the Journal of the
AMERICAN INSTITUTE OF HYPNOSIS

8295 SUNSET BOULEVARD · LOS ANGELES 46, CALIF.

VOLUME 1 OCTOBER, 1960 NUMBER 1

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The Journal of the American Institute of Hypnosis is published quarterly in January (Winter Issue); April (Spring Issue); July (Summer Issue); and October (Fall Issue). The Volume begins with the January number. All subscriptions will begin with the January issue. Subscription for 1961 include the first issue (October 1960) at no additional charge. Yearly subscription rate is Ten U.S. Dollars.

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All manuscripts, books for review, subscriptions, changes of address, news items, items for the problem clinic, Letters to the Editor etc. should be sent to:

THE EDITOR, JOURNAL OF THE AMERICAN INSTITUTE OF HYPNOSIS
AMERICAN INSTITUTE OF HYPNOSIS BUILDING
8295 SUNSET BOULEVARD, LOS ANGELES 46, CALIFORNIA

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Instructions for contributors are on the inside back cover of this number. The Journal of the American Institute of Hypnosis is published at Los Angeles, California. Second Class Mail privileges pending at Los Angeles California.

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EDITORIAL

A NEW JOURNAL IS BORN

With this issue a new journal is born. It is dedicated to the furthering of the scientific knowledge and understanding of Hypnosis. You are now beginning to read this first issue, but before you do, consider that this is just one of the many milestones of progress of the Institute. The American Institute of Hypnosis has had a tremendous history of progress and growth since its conception on May 4th 1955. It began its teaching program in July of 1958 immediately after the approval of Hypnosis by the American Medical Association at their 107th annual meeting. The Institute now offers more courses on Hypnosis than all other educational institutions in the world combined (see page 46 this issue). It has been responsible for educating thousands of physicians and dentists in the field of Hypnotherapy; has established the only referral service of its kind in the world; and has held the first international course in Hypnosis for physicians and dentists ever given. The Editor of the British Journal of Medical Hypnotism, Dr. S. J. Van Pelt, who is also the president of the British Society of Medical Hypnotism praised the A.I.H. for having "the most efficient teaching staff and the most enthusiastic group of students that I have ever seen." He further went on to say, "A very pleasing feature was that there was no attempt to belittle other professional teaching groups of which there are several in the U.S.A. In fact students were advised to take the courses provided by other groups."

association division has grown past the 4 figure mark and the Institute is well respected and well known not only in the United States but also abroad. Courses have been given in South America, North America, and Europe and future plans call for world wide coverage. It is therefore inevitable that from such an institution the best American Journal on Hypnotherapy must make its appearance. A lot of thought and planning went into this Journal so that when it did make its appearance that it would be the best. The following are some of the features which will help to make it so:

1. Practical Clinical Articles based on accurate clinical research.

2. Abstract section containing condensed literature on Hypnosis from all sources.

3. Letters to the Editor Section.

4. Problem Clinic for those seeking aid with their problem cases.

5. Particularly emphasized in the Journal will be the latest news about research projects, courses, and meetings of the Institute so that members may be quickly and adequately informed of the activities of the Institute.

YOU CAN HELP. Present your articles and case histories. We promise to give them thorough evaluation and you the opportunity to express yourself adequately. This will be your publication. We urge you to make the most of it. Contribute, correct, and comment.

William J. Bryan Jr. MD FAIH

WILLIAM J. BRYAN MD FAIH
Editor of the Journal

LETTERS TO THE EDITOR

Editor of The Journal
American Institute of Hypnosis
8295 Sunset Blvd.
Hollywood 46, California
Dear Sir:

Why don't the Journals devote more space to Hypnosis in Children. Since it is admitted that children make ideal subjects, one would think that a good deal more space should be given this very important part of hypnotherapy. I hope the AIH Journal devotes sufficient space to this problem.

Yours truly,
E.B. M.D.

Dear Dr. E. B.:

You will no doubt be happy to see that our very first issue carries an article dealing with Hypnosis in Children, namely, a specific problem of childhood one sees all too frequently, Eneuresis. Of course, we intend to vary the content of the Journal and all specialties of Medicine and Dentistry will be covered, but I can assure you that Pediatrics will always receive a place in the Journal of the American Institute of Hypnosis.

Very sincerely yours,
William J. Bryan Jr. M.D. FAIH
Editor, The Journal

Dr. William J. Bryan, Jr., M.D.
Executive Director
American Institute of Hypnosis
8295 Sunset Blvd.,
Los Angeles 46, California
Dear Dr. Bryan:

I consider it an honor to welcome the official Journal of the American Institute of Hypnosis to publication. As editor of the Tri-State Medical Association I wish to congratulate the Institute on it's new publication.

I realize that it is quite late in wrting, but if the editor of the Journal has already filled it's pages for that issue he may perhaps be able to put this in a later issue.

With kindest personal regards to you and Dr. Sloan, I am,

Fraternally yours,
R. B. Davis, M.D.

Dear Editor:

In the last issue of the Bulletin it was stated that one could obtain a copy of the Caribbean Hypnosis Teaching Film produced in color by the American Institute of Hypnosis and the Bonnie Highland Medical Film Company. I would like more details on this please.

Sincerely,
M.J.H., M.D.

Dear M.J.H.:

The Hypnosis Teaching Film produced in color with sound tracing the First International course in Hypnosis ever given for physicians and dentists is now available to physicians and dentists for showing to professional gatherings. (Hospital Staff meetings, County Medical Societies, Dental Societies, etc.) There is no charge for the use of this film. Brochures describing the current courses being offered by the Institute will also be sent on request for distribution to the professional audience. Merely write: Dr. William J. Bryan Jr., M.D., Executive Director A.I.H., 8295 Sunset Blvd., Los Angeles 46, California and request the film. Be sure to state (1.) The dates it will be shown, (2.) The Name of the Group that will see it, (3.) The Size of the group, and (4.) Your own name, degree, address and telephone number and the address where the film is to be sent if different from your own.

Naturally, as there are many physicians and dentists who would like to see the film, we must insist that the film be returned immediately by Parcel Post INSURED FOR $300.00. Allow at least 6 weeks when putting in a request. Anyone wishing to purchase a copy may do so at the purchase price of $300.00 per copy. Mail check to American Institute of Hypnosis and allow 6 weeks for copy to be produced.

Very sincerely yours,
William J. Bryan Jr. M.D. FAIH
Editor, The Journal

(Continued on Page 33)

A MESSAGE FROM THE PRESIDENT

by Arden R. Hedge MD, FICS, FAIH

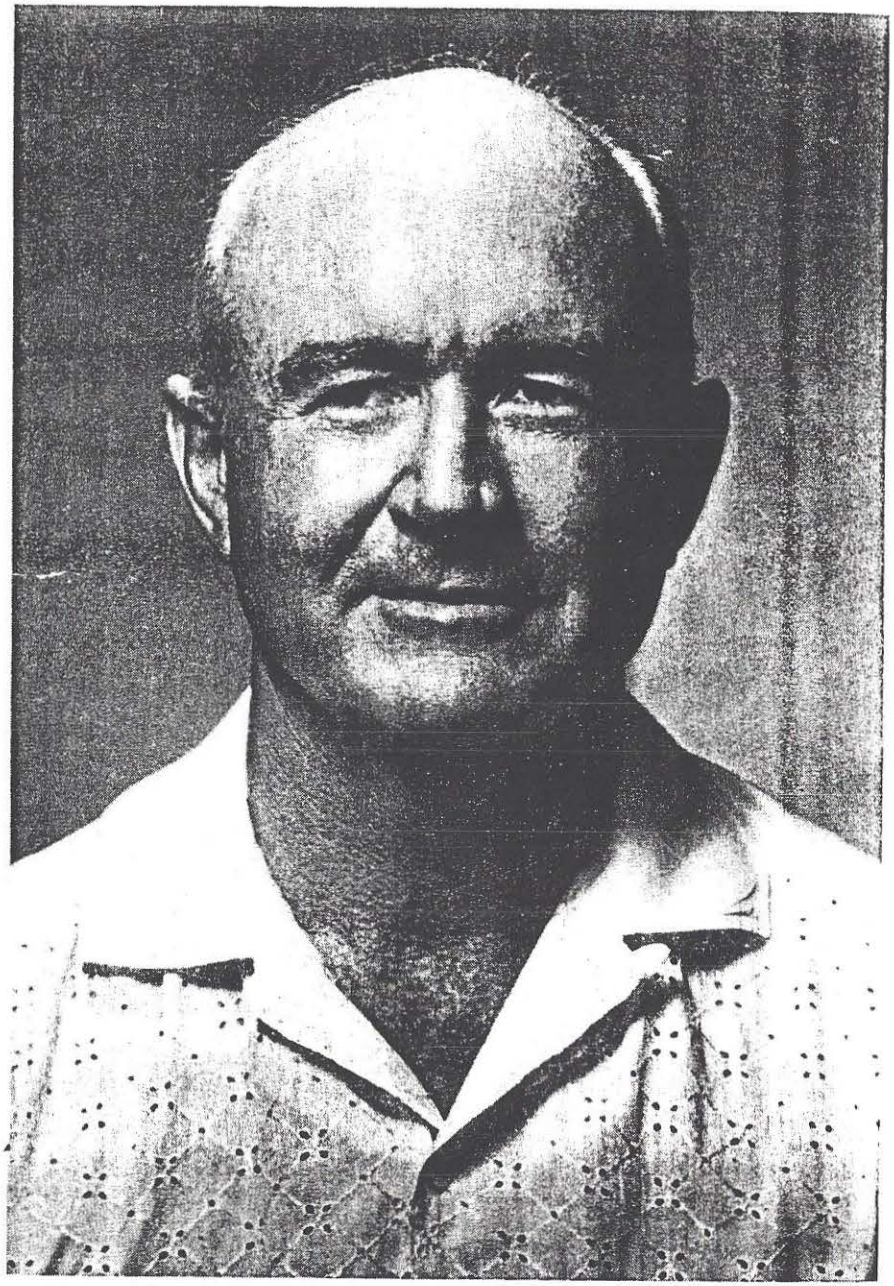
It is indeed a pleasure to welcome to the world of scientific literature, the Journal of the American Institute of Hypnosis. Most of the progress that the medical profession has made during the past few decades has been the result of a more extensive dispersion of our experimental and clinical experience and the expansion of our means of communication through published articles. The addition of a new Journal in this vast and rapidly maturing field, particularly serves as a healthy sign of progress and development. Knowledge is not competitive. It is a source of illumination and enrichment that we willingly share with one another. Every specialty in the practice of Medicine has an abundance of different types of journals to represent their specific field and each has something worthwhile to add. There have been too few Journals in this important subject and every bit of encouragement and support should be given the Editor and Publisher, as well as to the American Institute itself.

In as much as there have not been sufficient periodicals to adequately cover the rapid developments in this subject, the lay magazines have taken it upon themselves to dissiminate information to the medical and dental professions, as well as to the general public. This situation is less than desirable, for although many of the articles have been excellent, there are some which have been misleading and confusing.

There are two outstanding factors in Hypnosis which are very instrumental in giving this modality a place of greater stature, and which have served to influence others in our profession to take a keener interest. One is the fact that no longer is there a clear cut line drawn between functional and organic disease. The advancements in the understanding of psychosomatic medicine forces us to realize that the two are, in most cases, inseparable. So many of the so-called organic diseases that we see today, are the result of emotional tensions or trauma of yesterday and the treatment of these disorders—centers around recognizing these factors.

The second great step forward, is the recognition that we have within us far greater powers or capabilities to help ourselves physically than we formerly believed possible. Thus, through greater control at the sub-conscious level, we are better equipped to alter, for beneficial purposes, our circulation, metabolism, digestion, and a long list of other vital functions. Even EKG's can be changed, or antibody titres increased, and allergies eradicated. These physiological, biochemical and endocrinological alterations are tremendously interesting and more articles concerning them should be submitted so that others will be encouraged to delve deeper into this important problem.

One significant factor, which has been a great handicap in the past, has been the unalterable fact that hypnosis has been used perhaps foolishly or ineffectively by some, or by untrained novices, or by competitors in other branches of the healing arts. This however should not justify the continuation of a prejudicial attitude about newer concepts and developments which could be beneficial to our profession, as well as to humanity. After all the sole purpose of our existance as doctors is to benefit our patients to the greatest degree possible.



ARDEN R. HEDGE MD FICS FAIH
President of the American Institute of Hypnosis

HYPNOSIS IN MEDICAL PRACTICE

by Thomas A. Clawson, Jr., MD, FACP

The ever increasing number of articles about Hypnotism appearing both in Medical publications and popular magazines is gradually raising the aura of mysticism that has spread over it like an ominous black cloud and preventing the use of this most helpful tool in the practice of psychology and medicine.

A better understanding as to the nature of Hypnotism and its modus operandi is relieving the minds of those heretofore uninformed of the fear that their minds will be captivated by the Hypnotist and be forever subject to his beck and call for good or for evil and thus permitting them the use of this most helpful therapeutic procedure.

For those who are still somewhat confused as to the nature of Hypnotism, the physiological process taking place in the hatching of an egg could perhaps best clarify this in their minds.

An egg (persumed of course at the onset to be fertile) is placed in an incubator and at the end of a three-week period, a chicken or bird is hatched from the egg. The question as to what hatched the egg, is a logical question. To some, the answer seems to be obvious—the incubator, of course; but this is incorrect. The incubator did play a part in what it created a favorable surrounding whereby the fertile cells in the egg could divide and subdivide, thus developing into the chicken which eventually hatched the egg.

