on the tests were so good, the family once again called to report the news to me.

## Comments

These two cases illustrate the use of hypnoidal intervention in the psychological treatment of trauma in youngsters with chronic illness. The value of hypnoidal techniques is often unrecognized. They are an underutilized resource for the clinician working with chronically ill children. Children's easy movement between reality and fantasy, their capacity for imaginative involvement, and the rapidity with which they become entranced allow the use of hypnoidal techniques. When these techniques are interjected in treatment in a developmentally appropriate manner for empowerment, mastery and ego-strengthening these youngsters can experience a rapid resolution of PTSD symptoms. Like Billy and Susie who benefited from Show and Tell at school, the chronically ill youngsters can benefit from showing and telling their stories.

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# Preparation of Patients for Stressful Medical Interventions

## Some very simple approaches

*Christel J. Bejenke*

■ *Physicians who treat somatic conditions usually assume that hypnosis is not applicable to their practices because of the time required to learn and to apply it, and because they believe that their patients would be neither interested nor benefit sufficient to justify such efforts. The author shows that patients about to undergo medical interventions are exceptionally receptive to approaches derived from, or related to hypnosis. She gives examples of those approaches which require no additional time with patients and no special training for physicians. These are applicable to practically all medical specialties and can be of significant benefit to patients and physicians.*

The degree of distress patients experience in the period surrounding medical interventions is often underappreciated: Many patients are fearful, bewildered, overwhelmed, and feel intimidated. They may experience a sense of helplessness, dependence, and loss of control. They frequently see themselves as victims of their illness, of a 'hostile system', and as passive recipients of complex medical technology.

Our patients deserve to have strategies available which can alter these perceptions. But physicians who treat somatic conditions are reluctant to consider hypnosis even when they believe that hypnotic approaches might be beneficial:

1. They don't have the time to learn sophisticated hypnotic techniques.
2. They believe that much additional time must be spent with patients in order to achieve the desired results; yet such time does not exist in our practices.
3. And finally: our patients don't come to us to be hypnotized! They consult us to have somatic medical needs taken care of.

My experience as an anesthesiologist who has used hypnotic strategies with over 3000 patients, has taught me that benefits can be achieved surprisingly quickly and much more easily than is commonly assumed. In fact, in order for our patients to benefit,

1. We do *not* have to have extensive training in hypnosis.
2. We do *not* have to spend much additional time with our patients.

3. We do *not* have to schedule formal hypnosis sessions for patients.

As you may know, anesthesiologists often have only minutes to spend with a patient before a procedure, yet it is possible to achieve rapid and lasting beneficial effects in those few minutes. If this is possible in anesthesiology, it can work for other medical disciplines as well.

## Characteristics of patients under conditions of stress

Let me summarize what I have observed to be common characteristics of patients who are in the process of undergoing stressful medical procedures and which can lead to simple, effective approaches (Bejenke, 1993, 1996a).

1. Patients become exceptionally susceptible and vulnerable to suggestions.
2. Statements made during seemingly ordinary states of consciousness can function as suggestions which are as powerful as those given in formal trance states. This observation corresponds to that of Cheek (1962) that surgical patients behave as though hypnotized. In other words: a formal hypnotic state is not required in order for suggestions to become effective.
3. Non-verbal communications such as body language, sighs, 'pregnant pauses', glances, can function as equally powerful suggestions.
4. This state of heightened suggestibility extends from the moment a stressful intervention is contemplated until complete recovery.
5. Statements or words with negative connotations will usually elicit negative responses and result in detrimental effects, while those with positive connotations can elicit beneficial effects and can be utilized therapeutically.
6. Certain hypnotic laws appear to be operand: for example the laws of "dominant effect" and of "persons of superior authority." Thus, statements by persons of authority (e.g. physicians, nurses) are particularly powerful, while others may have little or no effect. There also appears to be a hierarchy of authority. Who qualifies as "authority" is determined by the patient's perception and can range from an orderly to a physician.
7. Patients exhibit characteristics which are commonly associated with the hypnotic state such as: "focused attention," "conscious amnesia," being very literal, concrete, suspending critical judgment (Bonke, 1990).
8. Patients are exposed to suggestions throughout their medical encounter whether suggestions are made intentionally or not.

