Chapter 1

HYPNOSIS: AN INTRODUCTION

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It is generally agreed that the modern history of hypnosis dates back to the late18th century with Mesmer. However, it was the Scottish physician, James Esdaile (1850), who first documented the use of hypnosis in the control of pain. Just prior to the development of chemical anesthesia, Esdaile was using hypnosis widely in India as the only form of anesthesia for amputations, tumor removals, and other complex surgical procedures. Overlooked in Esdaile's reports was the finding that most of the patients survived surgery! This finding was especially compelling because at that time most surgical patients died because of hemorrhage, shock, and infection.

As well as controlling surgical pain, hypnosis may have led to autonomic and immunologic effects that minimized the complications of the surgical techniques of the time. Esdaile's surprising result is only now beginning to attract research interest. Clinical reports document that hypnosis has been used as an effective technique to control chronic pains (Sacerdote, 1970; Hilgard & Hilgard, 1975). Only a few studies demonstrate the value of hypnosis in hemophiliac (Dubin & Shapiro, 1974) and cancer patients (Domangue & Margolis, 1983), and when used preoperatively or during surgery to reduce bleeding volume and time (Bennet, Benson & Kuiken, 1986) or to facilitate postoperative recovery measures (Enquist, Konow & Bysted, 1996), as well as reducing pain and postoperative medication (Turner & Chapman, 1982).

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The aim of this chapter is to provide an introduction to the understanding of hypnosis within the context of pain management, especially focusing on clinical techniques relevant to the control of pain.

THE NATURE OF HYPNOSIS: AN OVERVIEW

The popular notion that hypnosis is a form of suggestibility is certainly an oversimplification (Hammer, Evans & Bartlett, 1963; Hilgard, 1965), even though this definition has dominated the otherwise impressive research on hypnotic phenomena from the 1930s (Hull, 1933), through the 1950s, (Weitzenhoffer, 1953) until now. Although it is agreed that response to suggestion is an important aspect of what happens during hypnosis, it is also generally agreed that hypnosis is a more complex phenomenon (Lynn & Rhue, 1991).

Some authors emphasize the social-psychological or social-cognitive interaction between the hypnotist and the subject as central to hypnotic behavior (Barber, 1969; Chaves & Brown, 1978; Diamond, 1977; Sarbin & Coe, 1972; Spanos, 1986; Wagstaff, 1981). For these authors, pain reduction involves interpersonal processes or self-generated cognitive and motivational strategies such as anxiety reduction, attribution, conditioning, distraction, focusing attention, forgetting, imagery, reallocation of attention away from the symptom, reframing, role playing, social contagion and compliance, and verbal relabeling. All of these strategies may be useful in controlling pain, especially when the pain is acute. In the social-psychological model, these strategies are facilitated by the hypnotic relationship, although it is often not clear how this is achieved. The hypnotic induction procedure itself and individual differences in hypnotic ability are usually considered incidental and unimportant.

Another view of hypnosis is that it reflects a stable capacity of the individual. It is viewed, often controversially, as a special state of consciousness, or, in psychodynamic theory, as a manifestation of the unconscious mind (Brown & Fromm, 1986). Some clinicians view hypnosis as the preferred way to access unconscious processes. Hypnosis may facilitate wishes or emotions, memories of trauma, and loosen defenses, mostly through the use of metaphor and guided imagery (Erickson, 1980; Rossi, 1993; Cheek, 1994). Such concepts are very difficult to test empirically, even though they may lead to

compelling and clever clinical applications.

In a formulation that leads to more direct empirical investigation, hypnosis is considered in terms of dissociation theory. The hypnotic experience may involve an ability to readily change states of awareness or levels of consciousness. These changes in consciousness may be either interpersonally- or self-induced (Bowers, 1976; Evans, 1987; Hilgard, 1965, 1977). Hypnosis may be considered in terms of neodissociation theory or multiple cognitive pathways. For example, the pain patient simultaneously knows and does not know the severity of the pain. The awareness of pain and the analgesic experience are co-conscious (Hilgard, 1977). A similar process occurs during dental analgesia: during drilling, the patient reports feeling no pain, but retains the ability to know when the dentist is drilling at a site which should be painful, and even to know how much the drilling would hurt without the injection. In hypnosis, as in this example from dental analgesia, cognitive and somatic mechanisms are available to block or transform pain messages and sensations through controls in levels of consciousness. Pain awareness and hypnotic analgesia are co-conscious (Hilgard, 1977). Hypnosis may involve a more general cognitive flexibility, or switching mechanism, that allows one to change and control psychological, cognitive, or physiological processes, or readily access different levels of consciousness (Evans, 1987; 1991).

