the Sudden Awareness of Repressed Material

A more common type of anxiety reaction occurs when a patient suddenly becomes aware of repressed traumatic material. Of course, this kind of reaction may occur in any type of reductive psychotherapy, but it occurs more readily in hypnoanalysis because the hypnotic state can allow the sudden surge into consciousness of repressed conflicts. In this respect it is important to distinguish between release of repressed material and awareness of the material. It would seem that, so long as the patient remains reasonably deeply hypnotized, the release of repressed material, by verbal ventilation, by acting out, or by projective techniques, does not produce anxiety. The hypnotized patient can express the traumatic conflicts in words, he can abreact and express the emotion appropriate to the conflict without producing anxiety; but if, for one reason or another, the hypnosis becomes lighter and the patient is able to comprehend in consciousness what he is expressing, then there may be a severe acute anxiety reaction. There is danger in the therapist becoming too interested in the content of the repressed conflicts and failing to keep watch on the depth of hypnosis. Abreaction itself may lighten hypnosis to such an extent that the patient may wake spontaneously, and in such circumstances acute anxiety may result.

There is another factor. Sometimes the production of anxiety from the sudden awareness of repressed conflicts is dependent on the means by which the repressed conflicts are expressed. In hypnoanalysis the conflicts are ordinarily expressed in words. Material that is too traumatic to be borne in consciousness is dealt with by the various psychic defence mechanisms and is again repressed, so that, on waking, the patient may remember the less traumatic incidents but has a spontaneous amnesia for the more traumatic material. But in hypnography—a technique in hypnoanalysis in which the hypnotized patient projects his conflicts by painting or drawing—these defence mechanisms cannot work so easily. The spoken word is transitory; it is easily repressed and forgotten. The painted representation of a conflict has a degree of permanence. The patient is confronted with it, and it tends to impress itself much more on his conscious awareness. Although the paintings are removed before the patient is awakened from hypnosis,

experience suggests that this type of acute anxiety reaction tends to occur more often during hypnography than in verbal hypnoanalysis.

An inadequate, dependent young man was receiving treatment for loss of confidence. When hypnotized he was given a crayon and told that his hand would draw something that represented his problems. With a rhythmical movement he made a series of marks on the paper. He became more and more preoccupied with what he was doing. The rhythmical character of the movement became more pronounced. His expression was very intense, and it seemed obvious that the drawing was a sexual equivalent. He began to verbalize his thoughts, and the sexual nature of the activity was confirmed. He abreacted a good deal of emotion. Hypnosis became lighter. He suddenly turned very pale and started to sweat. He woke from hypnosis spontaneously. In a shaky voice he said that he thought he had woken up and thought he was going to vomit. He became intensely tremulous; the sweating was profuse; his pulse was rapid and of poor volume. He looked alarmingly ill. He was immediately rehypnotized and given suggestions of calm and well-being. His physical condition was restored in ten to fifteen minutes. In subsequent sessions care was taken to maintain an adequate depth of hypnosis, and no further complications were encountered.

At the Inability to Fulfil a Post-Hypnotic Suggestion

Post-hypnotic suggestion is the spear-head of suggestive therapy, but this extremely useful weapon may at times be the means of precipitating an acute anxiety reaction. There is an extremely compelling quality about a post-hypnotic suggestion, and if the patient is unable to carry it out an acute anxiety reaction may result. In this respect it does not matter whether the patient is prevented from fulfilling the suggestion by reason of outside environmental factors or by reason of psychic factors within himself.

Accordingly, in suggestive therapy, specific post-hypnotic suggestions are best used sparingly and only when it is as certain as possible that the patient has both the material and the psychic means of carrying out the suggestions. On the other hand, non-specific post-hypnotic suggestion has not the same power to produce anxiety reactions, but nevertheless can give suitable patients considerable symptomatic relief.