## Implications of such patient characteristics and their utilization

As a consequence of such patient characteristics, any interaction between caregivers and patients may assume significantly greater importance than expected and can have unanticipated results. This was dramatically illustrated by a patient for whom I had administered hypnoanesthesia for a major operation which she had undergone in complete comfort. However, she experienced excruciating pain postoperatively. The reason for this was eventually traced to a seemingly innocent remark her surgeon had made many weeks earlier. Recognition of this made it possible to resolve the problem (Bejenke, 1966, 1993). Physicians may therefore wish to be mindful of such possibilities during any seemingly innocent, casual conversation with or comments to patients.

Simultaneously, these observations imply that *we can speak to non-hypnotized patients in hypnotic language*. In fact, without having to take time for induction and deepening we can move directly to utilization. These observations further imply that therapeutic suggestions can become an integral part of our usual interactions with patients. Because each item of communication can contain suggestions, we should learn to choose our words as wisely as we do when employing hypnosis formally. For this very reason, nearly all suggestions mentioned in this presentation can be used without, but equally well with, hypnosis.

An integral part of patient preparation includes information and instructions. Egbert (1963, 1964, 1986) showed, that an interaction which includes these components is not only more effective than pharmacological sedation in reducing anxiety, but it also decreases postoperative analgesic requirements. In language which the patient can understand, information and instructions must be specific enough in order for the patients to gain an adequate understanding of the anticipated events, sensations and of his role in participating in the process. Surprisingly, patients are not frightened by such details. Instead, sufficient details increase his coping skills and sense of control; allow him to experience himself in active partnership with his care team; maintain or restore his sense of competence, self-mastery and independence; and help retain his dignity.

As a consequence, such simple interventions result in a number of benefits:

1. Relief of anxiety.
2. Improved sleep before the procedure.
3. Reduction or elimination of preprocedure sedation.
4. Reduction of physiologic stress responses.
5. Reduction of intra- and post-procedural pain.
6. Enhanced recovery: patients awaken post-operatively calm, comfortable and characteristically "smiling" - an uncommon sight in a recovery room.
7. Reduction of nausea and vomiting.
8. Earlier mobilization, discharge, and resumption of professional activity.
9. Improved patient cooperation, even when complications arise. They are reasonable, rational, and pro-active.
10. In addition, this approach offers a possibility to counteract the terror patients would normally experience, should unexpected intra-operative awareness occur. A prepared patient may not be overwhelmed by otherwise unexpected and not understood experiences.

Patients' comments reflect the quality of their experiences: "If it didn't sound odd, I would say this operation has been a good experience"; or a patient profoundly frightened before his extensive cancer operation followed by a second operation within several months: "One thing I know: I will never, ever be afraid of surgery again".

## Applicability of this approach

In the following I would like to briefly delineate some approaches which, for the purposes of the pragmatic practicing physician who has little time, may remove hypnosis from the realm of an esoteric curiosity. I hope to show that hypnosis can be an eminently simple, practical and useful tool for patient preparation in a wide variety of medical interventions such as surgery (all specialities); endoscopies (pulmonary or intestinal); invasive radiology; invasive cardiologic procedures such as angiography, pacemaker insertion, and angioplasties; for patients who are expected to spend time in the Intensive Care Unit; for anticipated prolonged artificial ventilation, chronic renal dialysis, in preparation of organ or bone marrow transplantation; in obstetrics; and particularly for cancer patients (Bejenke, 1995) in all aspects of the diagnostic and therapeutic interventions they must undergo, including chemotherapy and radiation.

## Common negative suggestions and possible modifications

Before embarking on describing *helpful* approaches in detail, let me give a few examples of statements by medical caregivers to which hospitalized patients are commonly exposed.These seemingly innocent communications can have unintended negative effects. (Their possible meaning to the patient is stated in brackets):

a) "You will be put to sleep" (for many a euphemism for death, especially for children who have lost a beloved pet or grandparent).
b) "You'll go under ... " (a symbolism for drowning).
c) At end of an operation: "It's all over," "You're finished" (I am dead, dying).
d) After surgery: "Let me know when you have pain;" "Tell me when you start hurting" (there will be pain, it is only a matter of when and how bad).
e) In the recovery room, as the nurse places the emesis basin next to the patient's face: "I'll put this here so you have it when you get sick (when you need it)," "Tell me when you want to throw up" (I am expected to and will get sick and throw up).