Now, Hypnotism is a similar process, the idea or egg is placed or suggested to the mind of the subject and the Hypnotist creates the favorable surrounding whereby the idea develops into the hypnotic state. The Hypnotist has in no way captivated the mind, as the suggestion or idea is only given and can be accepted and hatch into the hypnotic state or be rejected and produce nothing.

I have been impressed with the explanation of hypnosis given in a brief lecture by TRAIAN BOYER (One of the finest of stage hypnotists) just preceding his act. Quotes, "Hypnotism has been defined as an extension of concentration. It is the rather remarkable power that ideas possess when they claim our complete attention. Such dominant ideas are called suggestive ideas. If hypnotism is concentration; then concentration requires both intelligence and will power, but most important is one's mental attitude. If one's attitude is in a positive manner, he can be hypnotized. But if he attempts it with a negative attitude, daring one to hypnotize, or challenging him to hypnotize him, it had best be forgotten, because the hypnotist possesses no supernatural power. Half of the battle belongs to the subject, and all that the hypnotist can do is to help him do something that he cannot do for himself."

There are still some men in the medical profession who view with askance any suggestion of hypnosis and are too willing and eager to place into the category of quackery, anyone who uses this in practice, even though the American Medical Assn., has accepted hypnosis as a legitimate and useful tool in the practice of medicine.

The purpose of this paper is to present some well authenticated cases wherein hypnosis has been helpful in my practice of medicine, and to suggest to the Medical Profession, that this newly accepted tool should not be brushed aside lightly because of the stint of mysticism that has shadowed it for years.

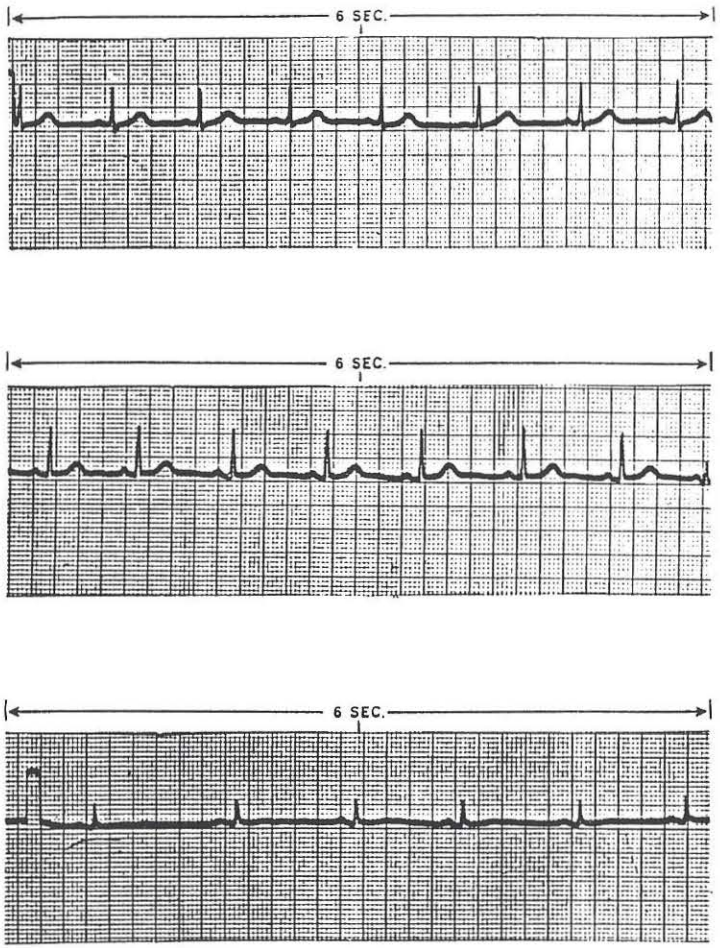
These cases have been chosen because of their variety in demonstrating how the power of suggestion given to a subject under the hypnotic state can be of great help in the relief of pain and adding to the general comfort of the patient.

It is a well known fact that under complete relaxation, any medical or surgical condition will improve or heal much faster; thense the plaster casts used by the surgeon to put at rest and relaxation the broken bones; the narcotic and soporific drugs that relax a patient after surgery, the new and ever-increasing tranquilizing drugs used to relax the emotionally disturbed. As a profession, these are readily accepted and used and in the case of drugs and tranquilizers, may prove to be eventually harmful because of addiction; whereas the same effects can be produced with hypnosis without any such fear as to the outcome.

Case #1, Mrs. L.M.W.—white female, age 37, who had been under my care as the family physician for some eighteen years. May 14, 1956, she came to my office because of a pain in the left chest actually starting in the left breast when it was bumped by her baby or jounced as she hurried down stairs. The pain, though originating in the left breast area, would radiate into the axilla and shoulder. Careful examination including an electrocardiogram proved that this condition was due to intercostal neuralgia which responded and was cured under appropriate medical therapy. The electrocardiogram is herewith presented, as it is normal and may serve as a basis for a normal standard in this most interesting case. (see diagram 1)

April 4, 1958, she was awakened about 3 a.m. with a severe vice-like substernal pain, radiating into her neck and down both arms; this was greatly aggravated by any exertion. I saw the patient at 3:30 a.m., and because of the severity of the pain, gave her an intra-venous injection of Morphine Sulfate, grains ¼. This relieved the pain and she slept the remainder of the night, and when awakening had only a slight residual of pain. Because of the age of the patient and my previous knowledge of her physical condition, I permitted her to be brought to the office in the morning. An electrocardiogram was taken and proved to be abnormal as the T waves were practically flat in all Leads. (diagram 2) A diagnosis of myocardial insufficiency with coronary spasm was made, and she was sent home to remain in bed and to take Pentoxylen, a vasodilating agent, four times daily. The following morning there was no pain, but there was an awareness of substernal distress especially when exerting herself in any way. An electrocardiogram was taken and showed no change in the pattern to the tracing of the previous day—the T waves remaining flat. (diagram 3) At this time, it was decided to use hypnosis. The patient proved to be an excellent subject and was readily induced into a deep hypnotic state, and the suggestion given that the pain would leave immediately and that she would awaken feeling perfectly normal in every way, which she did. The pain was gone and she stated that she felt fine. Another electrocardiogram was taken and the previously flat T waves were upright, and the electrocardiogram could be considered normal. (diagram 4) Subsequent electrocardiograms have been taken at various intervals during the past year, and all have been normal, including two tracings taken at 3:45 a.m. and 10:00 a.m., April 11, 1958, when the patient had right-sided chest pain which proved to be intercostal neuralgia. (diagrams 5, 6 & 7) A most recent electrocardiogram, including a Master's Test made June 18, 1959, was

PATIENT Mrs. L. W. Webster SERIAL NO. 1956 DATE 5-14-56
AGE 36 SEX F CASE NO. DOCTOR JAC



AURICULAR RATE 75 P-R INTERVAL 0.14 PATIENT POSITION
VENTRICULAR RATE 75 Q-R-S INTERVAL 0.04 ELECTRICAL AXIS
RHYTHM NSR S-T SEGMENT N T low III
REMARKS normal

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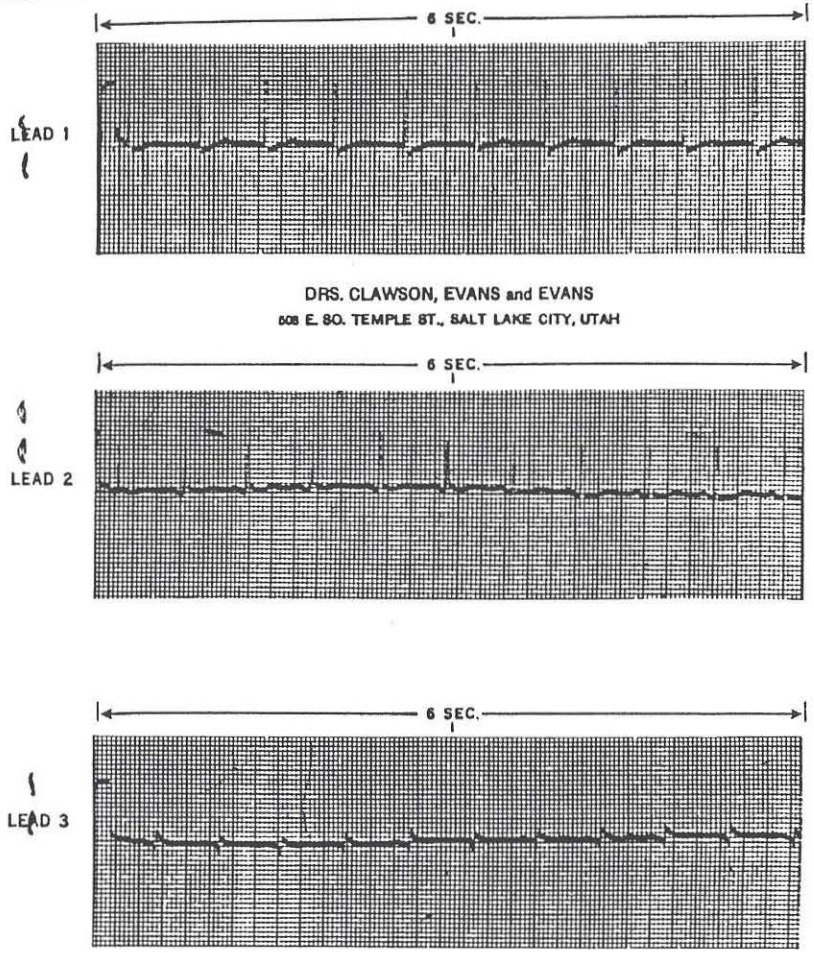
DIAGRAM 1

PATIENT Mrs. L. W. Webster SERIAL NO. I DATE 4-4-57
AGE 37 SEX F CASE NO. DOCTOR JAC



AURICULAR RATE [redacted] 107 P-R INTERVAL 0.14 PATIENT POSITION
VENTRICULAR RATE [redacted] 107 Q-R-S INTERVAL 0.06 ELECTRICAL AXIS
RHYTHM Sinus S-T SEGMENT
REMARKS T waves practically flat Thru and
Abnormal Tracing - Myocardial change -
Coronary Insufficiency

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DIAGRAM 2

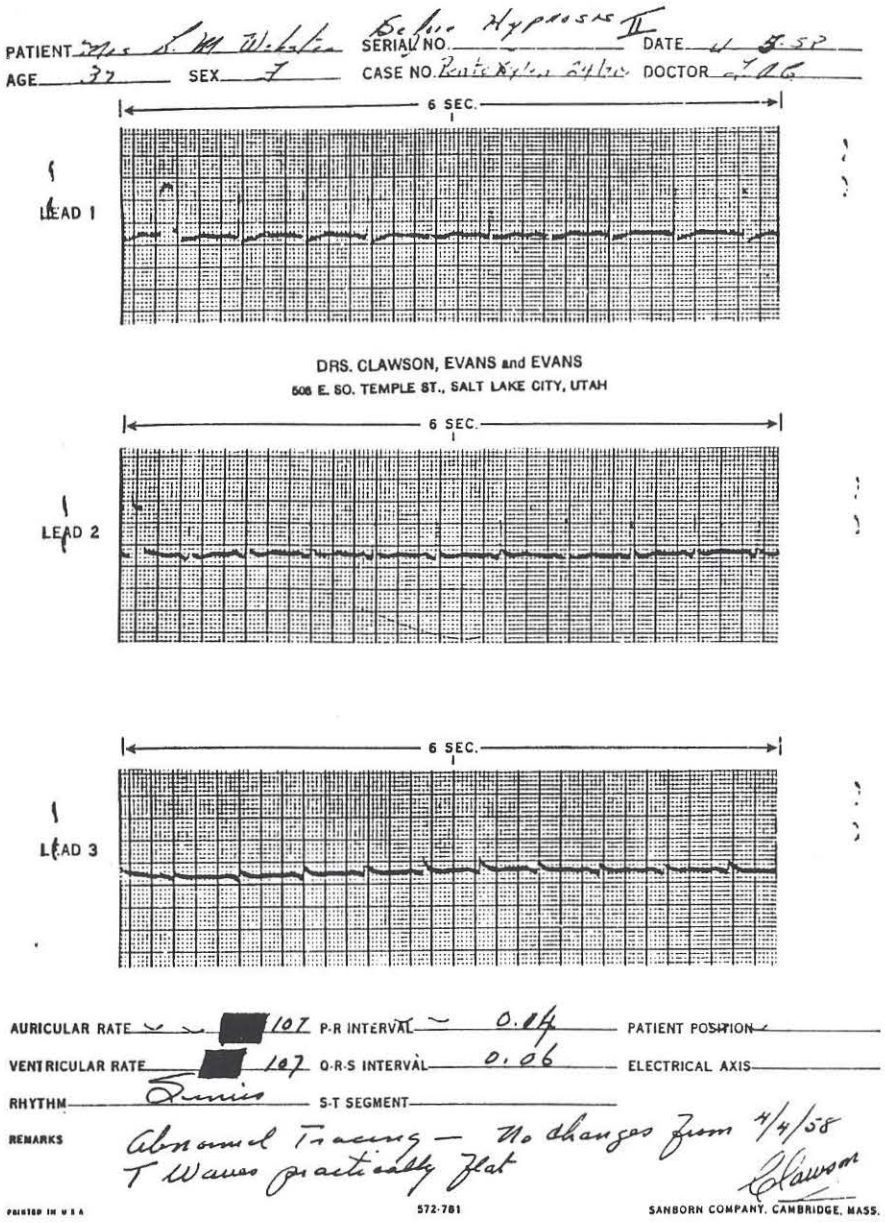
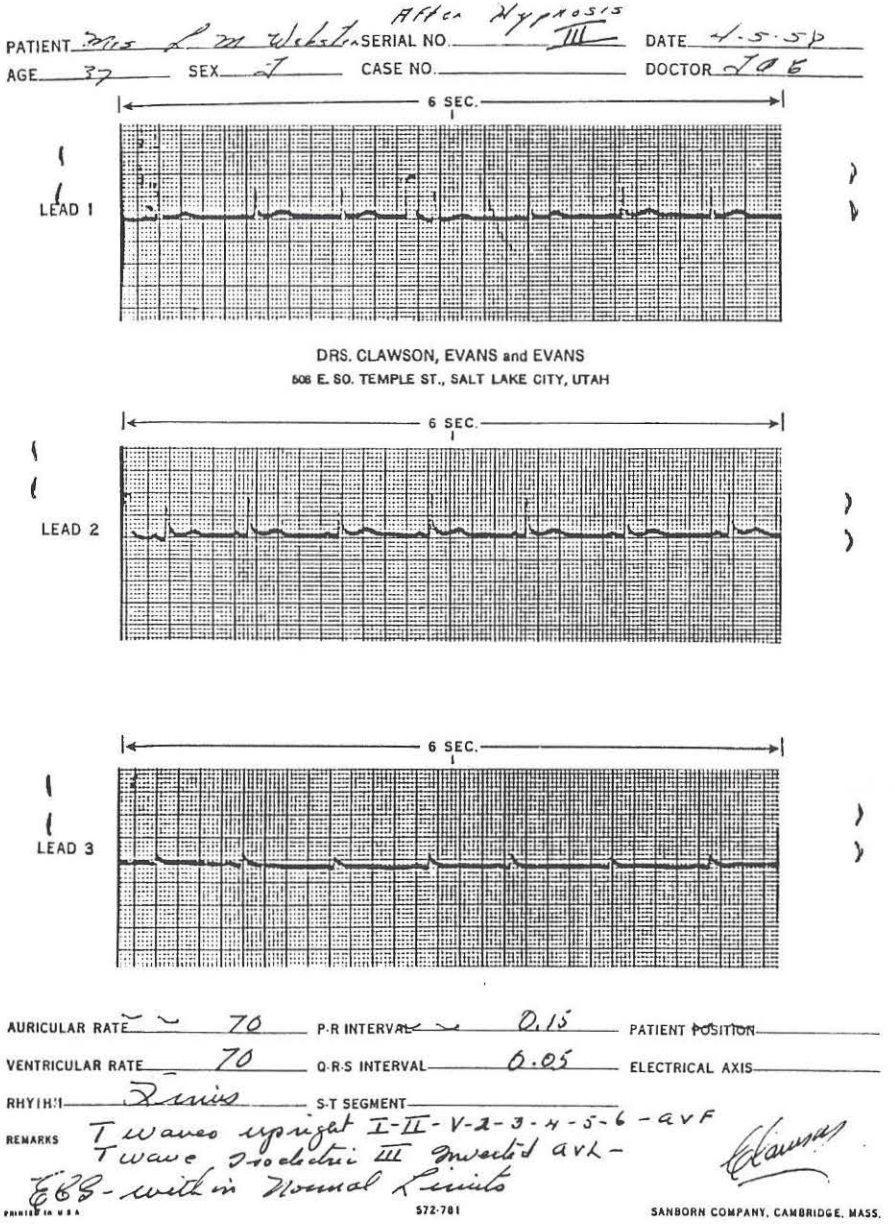