FOUR DIMENSIONS OF HYPNOTIC BEHAVIOR

It is useful to consider the domain of hypnosis as consisting of at least four conceptually independent constructs or dimensions. Noting which dimension an author is discussing will help the reader understand why hypnosis is a controversial field. Each dimension will have direct implications for the different ways hypnosis is practiced in the area of pain. Although these conceptual dimensions comprise the domain of hypnosis (Hilgard, 1973), most accounts of hypnosis usually focus on only one or two of them, leading to incomplete and even misleading conclusions.

1. Expectations and Beliefs about Hypnosis

The first of the four dimensions of hypnosis is an *expectation,* faith, or belief variable. It is probably common to any therapeutic modali-

ty and has its foundation in the special doctor-patient relationship. Laymen generally think of hypnosis as a quasi-magical technique, and also as something that is done to them. The typical chronic pain patient will arrive at a hypnosis treatment session with the expectation, "Doc, I understand that you're a hypnotist. Do it to me, fix me so I will feel better."

To appreciate the importance of expectations about hypnosis, note how much the practice of hypnosis has changed over the past 200 years. Considered the father of modern hypnosis, Mesmer is claimed to have hypnotized people by the thousands in Paris after he had been banished by the conservative Vienna medical establishment. The principles of physical magnetism had just been discovered. Mesmer (1779) argued that *animal magnetism,* or field forces that could be rearranged with magnets, could cure physical illness. At the height of his popular practice, he would hold seances where people would gather around tubs filled with water and iron filings, with metal rods protruding. When a participant arrived to be healed he or she would hold a metal rod, or hold somebody's hand, who in turn held a metal rod. As doctors do these days, Mesmer often arrived late (he often entertained ladies at the French Court), dressed in the purple robes of royalty (as some famous hypnotists still do, superstitiously). As many healers have done throughout the centuries, he would lay his hands on the nearest person. First that person, then the next person, as in a ripple effect through an audience, would immediately go into "hypnosis." What was hypnosis like then? One after the other, the participants fell to the ground and had a hysterical seizure. After the seizure, they fell into a deep sleep for a few seconds or sometimes several hours. When they awakened, they were allegedly cured of whatever ailed them. I personally know hundreds of colleagues who practice hypnosis with thousands of clients, but I do not know a single colleague who has reported that a patient went into trance, falling onto the floor with a seizure. In just 200 years, the nature of the hypnotic phenomenon has changed that much. This kind of behavioral compliance is not hypnosis. Responses may occur during a hypnotic session which may have nothing to do with hypnosis per se. They may be a result of the demands of the shared expectations and the need to be a compliant subject.

We (Evans & Mitchell, 1977) have shown this contagion-like compliance in hypnotic performance. During the administration of the

Harvard Group Scale of Hypnotic Susceptibility (HGSHS:A, Shor & Orne, 1962), subjects who sit next to each other score more alike than neighboring subjects sitting further apart. When the same subject pairs are compared on the individually administered Stanford Hypnotic Susceptibility Scale: Form C (SHSS:C, Weitzenhoffer & Hilgard, 1962), they no longer score more alike than previously non-neighboring subjects.

Hypnosis experienced a major resurgence in interest at the end of the nineteenth century when Bernheim (1889) introduced the now common view that hypnosis was merely a form of suggestion. It is still widely assumed that suggestibility increases during hypnosis, but this assumption has not been easy to document. It has been usually assumed that people are not suggestible in the normal waking state, and therefore, any response to suggestion during hypnosis must be due to hypnosis. This is like being surprised that a person who has red hair during hypnosis still has red hair when no longer in hypnosis (Hammer, Evans & Bartlett, 1963).

In conflict with Bernheim's suggestion theory, Charcot (1886) argued that hypnosis was a psychopathological phenomenon and was a form of hysteria. Charcot argued that only (hysterical) women could be hypnotized, although no sex differences in hypnotic ability have been consistently documented (Hilgard, 1965).

Freud was familiar with Charcot's observations and, influenced by his studies with Breuer on the abreactive cure (Breuer & Freud, 1924), his early work with hypnosis was instrumental in developing his theory of unconscious motivation (Ellenberger, 1970). Freud was later to give up hypnosis, giving as a reason that he could not hypnotize all of his patients. This is a surprising rationale: he never considered giving up free association or dream analysis because he couldn't make all patients associate freely or recall dreams. Freud's decision to discontinue using hypnosis highlights the crux of the lay person's view of hypnosis that the (malevolent) hypnotist controls the (gullible) patient's behavior (for suspicious motives). The lay person's view of hypnosis has been forged by two works of fiction–*Mario and the Magician* (Mann, 1930) and *Trilby* (Du Maurier, 1890)–in which hypnotists are depicted as irresistible exploiters of the innocent.

Most patients still think of hypnosis as a somewhat mysterious and magical technique in which they will be controlled by the hypnotist's suggestions, and they expect that they will have to accept uncritically