Identical information as contained in the above statements can be transmitted with neutral or positive connotations:

for a) and b): "An anesthesiologist will administer your anesthetic. Anesthesia has to do with comfort. And the anesthesiologist will be there with you and watch that everything is safe while you are very relaxed ... "

for c): "Good morning! (afternoon/evening)" (cheerfully). "Dr. XYZ just finished your operation and you are safe ... Pretty soon you will be very clear-headed and





maybe very surprised how much easier everything has been for you ... and how much better you can feel than you had thought ..."

for d): "Let me know how I can make you more comfortable" (followed by examples); "Can I make you more comfortable?"

for e): One does not need to put an emesis basin at the patient's face - especially not with this type of comment (an old, but common habit). If necessary, it can be reached quickly. When patients do vomit, this can be utilized positively: "Good! You're rid of that! Your stomach just was not in the mood to digest that stale stuff. Now you can feel so much better and you can already look forward to quenching your hunger and your thirst just as soon as Dr. XYZ says it's good for you ..."

Equally negative effects can result from well intended admonitions like: "Just relax" which only confirms to the patient his inability to do so and further increases his sense of helplessness; or "Don't worry." What the patient does hear is "worry" and that he will do. In contrast, instructing the patient *how* to relax *is* helpful as are *reasons* why he does not have to worry.

## The pre-procedure visit

Possibly the single most important interaction we have with our patients is the pre-procedure visit, for it sets the stage for, and determines whether, the patient's entire medical experience until eventual recovery will be a positive or negative one. It is therefore important that we use this opportunity well. For maximal effect, the key elements of *instruction, information*, and *suggestions* will be creatively intertwined and thus enhance each other.

### *What types of suggestions are useful for this approach?*

When suggestions without formal hypnotic induction, also known as waking suggestions are part of the usual pre-procedural visit, they are a part of an ongoing dialogue and are therefore spoken in an ordinary, conversational tone and manner. It is obvious that direct, authoritarian suggestions (e.g. "you will feel no pain" or "you will not be nauseated and will relish every food offered to you with a great appetite") would not be appropriate under such circumstances. This is not how we normally speak to patients and they would find it absurd.

On the other hand, patients experience *indirect, permissive, open-ended suggestions* as part of normal conversation. This type of suggestion allows the patient options and choices, respects his individuality and freedom of choice, and does not invite resistance. These suggestions challenge only his creativity and encourage him to come up with even better solutions. Anyone not experienced with hypnosis would not even recognize this type of suggestion as such. (The following examples are drawn from my own practice as an anesthesiologist, but require little or no modification for other specialties.)

Example (addressing a patient's fear of pain and nausea indirectly): "Wouldn't it be

nice if it could be a whole lot different for you this time; and quite a bit easier than you thought." Please note: no promises are made; but the patient is offered the option to modify his expectation and to re-interpret the experience and sensations more positively.

This example shows that even clinicians who have no experience with hypnosis can use suggestions, because this type of suggestions can be imbedded unobtrusively into routine conversations. We don't need to worry whether these suggestions will be acted upon: the patient is simply given this option as another choice, - and most patients will take it. With this approach there are no challenges to the practitioner nor to the patient and therefore one can hardly fail. Those clinicians already skilled with hypnotic techniques may discover that the benefits of informally given suggestions do not vary appreciably from those achieved by formal hypnosis. They can even use waking suggestions as if rehearsing a procedure in trance and thus beneficially influence their patients' experience of a feared procedure.

### *Examples of helpful preprocedure suggestions*

I would like to select a few examples which can give a sense of how verbalizations can be structured. (You might like to count how many suggestions each verbalization contains and how many issues are addressed).