DIAGRAM 3 — BEFORE HYPNOSIS



RIAGRAM 4 — AFTER HYPNOSIS

likewise normal. The relief of pain and changing of an abnormal electrocardiogram to a normal tracing within a 15 minute period, are evidence that the coronary spasm was relieved by hypnosis. *(due to limitation of space only leads I, II & III of the electrocardiograms are exhibited, however all leads were taken and correctly bear out the author's conclusions.—Editor's Note)*

Case #2, white male, age 40, a large heavily built Irishman, and plumber by profession. He was seen by me at the request of a well known orthopoedic surgeon who could not immediately have this patient admitted to the hospital due to an extreme shortage of beds brought about by remodelling taking place at the time. This patient was suffering from an acute herniated intervertebral disc at level L 4-5. The pain was so severe that his legs could not be elevated to 15 degrees. Hypnosis was inducted after a short preliminary resistance was overcome, and he entered into a hypnotic state so deep that two hemostats clamped on to the abdominal wall caused no outward expression of pain. While under the hypnotic state, it was suggested that he relax completely, which he did, and the orthopoedic surgeon then manipulated his legs and trunk to try and reduce the herniation. He was told to awaken free from pain and feeling fine. He awakened, stood up, stretched and said that he felt fine and accompanied us out of his home to our car. This patient was subsequently operated for the removal of the disc after a recurrence June 2, 1959. In spite of an eventual operation for this condition, this presents the fact that hypnosis can be an effective tool to be used in an acute situation while awaiting the opportunity to do a more definitive procedure.

Case #3, L.E., white male, age 31, executive in a large department store, While working in the garden one evening in April 1959 was seized with a severe knife-like pain in the lower back so severe that his wife had to help him into the house and into bed. Various home remedies were tried during the night without relief, and I was eventually called and saw the patient at 7:00 a.m. the following morning and found him practically immoble in bed because of the excrutiating pain in his lower back whenever he moved.

Examination suggested the possibility of a herniated intervertebral disc in the lower lumbar region, and two courses of therapy were offered; first, to be taken to the hospital and his back and legs placed in traction for several days, or that hypnosis be used. He chose hypnosis and being a very good subject was readily inducted into a deep hypnotic state. The legs and trunk were then manipulated without any outward sign of pain to him. He was then told to awaken feeling fine and without pain, which he did. He was able to go to his office about one and one half hours later and although he had a slight residual soreness of the back muscles for a day or so, he was able to carry on his usual work. Two and one half months have now past without any return of his trouble.

Case #4, Mrs. A. C. Stenographer, age 48 — On a Sunday morning April 5, 1959, the patient went into her kitchen, the sun was shining brightly through the window and on to the electric range, and because of the brilliance of the sun, the red color of the unit was neutralized and she did not realize that the plate was red hot. She placed her left hand on the plate where it momentarily stuck, and as her husband came into the kitchen attracted by her screaming, he could smell the burning flesh. They immediately packed her hand in ice and kept it so packed most of the day. I saw the patient about 10:00 p.m. of the same day. The fingers and distal one-third of the palm were discolored brown and showed evidence of a severe burn. She was bemoaning the fact that she would have to find a substitute to take her place in the busy law office where she was employed. I suggested that hypnotism could be of help to her in relieving the pain. This she readily accepted and was induced into a hypnotic

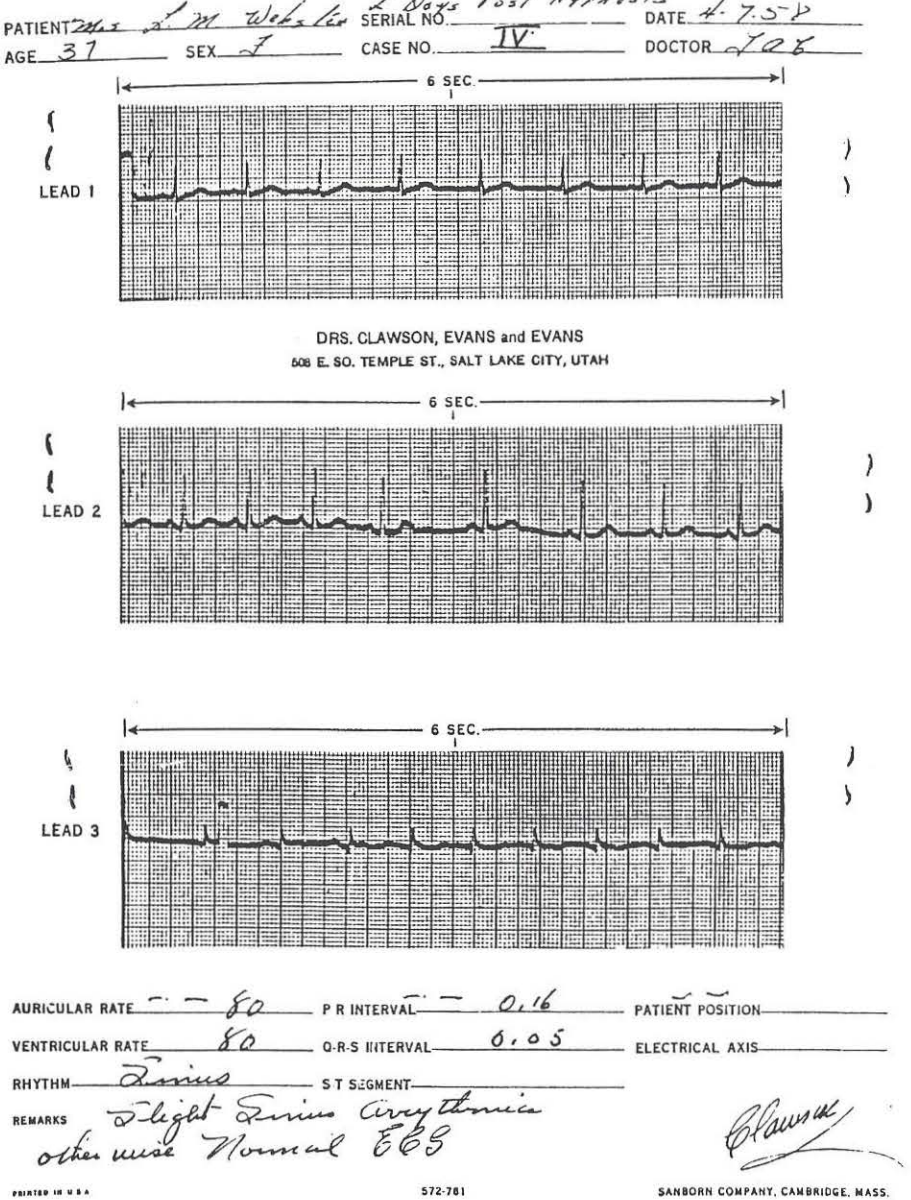
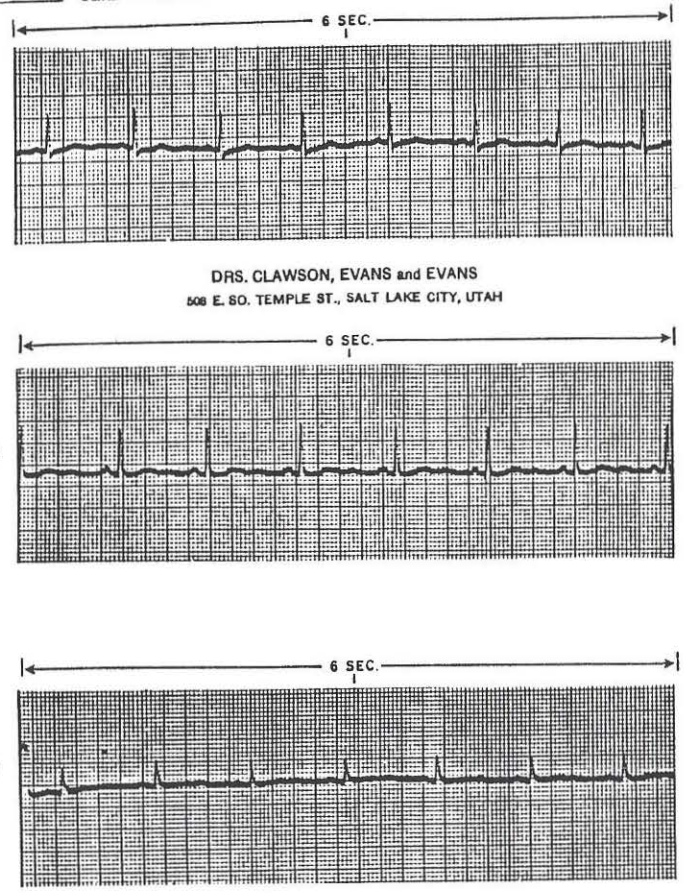


DIAGRAM 5

PATIENT Mrs L M Webster SERIAL NO. 345 DATE 4-11-52
AGE 37 SEX F CASE NO. V DOCTOR JDC



AURICULAR RATE 70 P-R INTERVAL 0.14 PATIENT POSITION
VENTRICULAR RATE 70 Q-R-S INTERVAL 0.06 ELECTRICAL AXIS
RHYTHM Sinus S-T SEGMENT
REMARKS T waves slightly lower than previous tracing
But still not diagnostically abnormal

Clawson

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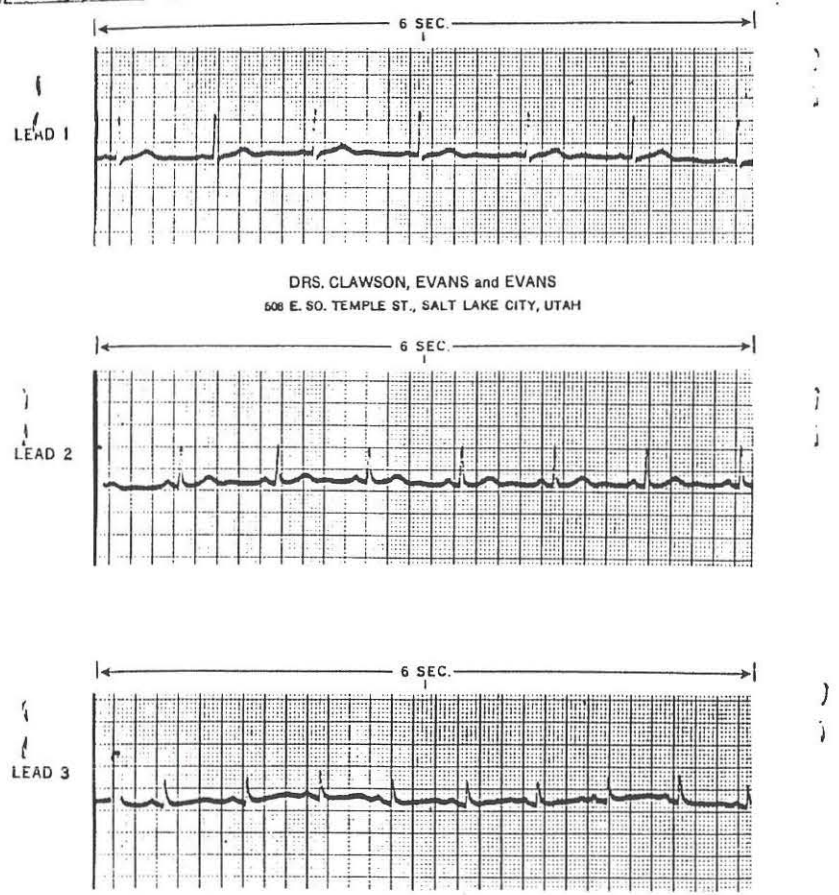
DIAGRAM 6

PATIENT Mrs L M Webster SERIAL NO. # 10:15 A.M. DATE 4-11-52
AGE 37 SEX F CASE NO. VI DOCTOR JDC



AURICULAR RATE 70 P-R INTERVAL 0.16 PATIENT POSITION
VENTRICULAR RATE 70 Q-R-S INTERVAL 0.06 ELECTRICAL AXIS
RHYTHM Sinus S-T SEGMENT
REMARKS Normal EKG.