A man of obsessive personality sought relief from particularly intractable insomnia of many years' duration. The severity of the insomnia had been confirmed by the hospital night staff, who reported that the patient hardly slept at all. He had previously been treated by narcoanalysis, "somnifaine," and E.C.T. without benefit. At different times he had been addicted to both paraldehyde and chloral hydrate. He also complained of irritability and uncontrollable rages. He was easily hypnotized, and after several sessions he was given the strong post-hypnotic suggestion that he would sleep each night without sedative until I saw him in a week's time. He was unable to fulfil the post-hypnotic suggestion, and arrived for the next appointment in a state of acute anxiety and covered with a generalized dermatitis. He was given suggestions of calm and relaxation, and ordered to take a sedative at night. In a week's time both the anxiety and the skin condition had subsided. He subsequently gained almost complete relief from the irritability and rages, although the insomnia persisted.

Discussion

Recent British and American literature suggests that there is a revival in the use of hypnosis, not only by psychiatrists using specialized hypnoanalytical techniques but also by the profession in general. Fortunately, acute anxiety reactions are not common, but when they do occur they may be alarming on account of the severity and the rapidity of onset. During the hypnotic session such reactions may occur from the sudden realization of having been hypnotized, or following the sudden awareness of repressed material. In each case the situation is met by immediately increasing the depth of hypnosis or by rehypnotizing the patient. Hypnosis with suggestions of calm allows the usual psychic defence mechanisms to re-establish themselves, and material that is too traumatic at the present degree of insight is automatically repressed again. Any attempt to deal with this type of acute anxiety at a conscious level is likely to get out of hand, and is best avoided.

Anxiety reactions from the inability to fulfil a post-hypnotic suggestion usually occur in the absence of the therapist. Such reactions can be minimized by using non-specific post-hypnotic suggestion, where possible, in place of specific suggestion. Specific suggestion should be used only when it is reasonably sure that the patient has both the physical and the psychic ability to fulfil the suggestion.

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TRAUMATIC RUPTURE OF THE PANCREAS

BY

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Traumatic subcutaneous rupture of the pancreas is a relatively rare condition. It was first reported by Travers (1827), whose patient was crushed by the wheel of a coach. The subject was reviewed by Stern (1930). Phillips and Seybold (1948) noted that the diagnosis was made pre-operatively in only 4 out of 15 cases found in the literature of the previous ten years. The pancreas lies deeply in the abdomen and is normally well protected against possible injury. However, Aldis (1946) pointed out that if the abdominal muscles happen to be flaccid at the time of injury the pancreas may be crushed against the vertebrae, even by mild force. A variety of other mechanisms may cause pancreatic injury; in a case described by Keynes (1944) rupture was apparently due to blast from an under-sea explosion. As might be expected, injury to the pancreas is often accompanied by damage to other abdominal organs, as in Travers's case, when both duodenum and jejunum were involved. This often complicates early diagnosis but makes operative treatment imperative. The case reported below was one of complete rupture of the pancreas occurring as an isolated injury due to an apparently minor blow.

Case Report

The patient was a young man, aged 20, in good health, with no previous medical history of note. About 24 hours before admission to hospital, while playing football, he had received a blow in the epigastrium from a player's knee. He felt "winded" and nauseated at the time. After a brief rest he returned to the field of play, but had to leave after a few minutes because he felt dizzy. He was able to go home after visiting the casualty department, where no serious symptoms or signs were found. Only slight epigastric pain was felt over the next few hours, but after a meal he vomited three times. The pain also became severe in the entire upper abdominal area. It was worse on moving and hiccuping. There was no pain in the shoulders or back. The pain and vomiting persisted during the night until his admission to hospital the following day.

When first seen he seemed in good general condition and had only moderate epigastric pain. The axillary temperature was 99.2° F. (37.3° C.), the blood pressure 120/80 mm. Hg, and the pulse 88. He was well coloured, the extremities were warm, and the veins were well filled. There was no wound or bruising of the abdominal wall. Only a minor degree of abdominal tenderness was present, generalized but more noticeable on the left side of the abdomen and in the left flank. No true rigidity was found, but there was some increase in muscle tone, again more pronounced on the left side. It was thought that a small amount of fluid was