"Often patients are very pleasantly surprised ... when they hear me tell them ... that their operation is already taken care of ... And I don't know whether you will be more surprised ... that everything might seem to have gone so quickly ... or more surprised that you can wake up so easily ... or even more surprised that you can feel a whole lot better than you might have expected ..." (Note: No promises are made! Multiple binds are used. Number of suggestions: 5)

"Often patients tell me that they feel such a sense of relief ..." (Relief of what? I don't specify: the patient will interpret it in the way most appropriate to him at the time.)". ... when they become aware of that pressure underneath the bandages ..." ( "pressure" defuses the fear of "pain") " ... as they were waking up in the recovery room ... Because then they know that the operation is safely finished ... and that healing has already begun ..." (Number of suggestions: at least 5, possibly more, depending on that patient's situation.)

Even in non-hypnotized patients the hypnotic technique of time progressions can be used effectively without being perceived as anything other than ordinary conversation: "When you look back after your operation ... you might discover that ... [the hard part was not that operation at all, but that which you have already behind you now: going to the doctor, getting all that information, making the decision, etc."]. In addition to other benefits, this technique counters the fear of dying during the procedure, since the procedure is viewed from the perspective of having recovered from it.

It is useful to *involve all senses,* but, since sound is the most persistent (explicit and implicit) perception even under profound sedation and anesthesia, it is the important sense to focus on. The cacophony of hospital sounds are distressing to patients. It is







wise to prepare patients in advance that there will be noise. But instead of allowing it to become the usual trigger for distress, the patient is offered the option of interpreting it as a basis for security. Thus we utilize it as a signal for re-assurance and comfort: "As you already know ... there are many sounds and conversations in the operating room, ... and you might find it very reassuring to hear the hustle and bustle that goes on ... which lets you know ... that everything that is happening in that room ... happens only for your benefit ..."

Drawing attention to sounds which are guaranteed to recur, can be a cue for the suggested response to be activated whenever the sounds occur; even post-operatively: "So, when you hear the beeping of the many monitors and machines ... it lets you know that you are safe ... because everything is being watched so closely ... And when you hear that huffing and puffing of the breathing machine ... and when you feel your chest rise and fall with those long easy (!) breaths ... which the machine helps you take ..." (the machine "helps"!, it does not overpower, or force )" ... this lets you know that you can relax even more ... because the machine is doing even the work of breathing for you ... And all these sounds let you know ... that there is someone watching these sounds ..." (this counters common fear during awareness that no-one is watching; c.f. Moerman, Bonke & Oosting, 1993) . "... and watching you ... to make sure that everything works as perfectly as possible ... and that you are safe ..."

"You are safe" is one of the most important statements a patient can hear pre-, intra- and post-operatively. Since we can assume that the patient will be exposed to negative suggestions, it is important to prepare him in such a way that he can disregard or reject them, for negative 'implants' are not easily erased, canceled, or modified after the fact.

### *Addressing specific functions and problems*

Somatic and autonomic functions can be influenced by suggestions with or without formal hypnosis such as: peristalsis, i.e. for early resolution of post-operative ileus (Disbrow, Bennett & Owings, 1993), decreased bleeding (Bennett, Benson & Kuikern, 1986; Enquist) tolerance of bladder catheters, resumption of spontaneous voiding after procedures which are commonly followed by urinary retention (Bejenke, 1966), nausea and vomiting.

You will have noticed that I have alluded repeatedly to suggestions intended to protect patients from possible adverse consequences of awareness under anesthesia. Today there is even greater justification to be attentive to this possibility than in the past when Cheek's (1959, 1960, 1962a, 1962b, 1964a, 1964b, 1966) and Levinson's (1965) reports were largely disregarded by surgeons and anesthesiologists. Numerous studies were presented at three international symposia on the subject, including retrospective (Moerman et al. 1993; Blacher, 1984) and experimental evidence(Bennett & Davis, 1984; Kaiser et al., 1993; Schwender et al., 1994) which have unequivocally demonstrated its occurrence. It has further been shown that potentially serious consequences such as post-traumatic stress disorder (Macleod & Maycock, 1992; Howard, 1987)

have accounted. This obligates us to take action (Bejenke, 1995) which can include hypnosis-related approaches.

Suggestions with or without trance are also helpful in preparing patients to tolerate common distressing devices such as endotracheal tubes, mechanical ventilation, paralysis in ICU (euphemistically called "muscle relaxation"), bladder catheters, chest tubes, or nasogastric tubes.