Clawson

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DIAGRAM 7

state with the suggestion that she would awaken feeling fine and free of pain. She did awaken free of pain and went to work the following day, typing better, she stated than she had even before the injury, and two days later the only remaining evidence of the burn was a slightly scabbed area on the tip of the little finger.

Case #5—Case of Demerol addiction. Mrs. R. McD., white female, age 68, who was bedfast due to left ventricular failure and complaining of severe pain in her right chest. Her husband requested my services, and I was called by her physician and asked to try hypnosis with her, as Demerol was becoming a very serious problem, her wanting to be under its effects all of the time.

She was inducted into a hypnotic state—and it was suggested that she would awaken free from pain and have no further desire for Demerol, which she did so. I saw the patient twice daily for three days, then once daily for two days. Three months have now elapsed and the patient has been free of pain and has not taken a single dose of Demerol since the first hypnotic state was produced. She was soon out of bed and is now living a normal but restricted life.

Case #6, R.R., white male, age 30, Demerol addiction. This patient has hemophylia with recurrent spontaneous massive hemorrhages into various joints, and because of the severe pain had been taking Demerol in the amounts of one or two 30 c.c. vials per week. He came to me because he realized that Demerol was becoming a very serious problem. He was readily inducted into a hypnotic state and the pain that he was having due to a massive hemorrhage into the left shoulder and right ankle, was removed through suggestion. He returned to my office daily for three days and was then taught self-hypnosis, the technique of which he readily acquired. Two weeks is too early to judge the effectiveness of the suggestion given, but it is the longest period that he has gone without Demerol for several months.

Case #7, white male, age 76—Cancer of the liver. This patient had an exploratory laparotomy one year ago and was told that he had two months to live. He outlived the prediction very well for a period of nine months, when he began to go downhill. The abdominal pain became very severe; his appetite became poor, and he could do very little because of weakness. I was called in at this time to use hypnosis. The patient was a very good subject and was inducted into a deep hypnotic state very easily, and it was suggested that upon awakening he would have no pain, that his appetite would increase, and that he would feel fine and gain in strength daily. He did awaken free from pain, feeling fine. He was seen on three successive days and again one week later. He has had no return of pain, is eating better and enjoying himself working about the garden. I am sure that we can make no claim for curing cancer under hypnosis, but this man can at least enjoy the remaining span of his life free from pain through its use. He has been taught self hypnosis which he uses daily.

Case #8, E.S., white male, age 45. This patient developed a spontaneous thrombophlebitis of the left calf, which was treated at home for three days when he had a sudden sharp pain in his right chest, diagnosed as a pulmonary embolus. He was sent into the hospital for more definitive treatment. X-ray examination showed a characteristic shadow in the base of the right lung, compatible with the diagnosis of pulmonary embolism. His temperature was elevated to 103 degrees and he was expectorating dark bloody sputum. He was placed on anticoagulant therapy and Morphine Sulphate which did not entirely control his pain. I saw the patient in the hospital and suggested that I could relieve his pain with hypnosis. He stated that he would like anything to relieve his plain. He was very cooperative and proved to be an excellent subject as he quickly entered a deep hypnotic state. It was suggested that the pain would leave him and that he would awaken feeling fine, breathing easily and with no pain. He did so awaken, much to the astonishment of his wife who was present during the whole procedure. I saw him again the following day and again inducted him into a deep hypnotic state, making the same suggestions but in addition teaching him self-hypnosis, whereby he was able to produce the same deep hypnotic state four times as I watched. The procedure was done as I was leaving town for a period of four days and wanted to make certain that he would be kept free from pain. During my brief absence, he was unable to do this and is now about ready to leave the hospital (June 23, 1959).

Case #9, Mrs. M.S., age 63, white female—Complaint, arthritic pains in various joints recurrent—no obvious hypertrophic changes and no spindle deformity of fingers—but she did complain of pains in her back and the inability to close her right hand into a fist which had been present for two years.

She was in Salt Lake City to attend her son's wedding and because of her limited time, no complete examination was made. Her son, an orthopoedic resident in the hospital, who had seen hypnosis in action, asked me to use hypnosis with her to relieve the pain. She was an excellent subject and was readily inducted into a deep hypnotic state, and the suggestion was given that she would awaken free from pain and feeling fine, which she did. However, in addition, her right hand became very flexible and could be opened and closed freely. Whether the previous inability to close the hand was due to arthritic changes of fibrositis, I am not prepared to say, as no X-ray was taken, but irrespective of the underlying factor, she was very happy with the results of hypnosis.

Certainly hypnosis is not a cure all for all diseases, and for one to consider it as such, he will miss the true value of this as a technique.

First and foremost in a physician's mind, should be that each patient coming to him should have a careful and complete checking over, including a careful history, complete physical examination, the necessary laboratory work done, electrocardiogram and X-ray examinations if so indicated. When this work has been performed and the disease condition correctly evaluated, then the proper form of therapy should be instituted. Hypnosis should not be the first therapy tried unless the condition is functional or of a psychosomatic orgin. Quoting from the book, SCIENTIFIC HYPNOTISM, by Dr. Ralph B. Winn, "Hypnosis as a curative agency should be applied only to those bodily disturbances and mental ailments which are directly or closely connected and regulated by the autonomic nervous system. Suggestion does not perform miracles, let it be understood once and for all. It is completely helpless in maladies roted in anatomical defects or in physiological troubles basically independent of the involuntary system. It is foolish to hope that hypnosis will cure diptheria, syphilis, or appendicitis. Fully recognizing these obvious limitations, we should not at the same time forget that there exist cases, quite numerous in fact, in which the symptom has merely the appearance of an anatomical defect, as in hysterical blindness, deafness or paralysis. The physician should remain strictly scientific in his diagnosis and know how to differentiate between these psychic ailments and similar organic maladies that require ordinary surgery or are totally incurable."

Again, it must not be forgotten that many organic conditions have a psychosomatic overlay which could be removed through hypnosis to the comfort of the patient, although the basic condition may not be affected by it.

The above cases have been presented demonstrating these facts.

The relative ease with which these cases were inducted into a hynotic state might cause some medical men to raise their eyebrows, but I am certain that everyone who is working with hypnosis knows that when motivation or the de-

(Continued on Page 28)

A NEW LAW ON HYPNOTISM FOR ONTARIO

by F. A. Evis MD, DPH, MRSH

ONTARIO HOSPITAL SERVICES COMMISSION

April 20, 1960

Dr. William J. Bryan,
Executive Director,
American Institute of Hypnosis,
8295 Sunset Blvd.,
Los Angeles 46, California

Re: Ontario Hypnotism Control Act

Dear Doctor Bryan:

For the information of yourself and the members of the Institute, enclosed please find six copies of my proposed Hypnotism Control Act for the Province of Ontario, with six copies attached of my supporting memorandum to the Honourable the Minister of Health for Ontario. Also enclosed is a copy of some of the newspaper clippings that I am using to indicate to our politicians the growing public interest in the subject of hypnotism.

As you know, politicians are more interested in the public's reaction to proposed legislation, and in whether or not there is sufficient demand for it, rather than in the intrinsic value of the suggested measures. That is why I must "sell" our government on desirable legislation provisions by means of a "popular" approach rather than on a strict scientific basis.

So far as I have been able to discover, the only precedent for this type of legislation is The Hypnotism Control Act that was passed in Great Britain in 1952. If your Research Director or anyone else in the Institute is aware of any other legislation in the world dealing with the subject of hypntism, I would be most appreciative of receiving the information.

If the Institute desires to supply any additional facts or ideas that will help to promote the passing of this legislation, your assistance will be highly valued, as will be any criticism you may feel called upon to offer.

Incidentally, you may enter my subscription for the Journal of the American Institute of Hypnosis and bill me when you are ready to begin publication.

With all good wishes for every success in your new permanent headquarters, I am

Yours sincerely,
F. A. Evis, B.A., M.D., D.P.H., M.R.S.H.,
Medico-Legal Consultant

FAE/ms
Encs.

THE HYNOTISM CONTROL ACT

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

1. In this Act
   (*a*) "hypnotism" means hypnotism, Braidism, Mesmerism and any similar act or process which produces or is intended to produce in any person any form of induced sleep or trance or any other condition of increased receptivity of the mind, in which the susceptibility of the mind of that person to suggestion, instruction or direction is increased or intended to be increased, but does not include hypnotism or

any such similar act or process that is self-induced; and

(*b*) "Minister" means Minister of Health or such other member of the Executive Council as is charged for the time being with the administration of this Act.

2. No person shall give, for entertainment, instruction or any other purpose, an exhibition, demonstration or performance in which hypnotism is used or attempted at or in connection with an entertainment or other gathering to which the public are admitted, whether by payment or otherwise.

3. No person, other than a legally qualified medical practitioner, a dentist licensed under The Dentistry Act or a person holding a doctorate degree in psychology from a reputable university, shall use or attempt to use hypnotism for the treatment, cure or alleviation of any mental or physical disease or disorder or of the symptoms or effects thereof, or for any psychological irregularity, distrubance of malfunction, or for any tic or undesirable habit, or for any other therapetutic purpose, or for the purpose of any research; or shall undertake to give instruction either personally or by any other means in the art of hypnotism.

4. Nothing in this Act shall prevent the exhibition, demonstration or performance of hypnotism for scientific or research purposes, or for the purpose of instruction by and for any physician, dentist or psychologist mentioned in section 3, or any persons who are bona fide students registered in courses leading to qualification in such professions, or for any persons who are members of the nursing profession or are registered in a course leading to qualification in a nursing profession.

5. Every person who contravenes any provision of this Act is guilty of an offence, and on summary conviction is liable to a fine of not less than $500 and not more than $2,000 or to imprisonment for a term of not more than six months, or to both fine and imprisonment.

6. It is the duty and function of the Minister to administer and enforce this Act and to make or authorize the making of any investigations and inquiries necessary therefor.

7.—(1) Every fine recovered under this Act, where the prosecution is at the instance of the corporation of a municipality, or the local board of health for a municipality or of a health unit, or a medical officer of health, shall be paid to the treasurer of the municipality in which the offence was committed for the use of the local board of health.

(2) Where the prosecution is at the instance of the Department of Health or of any officer or public servant of the provincial government, or, subject to subsection 3, where the offence was committed in a territory without municipal organization, the fine shall be paid to the treasurer of Ontario.

(3) Where the prosecution is at the instance of the College of Physicians and Surgeons of Ontario, the fine shall be paid to and for the use of the College.

8. Every prosecution under this Act shall be commenced within one year from the date of the alleged offence.

9. This Act comes into force on the day it receives Royal Assent.

10. This Act may be cited as *The Hypnotism Control Act.*

MEMORANDUM TO: Hon M. B. Dymond, M.D., Minister of Health.

FROM: Dr. F. A. Evis, Medico-Legal Consultant, Ontario Hospital Services Commission.

Re: THE HYNOTISM CONTROL ACT

Further to our previous correspondence on this subject, enclosed please find a draft Hypnotism Control Act that I wish to recommend to you and other members of the Government as being a highly desirable piece of legislation. Unfortunately, the pressure of my duties has made it impossible for me to prepare this submission at an earlier date. If it is too late for presentation at the present session, I would hope that you will consider it of sufficient importance to keep it in mind for introduction at the next session of the Legislative Assembly.

There is a precedent for this type of legislation in The Hypnotism Act which was passed in Great Britain in 1952. It is found as Chapter 46 of 15 & 16 Geo. VI and 1 Eliz. II.

The possibilities for misuse of this modality of treatment are very great and, as you may have noticed in various newspapers and magazines. courses in how to hypnotize are available to anyone for as low as $1.98. This means that any person who happens to have the talent to induce hypnotic sleep can hold himself out as a hypnotist giving treatments for pay. The induction of an hypnotic trance is, of course. the simplest part of hypnotism and the difficult, important and potentially dangerous part is instructing and treating the patient who has been put in an induced sleep or trance. Unfortunately, victims of amateur hypnotists and predatory charlatans are rarely in any mental condition to register complaints against the unqualified operators who have mistreated them. This is because the hypnotic subject can be made to feel quite happy, at least for a short period of time, with almost any set of circumstances, no matter how he may have been taken advantage of. There is also the factor that women who have been bilked out of money or otherwise illtreated are too embarrassed to come forth and make accusations.