## Precautions

It cannot be emphasized emphatically enough that giving positive suggestions *never* means deception, nor making unrealistic or exaggerated claims. Scrupulous adherence to presenting medical facts thoroughly, without minimizing potential problems, is mandatory. Risks must be presented honestly, and placed in proper perspective. The patient is, however, given an opportunity to re-interpret sensations or experiences positively. Of course such an approach does not end with patient preparation. It is continued during induction, maintenance, emergence from anesthesia and in the recovery room. It benefits, adults and children in elective and emergency situations and under numerous other circumstances (Bejenke, 1966).

## Conclusion

Let me close by illustrating what such an approach can achieve in an average situation by describing my last case before getting on my flight to Munich: Mrs. Green, scheduled for a total thyroidectomy because of malignancy, was extremely apprehensive, had not slept for some time and her blood pressure was dangerously high (225/125), despite taking powerful antihypertensive medication. After our routine pre-anesthesia visit she said she was more relaxed than she had been in a long time and her blood pressure had dropped significantly to near normal (150/87). She slept without a sleeping pill the night before surgery. Upon arrival at the hospital on the morning of the operation, her blood pressure was completely normal (134/84) and she was very relaxed. Her operation went well. She awoke immediately after the last suture had been placed, while the endotracheal tube was still in her windpipe. (As you may know, an endotracheal tube in a conscious or semi-conscious patient usually causes severe coughing and straining - anesthesiologists call it "bucking"). Mrs. Green, however was smiling (something patients rarely do right after an operation, but never when they have a tube in their trachea); she followed my instructions calmly and the tube was removed - without any difficulty - when it was appropriate. She continued smiling throughout her recovery room stay and experienced a very comfortable recovery.

Many of you, while listening to this presentation, will have discovered that much of what was presented is what you have always done. I hope I have been able to show that hypnosis related approaches are not as foreign to physicians as some might think, for, on reflection, I believe that every good and effective physician has been using such





techniques from time immemorial to this very day - albeit without having a sophisticated name for it. We can hone those skills, which many of us have developed intuitively - by trial and error, or by using what works, or by taking advantage of knowledge which has been around for a long time. Furthering one's understanding of modern hypnosis may be additionally useful.

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# Marie - A Swedish Case of Apparent Anxiety Disorder, Showing up to be a PTSD and DID (NOS), as Uncovered by Hypnosis

*Susanna Carolusson*

■ *I want to convey, from my own experience, that the therapist's curiosity about the dissociative phenomena doesn't create the diagnosis per se. Before Marie, I treated several patients sufferring from repressed childhood trauma, with ego state therapy (Watkins, 1992). I regarded dissociation only as a therapeutic tool, utilizing some normal dissociative tendencies, experienced as having different roles, aspects or states evoked by various contexts or environmental demands. So, one purpose with this presentation is to leave it to the reader to discover, as I did, that the characteristic dissociative phenomena of this patient were quite strong and part of her defenses against childhood trauma. The PTSD diagnosis has, as one of its criteria, some somatic symptoms. Is it possible to regard the onset of Marie's multiple sclerosis and later in therapy her tinnitus, as a result of trauma and decompensation of defenses against trauma? The question is controversial unless theory includes a perpetual link between psyche and soma. In this case presentation, I will put some of my retrospective reflections in brackets.*

Marie, a married woman with two children, requested hypnotherapy in order to obtain relief from symptoms that had not disappeared despite a two year psychotherapy a few years earlier. The remaining symptoms were nightmares with a recurrent theme of witnessing a murder and before falling asleep, fading away and feeling herself loosing her breath. These anxiety provoking symptoms appeared every time she was coming into a phase of multiple sclerosis, from which she also suffered. The interview disclosed some marital problems and a family background with absolutely no memories of closeness and trust. As a child, Marie's dog was her only comfort. In therapy, we continually used hypnosis both as a diagnostic tool and as a way of enhancing her immune system to help her ease her phases. Marie knew very little about hypnosis and was unfamiliar with hypnotherapeutic concepts or ideas. Neither did I introduce any theoretical assumptions about hypnotic, dissociative or trance phenomena.