In the past ten years hypnotism has been recognized as an extremely useful and unique therapeutic tool by all reputable medical associations throughout the world. Reports from various associations unanimously vigorously condemn the use of hypnotism for entertainment purposes because of the bizarre and distorted concept of it that is often left in the lay mind as a result, and because of other ill effects that may be produced. Entertainers and amateur operators can easily cause either a conscious emotional opposition to hypnosis in the lay mind or, what is even worse, a resistance to hypnosis on a subconscious level, that can prevent or make it extremely difficult for a person to receive the benefits of hypnosis as a patient; despite the fact that he may really, in his conscious mind, want to be hypnotized for a medical reason.

A large and increasing number of physicians, dentists and psychologists in Ontario are using hypnotism in the practice of their professions. In the Toronto Star of October 7, 1958, it is stated that 600 Canadian doctors and 400 Canadian dentists are currently using hypnosis for the benefit of their patients.

You are no doubt aware that the British Medical Association and the American Medical Association have, in recent years, done a great amount of investigation into the medical use of hypnosis. A very full report of the British conclusions appears in the British Medical Journal of April 25, 1955. On September 13, 1958, the American Medical Association issued its report which appears in Vol. 168, issue No. 2. of the Journal of the American Medical Association.

The American Medical Association Report practically reiterates the British conclusion that there are definite and proper uses for hypnosis in medical and dental practice in the hands of those who are properly trained. In part, the conclusions of the A.M.A. report are as follows:

"It should be stressed that all those who use hypnosis need to be aware of the complex nature of the phenomena involved."

"Teaching of hypnosis should be under responsible medical or dental direction, and integrated teaching programmes should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be discouraged."

"Certain aspects of hypnosis still remain unknown and controversial, as is true in many other areas of medicine and the psychological sciences. Therefore, active participation in high-level research by members of

the medical and dental professions is to be encouraged."

"The use of hypnosis for entertainment purposes is vigorously condemned."

Incidentally, religious leaders endorse the use of hypnosis for medical treatment and dental purposes and are unanimous in condemning its use for entertainment purposes and the practice of it by unqualified amateurs. In an article entitled "Hypnosis as Anaesthesia" by the Rev. Gerald Kelly, S.J., that appeared in Hospital Progress, December 1957 issue, the writer indicates that His Holines Pope Pius XII gave approval to the use of hypnosis on several occasions. The first quotation from the Vatican is from an address given to an audience of physicians on January 8, 1956, on the use of hypnosis in childbirth. Rev. Kelly summarizes the Pope's three cardinal points as follows:

"1. Hypnotism is a serious scientific matter, and not something to be dabbled in.

2. In its scientific use, the precautions dictated by both science and morality are to be heeded.

3. Under the aspect of anaesthesia, it is governed by the same principles as any other form of anaesthesia — This is tantamount to saying that the rules of good medicine apply to the use of hypnotism and, in so far as its use conforms to these rules, it is in conformity with good morality."

Enclosed are four Verifax pages of a few of the many articles that have appeared on the subject of hypnosis in the local press. These are indicative of the great public interest in this field, and they have been selected almost at random to show, not only the ways hypnotism is used to benefit mankind, but also how it can be misused and abused by unqualified hypnotists. Your attention is especially directed to the few typical advertisements of some of the hypnotists who are making a living in Toronto by practising what virtually amounts to medicine and psychiatry without a lciense to practise medicine. You will note that one advertisement boldly advertises that a Mrs. L---- S---- holds herself out as using "a dynamic psycho-therapy" that really amounts to the practice of psychiatry. Such people who victimize and endanger the well-being of the public should be put out of business permanently and without undue delay.

As a matter of fact, you might feel that even a person holding a Ph.D. in Psychology should not work in the field of hypnotism except under the direct supervision of a legally qualified medical practitioner. If this is desired, the following words should be inserted after the word "or" at the beginning of the third line of section 3 of the Act: "when working under the direction and supervision of a legally qualified medical practitioner."

You no doubt noticed the very good article on "The Use of Hypnosis to Cure Mental Ills" in the March 7, 1960, issue of LIFE magazine.

May I conclude by reminding you that it is axiomatic in the good practict of medicine that the physician should always try to diagnose the cause of an ailment or complaint. and not merely treat its symptoms. In a neurotic person, the arbitrary removal of a symptom can do real damage, because the symptom may be only an outward sign of a deep inner disturbance. By merely removing a symptom, the unqualified hypnotist may be removing the patient's only protection, or his only "safety valve."

F. Evis, MD

Editor's Comment:

It appears that Dr. Evis has done an extraordinary good job in formulating a Hypnosis Control Act for the province of Ontario.

It was many years before the first Hypnosis Control Act in Great Britain was passed and it was enacted largely because of the excellent work of Dr. S. J. Van Pelt, President of the British

(Continued on Page 28)

REGISTRATION BLANK

American Institute of Hypnosis
8295 Sunset Boulevard
Los Angeles 46, California

Dear Sirs:

Enclosed please find check for$..... (Minimum $100 deposit for each person taking course.) (plus minimum $100 deposit for each person taking tour.) I understand this money is a deposit for Course #106 and/or the Deluxe Hawaiian Air Cruise (Oct. 29-Nov. 5) as indicated below. Fees completely refundable until Sept. 1, 1960.

How Many Persons Taking Course?.....

Names:.....

.....

How Many Persons Taking Tour?.....

Names:.....

.....

Children? (state names and ages):

.....

.....

Single or Double Accommodation?.....

PLEASE PRINT IN BLOCK CAPITALS AS YOU WISH DIPLOMA TO READ

Name .....

Address .....

City ..... State.....

Telephone ..... Degree.....

From ..... Year.....

Specialty, if any .....

Those physicians and dentists living in Hawaii will wish to take only the course. Others will wish to take both Tour and Course to avail themselves of the cheaper travel rate with superior accommodations as well as to be present at the official banquet functions which are included. Physicians and Dentists living in Hawaii may purchase individual tickets to the Luau and Catamaran Ride at the Hotel.

COST OF HAWAII COURSE NO. 106

Price of Week Long Course.....$300

Price of Week Long Course
$300.00 per person

Price of Tour single occupancy
$398.00 per person

Price of Tour double occupancy
$360.00 per person

Tour includes: Round Trip Jet transportation aboard either United DC-8 or Pan American Boeing Jet 707 from Los Angeles or San Francisco and greeting and transfer to the Hotel on arrival in Hawaii. 7 nights at the Hawaiian Village Hotel in Deluxe Village Tower rooms whose regular rate is $22 and $24 per day. These rooms all have individually controlled air conditioning, private bath and Lanai. Tour also includes Luau, Circle Tour of the Island, Catamaran Ride with Chicken Dinner on board.

NOTE: EITHER THE TOUR OR THE COURSE MAY BE TAKEN TOGETHER OR SEPARATELY.

United DC-8 Jet Mainliners and Pan American Boeing 707's will leave San Francisco and Los Angeles early Saturday afternoon, October 29th, 1960, and arrive in Honolulu between 3 and 4 P.M.

HYPNOSIS IN MEDICAL PRACTICE

(Continued from Page 17)

sire for some help is present, hypnosis is a relatively easy procedure. "If one has a positive attitude and an open frame of mind, he can be hypnotized."

Hypnosis is by no means a panacea for the treatment of all disease conditions, but let me again state, it is a wonderful tool to have in a physician's or a dentist's armamentarium.

A NEW LAW ON HYPNOTISM FOR ONTARIO

(Continued from Page 22)

Society of Medical Hypnosis and Editor of the British Journal of Medical Hypnotism. Certainly we must thank such public spirited citizens who devote their time to such worthy projects to the end that the public will be protected against charlatons.

These two legislative acts may well form the basis for legislation in this country in the future.

HYPONSIS AS AN OFFICE EXPEDIENT CASE PRESENTATIONS AND DISCUSSION

by John A. Ray, MD, FAIH

A prevalent concept among professionals and laity alike regards hypnosis as a lengthly, time-consuming, mystic modality. This "feeling" or impression, whether openly expressed or implied, creates a preconceived, deterrant force of vast magnitude to the physician with limited experience in hypnosis. How often one hears the comment "I'm too busy to take the time to use hypnosis"; or "I *would* like to use hypnosis, *but* . . .".

Hypnosis *can* be utilized in selected routine office procedures *not* as a consuming adjunct, but as a profitable expedient. The patient profits by freedom from anxiety and discomfort. as well as by the rapid formulation of rapport. The physician profits by conservation of his time, his effort, and by the emotional relaxation which he derives.

Hypnosis is employed in this office for two broad categories of patients:

1. Those patients who are injured or in acute discomfort;
2. Selected patients with psychological or emotional problems of chronic nature.

Patients in group 1 are seeking immediate relief from discomfort and/or restoration of an injured member to "normal." They are not seeking hypnosis per se. . . conversely, patients in group 2 have been previously evaluated both physically and psychologically. They *are* present for hypnosis *and they know it.*

Generally, patients of group 1 are willing to grasp eagerly any avenue of escape or relief offered without unnecessary rationalization or emotional introspection. Often they border on hysteria or collapse. As such they usually accept hypnosis with minimal resistance and with an aclarity often surprising to the operator. Initially, patients in group 2 may exhibit varying degrees of reluctance or resistance toward hypnosis. Yet, by the time the patient voluntarily presents himself for hypnotherapy he is virtually saying "*please* . . . I want your help . . . I am ready to cooperate now." Those patients still resistant or reluctant after the mind-set or orientation seldom make, and rarely keep an appointment for the actual therapy. The mind-set, the special fee, the prestige factor and rigid screening all combine to minimize induction problems within this group.

With patients in group 1 formal induction techniques are seldom employed. Despite this, hypnosis readily develops through the simple expedient of observing the actions and interests of the patient, elaborating upon them, and re-directing them toward the therapeutic objective.

CASE PRESENTATIONS

The first case is that of a three and one-half year old child brought to the office for repair of a through-and-through laceration involving the pinna of his left ear. Bleeding was moderate but the cosmetic defect was very obvious. When first seen the child was lying on a treatment table, wide-eyed, terrified, wet with perspiration, a wet bloody towel wrapped about his head, and a restraint sheet tightly about the remainder of his body.

DR.—"What in the world happened to you?"

PT.—"Hurt my ear" (sobbing loudly)

DR.—"It must be awfully bad to make you bleed like that . . . (Pt. sobs louder) . . . I want you to tell me all about it; but first you look very hot lying there all wrapped up in that sheet, aren't you?" (Pt. stobs sobbing and nods head). "*I* think you are much too big to be tied down . . . would you like to have that sheet taken off so you may

sit up and be comfortable?" (Pt. nods and immediately sits upright on the edge of the table). "You look better already . . . now, let's take a look at that ear (removes towel) . . . My that *is* a bad cut . . . it must have hurt you very much . . . tell me, how did it happen?"

PT.—"Wethlin wif my buther."

DR.—"Is your brother bigger than you or smaller?"

PT.—"He bigger."

DR.—"When you wrestle does *he* always win . . . or do you win sometimes?"

PT.—"He *always* win!"

DR.—"Now that just isn't fair . . . you should win sometime and he should win some . . . don't you think it should be *your* turn soon?" (Pt. nods head). By this time the wound had been completely cleansed and prepped without any apparent reaction by the patient . . . "Now *I* need *your* help . . . would you like to play a little game that would be lots of fun, and would help me be sure that you will be all well very soon?"

PT.—"Don't know."

DR.—"All you have to do is to think about how you got hurt . . . and when you think about it hard enough it will be just as if you were there wrestling again . . . then when I ask you about it you can tell me everything that happened and I can be sure everything is just right! Can you do that?"

PT.—"Don't know."

DR.—"Would you like to try?"

PT.—"Yes."

DR.—"Go ahead."

Within a few seconds the child's gaze became fixed and his facial muscles relaxed. Testing the skin about the wound with a needle elicited no response. No anesthetic agent was employed. The wound was repaired and a dressing applied. The child had remained immobile throughout the procedure. On his return visit the patient gave me the cue as I walked into the room.

PT.—"Dot a new hobby-horse!" . . . (what more could I ask for.)

DR.—"You did? . . . I think that's wonderful . . . what color is your horse?"

PT.—"Back an wite."

DR.—"Is he a big hobby-horse or a small hobby-horse? Show me."

PT.—"He big!" (holds hand over floor)

DR.—"I'll bet you love him . . . but I know you haven't been able to ride him much with this bad ear. have you?" (Pt. shakes head) . . . "But you *will*, just as soon as I make sure you are *all well* . . . I'll tell you what; you know I'm not going to bother you here, don't you?" (nods again) "Then, if you like, you can play that game again . . . if you think about riding that horse hard enough it will be *just as if* you were riding him all the time I am looking at your ear! Would you like to do that?" (Pt. nods) "Go ahead."

Response was identical to the previous visit. After removal of sutures and application of a small bandage the patient was told "All right . . . we're all through." The child looked up and asked "Foo?." He then looked scornfully at his mother stating indignantly "Tee . . . told you, no tiches!".

Case two is that of a fifty-seven year old executive employed in a purely seasonal enterprise presenting a complaint of chronic, intermittent insomnia of eight years duration, most pronounced during vacation periods. During previous "vacations" at least part of his leisure had been utilized for hospital care in an attempt to solve his problem. He had summaries of evaluations from Johns Hopkins, Oschner Clinic, and Duke University. Each reported no physical abberation but reported an amazing capability of this man to remain apparently wide awake despite heavy and varied sedation while under constant observation.

He had been referred for hypnotherapy and literally demanded immediate results without examination or evaluation. He was assured that such relief *was* available, but only *after* his insusceptibility to conventional sedation had been established to *my* satisfaction. On each subsequent visit he denied any benefit from prescribed sedation and repeatedly insisted on hypnosis. Each time his request was firmly denied until *I* was satisfied.

On his fourth visit he walked behind my desk and placed a fifty dollar bill into my jacket pocket. "Money is no object. I know this is more than you charge for one visit, but *please* help me *now*, won't you?"

It was agreed that I would treat him as *I* felt indicated *if* he would do exactly as he was instructed and would give me a completely honest report.

"Tonight after dinner take a hot bath; dry thoroughly; put on your pajamas; turn off the light; then kneel at the side of your bed and say your prayers — everyone should say their evening prayers; then get into bed; make yourself comfortable and finally see how many deep, slow breaths you can take before you go to sleep . . ."

After a silence of approximately thirty seconds the patient asked indignantly "Well what then?"

"That's all . . . call me tomorrow," he was told.

The patient exploded verbally with derogatory comments of which the most complimentary were "Crook, thief, and charlatan." After exhausting his colorful vocabulary the patient remained silent.

Dr. — "Would you really like to get your money back?"

Pt. — "H--- Yes!"

Dr. — "How many deep breaths do you think you *can* take before going to sleep?"

Pt. — "A million! I couldn't sleep now!"

Dr. — "All right — If you honestly take as many as *ten* before going to sleep, I'll give you your money back. Is that fair enough?"

Pt. — "I'll be waiting when you get here tomorrow!"

The following morning this man was seen first and was smilingly offered his money back. He waved it aside.

Dr. — "Did you sleep well?"

Pt. — (Nodded head).

Dr. — "How many deep breaths did you count?"

Pt. — . . . (Flushing) . . . "*Two.*"

Dr. — "Do you still want your fifty returned?"

Pt. — "No . . . But I'll give you fifty more if you'll tell me how you did the trick!"

Subsequent correspondence with this subject has revealed no recurrence of insomnia for over six months, surprisingly enough.

Case three is that of a thirty-two year old cartoonist seen on his first visit for a ragged laceration across the dorsum, left hand. Upon entering the treatment room one saw a slender, quite pale young man. He was perspiring profusely, trembling, and gently snifting aromatic ammonia.

Dr. — "Let's take a look at that hand . . . That *is* a nasty cut . . . How did it happen?"

Pt. — "I cut it on a piece of metal on my car."

Dr. — "That must have been extremely painful . . . (Pt. agrees and holds ammonia closer) I see from your record that you are an artist . . . You must be quite concerned about any injury to your hand."

Pt. — "I *am!* And I am supposed to finish a lay-out before tomorrow . . . I don't know what to do!"

Dr. — "Now that we've cleaned this up a bit it looks much better. I feel sure that we can have you able to meet that dead-line."

Pt. — "But I was just telling the nurse . . . I was a Navy medic for two years . . . never did learn to stand pain or the sight of blood . . . and novacain. I saw a lot of guys worse off from it than from their injury!"

Dr. — (Selecting a tuberculin syr-

inge and withdrawing 0.02cc blokain) "Then *this* should be very interesting to you . . . you know how much novacain you would need for a cut this long, don't you? . . . (Pt. nods) . . . then look at this carefully . . . this *new* local is really terrific! . . . only a minute amount is required, yet it acts instantaneously and spreads very rapidly over a wide area." (At this time the needle was suddenly inserted intra-dermally adjacent to the wound) . . . "As you can notice . . . . You feel immediate coldness, numbness, and tingling, don't you?" . . . (Pt. nods and smiles, ignoring the ammonia) . . . "Now this numbness will spread rapidly over your hand . . . how far has it spread now?"

Pt. — "Gee!, My whole hand is numb back to the wrist! That *is* something!"

Dr. — "I thought you would like that. Now you may relax and enjoy yourself since you have nothing to worry about. Think about your sketches or whatever you like . . . You'll be surprised at how very good you will feel soon."

The patient closed his eyes and became quite relaxed. His glove anesthesia was more than adequate to permit debridement and closure of the wound without conscious perception by the patient.

Dr. — "You look so comfortable . . . almost as if you were asleep . . . I don't wish to disturb you . . . but, in a minute or so, whenever you are ready you may arouse yourself feeling wonderful and refreshed . . . the next time you come here, and every time, you will know only pleasant anticipation . . . (Pt. opens eyes, yawns, and smiles) . . . "How do you feel?"

Pt. — "Wonderful! . . . Would you please give my dentist the name of that drug?"

DISCUSSION AND COMMENTARY

These are not isolated, "special" cases; nor are the techniques new or original. Many, many other examples of this type application are available, not merely from my practice, but from everyone's. They are available from the practice of physicians who have never thought of the term "Hypnosis" as related to their work. And yet, regardless of the label, whether it be hypnosis, suggestion, distraction, or any other word one may prefer—*The result is the same!* and that is the froemost point to bear in mind.

As physicians it is not our desire to prove the validity of hypnotic phenomena to *any* patient, but rather to relieve the discomfort of that patient, and to restore the function of that patient to his or her "Normal" by the easiest, most direct and least expensive means available.

Every physician will derive a certain degree of personal satisfaction or pride from his efforts in cases similar to these. This must be satisfaction and pride based on two factors . . . the final therapeutic result, and the interpersonal relationship established with the patient . . . if at any time we covet the idea that we, through our own prowess, have been able to force or fool the patient into submission to our desires or obedience to our fancy, we are not longer acting as physicians without ignorance, bias and prejudice.

I have been deeply impressed by the work of Dr. H. Joshua Sloan of the American Institute of Hypnosis. Dr. Sloan has devoted a great deal of time, energy, and personal enthusiasm into the attempt to stimulate or motivate physicians toward improving their communication — not only among themselves, but also with their patients and their families in everyday living. How often do we ask our patients, or our friends, or our family "How do you feel?; What seems to be the trouble?" Yet do we really mean this? How adequately can anyone describe "How" he actually feels? The feelings, the sensations, the emotions, which a person has may, perhaps, be understood in part by that person, and yet the very act of labeling them or attempting to describe them may distort the original concept to the point that one may reach a totally erroneous interpretation. If throughout our lives we were capable of equanimity and understanding to simply stop talking and observe and listen to the other man—to try as best we are equipped to fully comprehend the emotions, the feelings, or the ideas which he is so earnestly attempting to communicate to us — what a different world we would have.

Yet all too often we as physicians, as scientists, as supposedly learned men become antagonistic toward those patients who may express themselves, not incorrectly, but in some manner different from that which we expect. So frequently we are misled by our own emotions and by our own inability to evaluate the basic motivations involved. The cases presented, basically, are nothing more than simple examples of applied communication. One must fully realize that an injured child is not trying to be "mean" or angry toward the doctor when he screams and fights frantically. He is pleading for help and begging for escape from his present uncomfortable situation and it's ominous implications. He is using the only means known to him through which the seriousness of his plight may be recognized and perhaps relieved. True, the injury may seem inconsequential to the physician; yet, to the child, it may well be the embodiment of every antisurvival concept he has. The child knows he is in pain. He may be in fear of losing his life. The physician who fails to understand this immediately assures the child that "It's really nothing; it doesn't hurt that much . . . you are just a cry-baby." To the child this doctor becomes just another stupid adult who doesn't understand. After all how can the child have faith and trust in the doctor's ability to make him well if the man does not have sufficient intelligence to recognize a serious condition when he sees one? However, if the doctor approaches the child *on his own level,* sincerely recognizing the sesevere pain and horrible fears, and discusses them with the child, he then becomes a reasonably intelligent grown-up, *maybe* even worth listening to.

With all the interpersonal relationships keep in mind that the word can never fully express the emotion; the label will never completely describe the article. Perhaps it will to one person, but not to all. Try to understand the difference. Once one does it becomes much easier to re-direct these apparently misplaced emotions of patients into channels which may prove rewarding to both parties. Yet do not attempt to force your ideas or personality on the patient in acute distress for they will be rejected in most instances. *We* learn from the patient in acute distress what he wants us to do to relieve his discomfort, through his speech, actions and responses. Permit him to show or tell you the "magic" he wants; evaluate his desires; then, if practical, use them directly or indirectly to motivate the desired response or reaction . . . listen, observe, evaluate, *and then act!* Take your cue from the patient . . . be the "Magic-Wielder," but wield the "Magic" which the patient indicates he thinks most advantageous for him. By following this simple rule, the induction of hypnosis in patients with acute discomfort will create little problem with respect to time or effort expended.

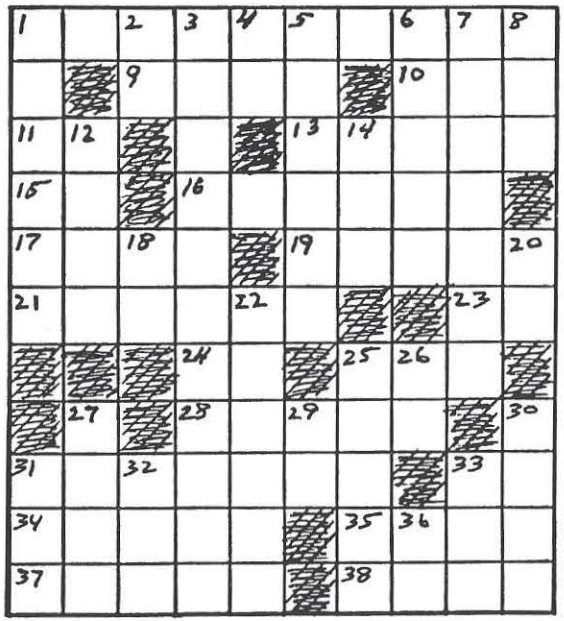
LETTERS TO THE EDITOR

(Continued from Page 3)

TO WHOM IT MAY CONCERN:

This is to certify that I have lectured for the American Institute of Hypnosis both in U.S.A. and Europe, and have published articles by members of the Institute in the British Journal of Medical Hypnotism. From what I have experienced, I am sure that the Journal this Institute proposes to publish will be of an excellent standard.

S. J. Van Pelt, M.B., B.S.
President of the British Society
of Medical Hypnotists.



DEFINITIONS

ACROSS

1. Hypnosis (French)
9. Moveable structure
10. Plot of ground
11. Toilet
13. Love (Ital.)
15. Account of
16. Yearly
17. Flower
19. Passageway
21. To cause to enter a trance
23. Organization for treatment of alcoholics
24. Company (Abbr.)
25. Repeat
28. First half of Rum & Coke
31. ⅓ of the French motto
33. Pronoun
34. Scottish Miss (2 words)
35. 2nd phase of development
37. Patient took a turn for it
38. Home

DOWN

1. Location of latest International Course in Hypnosis
2. Police Dept.
3. Failure (3 words)
4. Egg
5. "Sleep"
6. Dental hypnotist
7. Most famous French contemporary hypnotist
8. Summer (French)
12. Grain
14. Greek letter, English article (2 words)
18. Reservoir of the Libido
20. HQ of the Institute
22. What the Institute gives
25. Exec. Director
26. For example
27. A part of 1. Down
29. Bachelor of Theology
30. Last name of World-famous medical hypnotist
31. Order
32. Counter
33. Possession
36. Neon

Solution to Crossword on Page 48.

THE TREATMENT OF ENURESIS

by William J. Bryan, Jr., MD, FAIH

Some textbooks have stated that Hypnosis is of little value in the treatment of the Enuretic patient. It has been further stated that the greatest value of Hypnosis is in reducing the child's anxiety with regard to his bed wetting.[1] It has always seemed to me that anxiety regarding one's illness, especially an illness as socially unacceptable as bed wetting is a perfectly normal thing and any child who didn't feel ashamed of bed wetting would be a rather abnormal person at least in our society.

Since it is the object and function of good medical care to cure the patient whenever possible, we should first endeavour to do this. In my own experience, the treatment of enuretics by hypnosis has met with almost 100% success. What then is the correct treatment through the use of hypnosis?

In the first place, the treatment of any condition through the use of hypnosis must be carried out in 5 distinct phases. We have all heard of the 3 R's (Readin', Ritin' and 'Rithmetic) but the treatment of any case by hypnotherapy has 5 R's. RELAXATION, REALIZATION, RE-EDUCATION, REHABILITATION and REINFORCEMENT. Here's how each of these stages applies to the treatment of Eneuresis:

1. RELAXATION. In the first place, the child who presents himself for treatment is usually very nervous and has generally been dragged there by one or the other of the parents (usually the mother) who are also quite disturbed by the child's behaviour. Indeed Enuresis does not become a problem until the parents recognize it as such! In any case the parent must be interviewed and a careful history taken from the parents separately and alone. Much insight is gained from this and now, feeling they have contributed their part, they will be able to sit patiently in the waiting room while a complete history is taken from the child both in the waking and hypnotic state and a complete physical is done. After this procedure is completed and we have been able to put the patient at ease so that he is able to enter the hypnotic trance, we then carefully explore his feelings regarding his parents. Under Hypnosis we proceed with analysis to get at the underlying cause of the bed wetting. (Assuming from our physical examination of course that the disease is NOT on a physical or organic basis.) (and the vast majority are not.)

In my experience, nearly all of the children who are enuretics show a greater than normal hostility for the parents who in one manner or another prevent the child from expressing it. Either the parents are overly dominant and will tolerate no expression of hostility from the child at all or they are overly permissive to the point that nothing the child does angers them; hence the child is still prevented from adequately expressing hostility since he "can't make his parents mad or anxious." The psychopathological mechanism here is usually that the child is really fantasying that he is urinating on his parents. When the child is permitted some expression of hostility by the parents (and this is partly an educational job on the part of the doctor toward the parents) then frequently the need for the Enuresis disappears and the child stops automatically without further treatment. However, even with this reaction the treatment should be completed in order to insure a permanent cure.

2. REALIZATION. In this phase the patient actually realizes why he is wetting the bed and then works the problem through with the help of the physician who frequently plays the role of the father or mother and allows the pa-

tient to take out his "hostility" on the physician through various subterfuges. Dr. H. Joshua Sloan, Research Director of the Institute maintains a tackling dummy in his attic labeled "Daddy" just for this purpose. At evening, the children are so tired from beating up the tackling dummy in the day time that when he arrives home he is met at the front door by his children with his pipe and his slippers in their hands.

3. RE-EDUCATION: This phase must take place in which the child actually sees that the Enuresis is after all a very ineffectual method of expressing hostility, and that we all need to express some hostility once in a while and that there are some very acceptable methods of doing it. (For instance in the case of one musically gifted child, he himself decided that he would beat his drums every time he got mad. He established this habit pattern and is now well on the way to becoming an excellent jazz band drummer.)

4. REHABILITATION. Even though the *Underlying Cause* has been discovered and worked through, in many instances the *HABIT PATTERN* established by the child has been so strong that the enuresis will remain even though the cause has been removed. It is in this phase of treatment therefore that the most ingenuity must be used. Here are some of my techniques for REHABILITATION of the Enuretic:

A. Frequently we use Hypnosis to strengthen the muscles surrounding the urethral orfice thereby preventing bed wetting on a neuro-muscular basis. This is done in two ways: 1) by having the patient start and stop 3 or 4 times every time they urinate. (A post hypnotic suggestion is given which keeps the patient doing this during the treatment phase then is removed later.) 2. By letting the muscles around the urethal orfice contract as all other muscles relax (under hypnosis.)

B. Drying the Bed in Stages. We never speak of bed wetting but only of bed drying emphasizing the positive aspect. For example: The Doctor may inquire, "How much of the bed were you able to keep dry last night?" or "How many days last week were you able to keep the bed completely dry?" By continuing with this approach, the patient himself may be asked "When will you be able to keep your bed completely dry all the time?" and frequently the patient will then set a goal for himself which he will be able to keep quite accurately! One may very gradually dry the bed by keeping one per cent more dry each night until the bed is all dryed up.

C. A recent article in GP magazine[2] praised the merits of the enuretic alarm. Others found it useless. Such alarms are usually manufactured and installed so that when the patient wets the bed it will complete an electrical circuit thereby waking the patient. The unfortunate part of this is that the patient is never awakened until *after* he has already *wet* the bed. It not only does not prevent the patient from wetting the bed but also calls to his attention that he is performing an unaceptable behaviour pattern and adds to his anxiety.

An eneuretic alarm which would waken the patient *before* he wets the bed would seem to be of inestimable value since it would actually *prevent* the bed wetting. Such an alarm can be installed *within* the patient himself through the use of Hypnosis. We simply suggest to the patient that as his bladder fills during his sleep, his right arm will rise, rise high in the air, until, JUST BEFORE his bladder is full, his hand will touch his face and wake him up. He understands and interprets this as a suggestion to the effect that he will awaken *before* he wets the bed yet the term bed wetting has never been mentioned. He then will awaken and go to the toilet. Some critics of this alarm have stated that this merely converts enuresis into nocturia, and so it does, but certainly nocturia is much more accepted socially than enuresis; and since it is accepted by the parents, the child is no longer able to express hostility through the means of nocturia

as he was previously able to do through enuresis, and frequently, after the alarm has been in effect for a month or two, both enuresis and nocturia cease. Since the patient's need to use them to express hostility in the first place has already been removed by the use of Hypnoanalysis, all that was necessary was to break the habit pattern through these techniques of Rehabilitation and a permanent cure results. No need to worry about a substitute mechanism taking the place of the eneuresis since the patient himself has already developed a different method of expressing hostility to his parents.

5. RE-INFORCEMENT: This may have to be done at certain specified intervals in order to maintain the progress achieved, however frequently this phase may be omitted altogether.

CASES:

Case No. 1

A 4 year old girl Miss R. A. w'd w/n daughter of a young widowed secretary developed enuresis following her father's suicide. She exhibited hostility toward her mother especially when her mother had to go to work to support the family. Physical examination revealed nothing abnormal and after three treatment sessions the Bryan Eneuretic Alarm was installed by post-hypnotic suggestion. One month later the patient was able to keep her bedding dry except for the nights before each medical visit. This indicated a transference of hostility to the physician and after working this through she remained dry altogether and has had no recurrence for 1½ years.

Case No. 2

Miss R. C. — a 14 year old girl has a background of 2 previous broken homes. Her father died while she was very young and her stepfather though good to her had not replaced the idea that her real father somehow deserted her. Both parents have had psychiatric care and at one time previous to their marriage the stepfather had performed an illegal abortion on the girl's mother. The girl however is unaware of this but the family life is one of constant tensions. Soft spoken and shy, the girl was unable to express her hostility for her mother, father (now deceased), and stepfather in any way but bed wetting. After one month of treatment she became more normal in her expression and with the aid of the Hypnotic Alarm and start and stop exercises she conquered her problem in less than 6 months. No recurrence to date. (four years ago).

Case No. 3

Master B. M. a 9 year old boy whose parents were very permissive. So much so that he would lash out at them in order to receive some authoritarian behaviour from the father, but the father being a milk-toast individual tolerated all sorts of abuse from the boy and only became upset when at the age of seven the boy spilled a glass of water on a new bed-spread. Since that time eneuresis has been a problem. When the boy realized the reason for his bedwetting, he stopped immediately and no alarm or exercise were necessary. (No relapse in two years). Further educational training for both parents was recommended.

Case No. 4

Miss P. T. a 16 year old girl who had seen numerous psychiatrists, surgeons, internists and has maintained her enuresis on a psychogenic basis since birth. Her father was a physician and mother was an architect. Neither seemed to have time for the child except of course to aid her with her illness. By age regression many instances were found in which attention was lavished on the child only if she were ill and gradually this chonric illness took the form of enuresis which enabled the girl both to receive attention and to exprress hostility. One other incident occurred at age 5 when the girl was almost raped by an over amorous uncle, but she saved herself by urinating on his clothes and this defense mechanism also had entrenched itself. When substitutes for all three mechanisms were found:

1.) Hostility — she became champion of a rifle team.

2.) Attention — she began going steady with a boy friend (of whom the parents incidentally disapproved. He was a portrait painter.)

3.) Defense — no longer needed as she was unlikely to be raped.

Then she gradually began to stop wetting the bed and six months later, installation of the alarm brought about complete recovery. The girl finally broke up with the artist and went to college after a painful episode in which she feared she was pregnant, but even these blows to her ego did not restart the enuresis. Patient is now an honor exchange student in Europe in her junior year.

Bibliography:

[1] Hypnosis in Modern Medicine by Jerome Schneck.

[2] Enuresis in Children by Harry Bakwin, M.D. GP April, 1959, page 120.

REPEATERS: A.I.H. RETURNED TO THESE CITIES

GALVESTON
TEXAS

LAS VEGAS
NEVADA

MACKINAC ISLAND
MICHIGAN

NEW ORLEANS
LOUISIANA

Since the approval of hypnosis by the American Medical Association, the American Institute of Hypnosis has led the field in holding training courses for physicians and dentists throughout the world. Indeed, in the January issue of the Journal this year a pictorial report to the nation was given on the international courses which were offered by the American Institute of Hypnosis. From such far points as Paris, Hawaii, and South America, doctors have congregated to learn about this new medical therapeutic tool. Many physicians, having taken one course in hypnosis are not satisfied to stop there, but progress, taking more and more advanced courses, and from their utilization of it in their practice, gain practical experience so necessary to becoming an expert in the field. It became necessary, therefore, to repeat courses in certain cities and to even offer additional advanced training where the demand was great. We found four particular cities in the United States to which we have returned and to which we find our physician-dentist students desire to return. They are: Galveston, Texas; Mackinac Island, Michigan; New Orleans, Louisiana; and the grand repeater of them all — Las Vegas, Nevada.

Having held five courses in Las Vegas, the American Institute of Hypnosis must recognize the great popularity of this American resort. Contrary to popular belief, however, the big attraction in Las Vegas seems to be the ability to relax there rather than the obvious attraction of gambling and nightclub shows. Swimming, golfing, and boating on nearby Lake Mead help to relax the tired physician and enable him to actually get more out of his training. Astonishing as it may seem, our attendance reports show that less than two percent of our students are missing from class at any one period despite the fact that the training extends from early morning to late at night so that physicians and dentists will make the maximum use of their time. With all the possible distraction in Las Vegas, this fact alone is a tremendous compliment to the teaching staff of the American Institute of Hypnosis, and hotel managers and casino managers (sometimes to their dismay) have been open-mouthed in amazement at the fact that our classes invariably have near perfect attendance. This goes to prove another important point, which is that the students that sign up for the American Institute of Hypnosis courses are serious-minded doctors who are eager to learn this new and extremely useful therapeutic technique for the benefit of their patients. This is perhaps the one characteristic that most frequently characterizes the general student body in institute courses.

New Orleans, Louisiana with its picturesque French Quarter is a popular gathering place for physicians and dentists during the winter months, and strange as it may seem, classes in New Orleans have always outdrawn those in Miami Beach. In January of 1959 the Institute held a course at the Roosevelt Hotel in downtown New Orleans where a number of doctors gathered not only to learn about hypnosis in medicine, but also to view a fabulous collection of rare books on hypnosis, which included over four hundred publications, many in foreign languages and many out of print. Those who attended that course will never forget this thrilling display. One year later the course was repeated at the beautiful new Fontainebleau Motor Hotel on Tulane Avenue in New Orleans. The faculty was expanded at this course to include Dr. Lester Millikin from St. Louis and Dr. John A. Ray from St. Petersburg, Florida. Those who attended this course will remember the fascinating talk on Hypnosis in Pediatrics given by Dr. Ray as well as the showing of additional movies made by Dr. Millikin himself in his many surgical films showing the various possibilities for the utilization of hypnosis.

On two occasions the warm waters of the Gulf of Mexico and the beautiful surroundings of the Jack Tar in Galveston, Texas proved irresistable to physicians and dentists seeking training in hypnosis in a relaxed atmosphere. It has been a guiding principle of the Institute that we should practice what we preach and that it is very difficult for a tense doctor to relax a tense patient. The doctor who himself shows that he is relaxed, comfortable, and at peace with himself through his own actions is obviously a much better prepared individual to handle the tensions of others. By holding courses in hypnosis in areas where the physician himself finds it easy to relax, we not only teach the relaxation therapy of hypnosis, but we actually put it into practice while the course is in progress. Students and instructors at the Galveston course line up along the beautiful bridge over the picturesque swimming pool for their class picture (pg. 41). One group of doctors in Texas has sent a different member of their clinic each time the Institute has held a course in the Gulf area.

Perhaps one of the most famous areas for relaxation in this country is the "Bermuda of the North," the beautiful Grand Hotel at Mackinac Island, Michigan. In this setting of thousands of pine trees, with hundreds of acres of virgin forest land, the Grand Hotel sits atop majestic Mackinac Island, dignified and genteel. Erected in 1888 by Commodore Vanderbilt and other railroad interests, the Grand Hotel has been a meeting place for elite conventions from all over the world. The largest summer hotel in the world with European style cuisine served only to those who "dress for dinner" the hotel maintains its aloofness and still makes everyone feel relaxed and comfortable.

Perhaps the most quaint feature of the island is the fact that no automobiles are permitted and the horse-drawn carriages take over the duties of taxi cabs, trucks, and passenger vehicles. This instills a no-rush attitude into the visitor as soon as he arrives and the Mackinac Island guest soon finds that "you can't hurry a surrey." With this suggestion of relaxation skillfully planted in the mind of the newcomer, it is not long before the blood pressures of the various physicians drop and the leisurely, relaxed, thoughtful attitudes so necessary for the deep thinking in learning hypnosis, replace the rushing, frantic pace of the average doctor's existence. •••

A METHOD OF RAPIDLY OBTAINING THE THERAPEUTIC STAGE OF HYPNOSIS

By: H. Joshua Sloan, DDS, FAIH

In course 101 of *The American Institute of Hypnosis*, Dr. William J. Bryan, Jr. of Los Angeles outlines a novel manner of evaluating the depth of the hypnotic state. Correlating hypnosis to anesthesia, the planes and stages of which are familiar to all physicians and dentists, he labeled this unique table as "HYPNOSTHESIA" (not hypno-anesthesia).

Hypnosthesia Chart I:

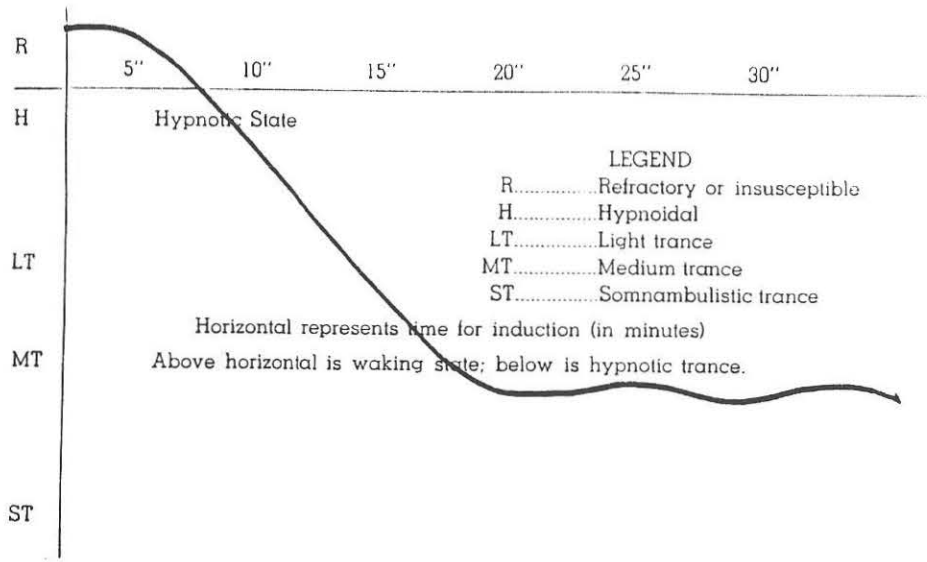
Hypnosthesia

1st			1st Stage—Hallucinatory Phase of Induction
2nd			2nd Stage—Resistance Phase of Induction
3rd	1	Third Stage Diagnostic & Therapeutic	1st Plane—Hypnoidal
	2		2nd Plane—Light Hypnosthesia
	3		3rd Plane—Medium Hypnosthesia
	4		4th Plane—Deep Hypnosthesia
4th			4th Stage—Stuporous Stage

An older, still useable method of gauging hypnosis is Moss's Hypnograph. This introduces an important factor, the element of time.

Chart II:

MOSS HYPNOGRAPH



Some of us who have labored a long time "in the vineyards" of hypnosis and who have had the opportunity to learn Dr. Bryan's chart have noticed an outstanding characteristic about the 4th stage of hypnosthesia. (Unlike the 4th stage in anesthesia, the 4th stage of hypnosthesia has little significance of disaster or danger in *qualified hands*).

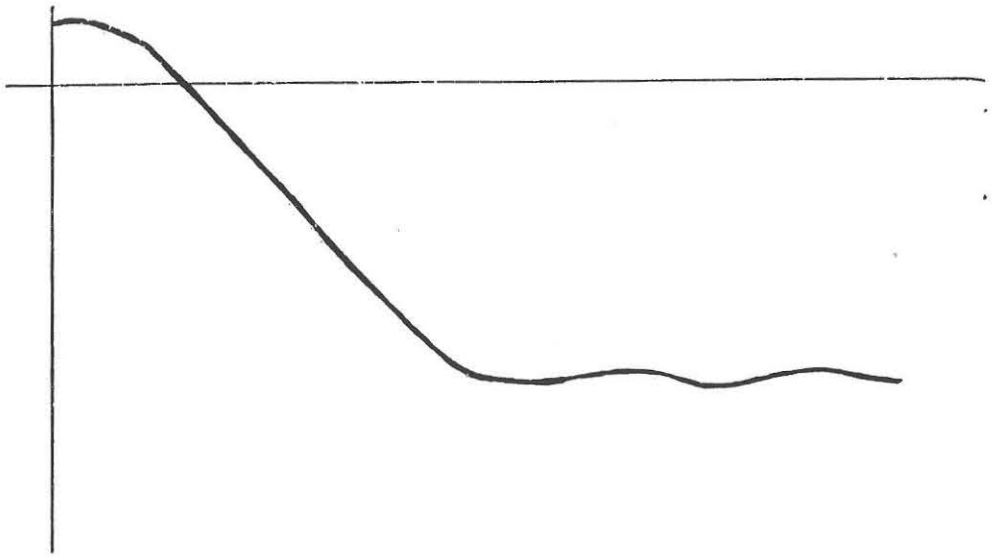
THE OBSERVATION:

When induced in a simple manner, most patients demonstrated a rapidly acquired comotose state comparatively early in the induction procedure. We noticed that this state seemingly disappeared with certain "deepening" procedures and/or "tests," therfore we conjectured:

THERE IS A STATE, RATHER EASILY AND QUICKLY OBTAINED IN INDUCTION, THAT RESULTS IN AN ALMOST SPONTANEOUSLY ACHIEVED FOURTH STAGE OF HYPNOSTHESIA. Some characteristics of this state are: SPONTANEOUS ANESTHESIA OF PROFOUND DEPTH, EXTREME RELAXATION, AND EXCEPTIONAL REJUVENATING PROPERTIES. THESE ARE DISSIPATED RATHER THAN AUGMENTED BY THE USUAL TESTING PROCEDURES.

When the usual induction and deepening procedures are used, a chart of the time versus depth was described formerly as follows:

Chart III:



Our observers have noticed that the chart should be as follows:

Chart IV:

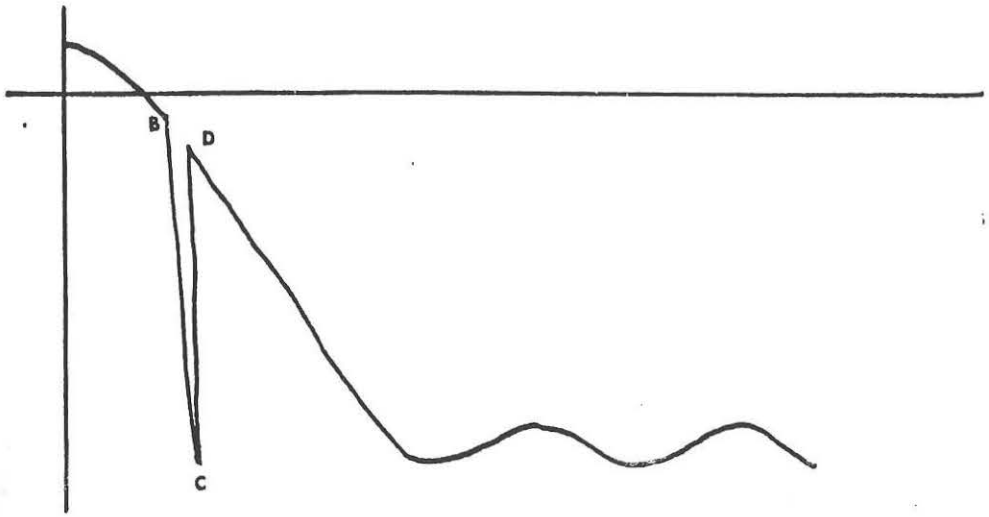
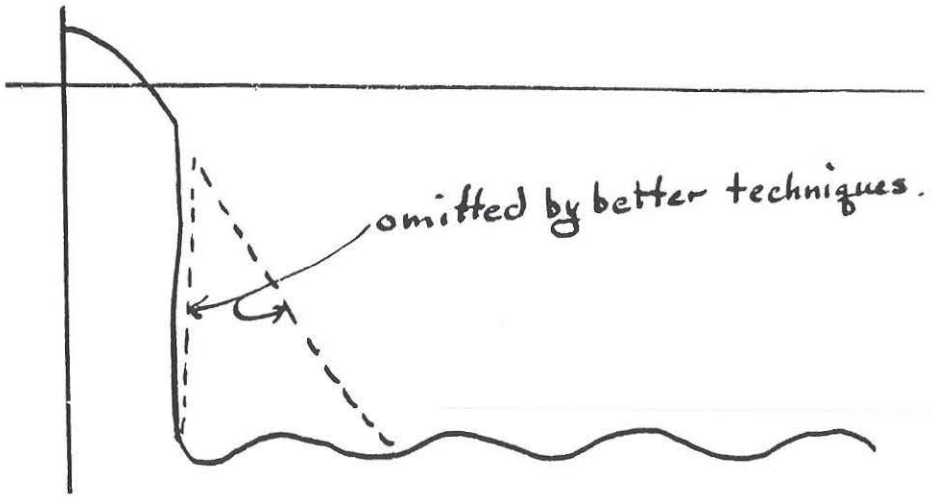


Chart V:



THREE MAJOR ADVANTAGES:

1. Less conflicts in patient.
2. Greater depth achieved.
3. Less time to achieve desired depth.

Sample simple induction procedure (one of the very many presented in courses of the A.I.H.)

After proper orientation of the patient, the doctor states:

"Fix your gaze on that spot." Usually on ceiling slightly behind patient which would cause the patient to exert a slight effort. With children (as well as adults), a gold paper star fixed on a bare ceiling is a good point.

"Soon your lids will feel heavy and you will want to close yours eyes."

"When you close your eyes, you will keep them closed and relax all over."

"Please keep your gaze fixedly on that spot."

"Your lids feel heavier and heavier."

To some patients: "The spot will become dim or blurred as the lids feel heavier."

"The lids feel heavy as the spot becomes blurred."

"With each breadth, your lids become heavier and heavier."

As lids falter: "There, they are very heavy."

As lids close: "Now colse your eyes and relax all over, completely relaxed."

Simple deepening procedure No. 1: "With each deep breath, you become twice as relaxed as before."

Doctor exhales deeply. Well induced patient will follow suit.

Simple deepening procedure No. 2: "Let his hand float into the air in front of you." Doctor helps.

"It will float down to your lap."

"As it floats down, you will go deeper and deeper."

"As you go deeper and deeper, your hand will float down."

"When it reaches your lap, you will be twice as deeply relaxed."

Simple deepening procedure No. 3:

"Let this finger float up" or

"Raise your finger." Doctor touches.

"Just as we went deeper with each breath and with the hand floating down, you will go deeper as your finger floats to your lap."

(Continued on Page 45)

PROBLEM CLINIC

Conducted this month by:

H. Joshua Sloan, DDS, Director of Research

Dear Problem Clinic:

I have a patient, a bright boy, ten years of age. Although he seems to be well adjusted and enjoying a healthy relationship with his siblings, a sister age 14 and a brother age 8, as well as with his parents, friends, teachers, etc., he still constantly sucks two of his fingers and wets his bed at night. The parents have tried many methods which included the electric alarm, psychotherapy (via a licensed therapist), alteration of the family relationship and attitudes, etc., to stop the problem of enuresis with no success. We are reluctanct to institute treatment for the "thumb-sucking" because of our lack of success with the treatment of the enuresis via the many prescribed methods. Can you suggest method likely to have success?

R.J. DDS.

* * *

Dear Doctor:

In answer to your letter I am certain that there is no need for me to state that every patient must be evaluated individually and personally. You state that in your opinion, the child does seem to be well adjusted in all the important areas. This indicates that the psyche of the child has been well attended to by the responsible individuals. We should never forget the five important steps of pattern alteration. A habit changing therapy for the above case can be considered as follows:

1. Establish a good relationship with the child and be certain that the child has a good opinion of himself.

2. Let him know that you had the same problem and solved it.

3. In hypnosis have him experience the bad habit so that he becomes "aware" on the conscious level of the sensations of the habit and on the unconscious levels of his desire to eliminate this habit.

4. Again while in hypnosis, have him experience the substitute habit. In cases such as this, I have suggested to grasp the fingers used in the sucking in the fist of the SAME hand.

5. Remember to encourage, to be optimistic and to compliment the patient upon the slightest success.

6. Be prepared to even accept any regression as only *temporary*. Be certain that the parents are not involved in the role of reminding the patient. etc. (The parents' reminders in the past seemed to have had the sole effect of intensifying the habit). Insist that. for most rapid results, that the parent's role is that of less-than-observers. insofar as this problem is concerned. The responsibility to remind the patient must come from the doctor.

7. We have repeatedly emphasized that the indirect suggestion is much more effective than the direct suggestion. One of the techniques used in reminding the patient is to give him a bite plate with a rather pronounced ridge upon the palatal portion lingual to the upper incisors. It is surprising how prominent a ridge that patients can tolerate, how small a ridge is necessary as a reminder (however, a pronounced ridge has other benefits) and the appliance is quite effective. This appliance should not be used for longer than 6 weeks, unless under the supervision of an orthodontist. One patient who stopped the thumb-sucking the first night lost her appliance at the end of a week. It had been so effective that the parents decided that it was not necessary to make a new one. .

Our files show 8 cases where the combined habit patterns of finger-sucking and of enuresis were present, where each child was otherwise well-adjusted, and where this therapy had been effective. In the first two cases in our records, the doctor did not know of the enuresis, yet the bed-wetting stopped simultaneously with the cessation of the finger-sucking. It has been suggested that the relationship between the urinating urge and a moist finger might be the same as the reflex need to urinate that we experience when stepping into a pool. And this pool-urinate syndrome could be a conditioned response to the infant's urinating when bathed.

HYPNOTIST IN PARIS

Dr. William J. Bryan, Executive Director of the Institute, examines a four ton marble vase in the Paris City Hall. The vase was given to the Parisiennes by the Czar of Russia many years ago, and is located in a Hall of similar art treasures next to the office of the Mayor.

Left to Right: Dr. Bryan; an official of the French Tourist Bureau; and the official greeter of Paris, a woman, "naturalment."

THERAPEUTIC HYPNOSIS

(Continued from Page 43)

"Any time you are in this state which can only be induced by a qualified medical practitioner, you can achieve twice as profound relaxation by taking a deep breath or by raising and lowering your finger."

Of course, the doctor includes whatever modifications are necessitated by the patient's responses and he includes the proper therapy and awakening procedures as well.

SUMMARY:

1. Attention is called to the fact that many hypnotists are missing a very deep trance early in induction by passing over it with excessive deepening procedures.

2. A way is suggested by which this deep trance may be rapidly achieved and utilized to it's fullest extent.

A pretty young lady, obviously in a big hurry, hailed a cab at Hollywood and Vine, and informed the cab driver to take her to the office of a local medical hypnotist.

"I have an appointment with my analyst at 11 a.m. Please hurry, won't you, because if I don't get there on time he starts without me"!