Clark County Dental Society talk 11012012

Get more business with hypnosis.

Based on the suggestions given and where the attention is driven to, hypnosis can be a tremendous adjunct or complimentary therapy to modify behavior in getting the patient to come in to get their work done to sitting still and acting like the perfect patient while in the chair.

It is my opinion that all of you would have some greater amount of business if you were to survey or ask your clients, not the ones that come in every 6 months, but the ones that are scared or reticent to come on a regular basis or have work that needs to be done and do not come in from a non-money aspect and were to let them know that there may be a way that they could have some help from hypnosis, so they could come in and get their work done.

This talk will be a brief explanation of what hypnosis is and is not, with some behavior and business examples discussed.

1) A little history about hypnosis:

Hypnotic-like trances have been around for at least 3,000 years, in Egypt, the tomb of Ramses 7 has pictures of people on tables with other people standing over them and making hypnotic passes, and other hieroglyphs that describe different stages of trances. In the late 1700's, Franz Anton Mesmer, a fellow from Germany developed a procedure of what he termed "animal magnetism" which is the start of our "modern recognition" of hypnosis in our common era.

About the same time there was a Catholic priest named Father Gassner from Switzerland, who discovered a way to do exorcisms without using the churches approved protocol of the Roman Ritual, who was also affecting healing cures without medical intervention which also added to the mystique of the mind body connection in those times.

An interesting sidenote--at the time of our revolutionary war, Ben Franklin used to go to Mesmers presentations when he was in Paris to see what Mesmer was doing, and was also involved in the French version of a grand jury investigation against Mesmer (which by the way did not come up with anything against Mesmer).

Apparently Mesmer had scared the beejesus out of the French by what he did, as it is still illegal to perform hypnotism in France, unless you are a doctor.
Despite this conundrum in society about hypnosis, trance states continued to be used in medicine by doctors like one of the founding fathers of hypnosis, Benjamin Rush. Another founding father, James Braid became the father of hypnosis by actually coining the term "hypnosis" in 1842. He actually saved hypnosis from oblivion back then. Braid

divorced himself from the mesmerists, relating hypnosis to "nervous sleep". He never broke with the medical profession and was a far less controversial figure than John Elliotson, an English surgeon (1791-1868), reported in 1834 on numerous surgical operations performed painlessly under mesmeric sleep. In some sense, hypnosis as we know it began with Braid, who used it widely in his medical practice, even treating his own pains with self-hypnosis.

A doctor from Scotland, James Esdaille, performed 345 operations in India, without any anesthetic other than hypnosis, and had a superior survival rate and success rate than other surgeons at the time. The practice of surgery using hypnosis as the sole anesthetic, without ether (1846) or chloroform (1847) had a tremendous opposition and died out shortly after these 2 anesthetics came out.

It must not be supposed that the introduction of chemical anesthetics alone brought a halt to the use of hypnosis; the practice had met vigorous opposition from the start. In 1842 a physician named Ward amputated a leg while a patient was hypnotized; he reported the successful outcome to the Royal Medical and Surgical Society in London. All evidence indicated that the operation was performed painlessly, but the society refused to believe this. Marshall Hall, whose name is familiar in the history of reflex action, moved that the record of the paper's presentation should be struck from the society's minutes because the patient must have been an impostor. Eight years later, on the basis of a rumor, Hall informed the society that the patient had admitted having falsely denied his pain. Witnesses came forward, however, with a signed declaration from the patient himself that the operation had actually been painless.

Despite the moderation of Braid's views, hypnosis declined again until another revival occurred in France. Here we find two schools of thought in disagreement about hypnosis-that of the Salpetriere, headed by Jean-Martin Charcot (1835-1893), and the Nancy school, led by Auguste Ambrose Liebeault (1823-1904) and Hippolyte Bernheim (1840-1919). From them we are led to Sigmund Freud (1856-1939), a name more familiar today.

Charcot was the most distinguished neurologist of his day; the fact that he gave demonstrations of hypnotic phenomena in his clinic and explained hypnosis neurologically gave it scientific respectability. Charcot presented his findings on hypnosis in a paper read in 1882 before the French Academy of Sciences-the same academy that had assisted in the earlier rejection of mesmerism. Charcot believed that hypnosis was essentially hysterical and that its major manifestations were limited to those who suffered some abnormality of the nervous system. He was wrong in this, but because he linked hypnosis to disease, his findings became acceptable to his scientific colleagues. Freud spent some time with Charcot in 1885-1886, while Charcot remained interested in hypnosis. The Nancy school, on the other hand, regarded hypnosis as an entirely normal phenomenon and attributed it to the influence of suggestion. History has proven the Nancy school more nearly correct. Freud wished to learn from both sides and, in fact, translated the works of both Charcot and Bernheim into his native German.

Because both Charcot and Bernheim were medical men of sound reputation, their disputes were considered as part of normal scientific discussion; hypnosis' now became a matter of scientific interest and investigation. This interest was soon so general that the First International Congress for Experimental and Therapeutic Hypnotism was held in Paris in 1889. The list of participants includes many distinguished names, such as the American psychologist William James, the Italian psychiatrist and criminologist Lombroso, and the psychiatrist Freud, who did not establish psychoanalysis until later.

At this peak of interest in hypnosis in the 1880s, academic psychologists took their places along with the clinicians. It was most natural for William James, in 1890, to include a chapter on hypnotism in his classic *Principles of Psychology;* Wilhelm Wundt, often called the father of modern experimental psychology, wrote a book on hypnotism; Wilhelm Preyer, important in the history of child development, had his book also; and there were many others in many languages. Several journals devoted to hypnosis appeared, and long bibliographies were assembled to help keep abreast of the flood of books and articles. By 1900, however, it was almost all over.

In Vienna, Freud, along with Joseph Breuer (1842-1925), had begun to use hypnosis successfully in psychotherapy with patients then classified as hysterical. The result was their classic book, *Studies in Hysteria*, published in 1895. By the time the book appeared, however, Freud had rejected hypnosis. He had already substituted his method of free association and psychoanalysis; only the couch remained from his hypnotic practice. This was another blow to hypnosis, for because of their psychological orientation, Freud's followers might have been sympathetic to the use of hypnosis had not a kind of taboo been set up against it.

Pierre Janet (1859-1947) was Charcot's successor, although too independent to be thought of as a disciple. He had a large share in developing the theory of dissociation of personality as an aspect of hypnosis, and had followers in the United States early in this century-particularly Morton Prince (1854-1919), founder of the Psychological Clinic at Harvard. Janet lived a long life and was aware of the fluctuations of interest in hypnosis. In one of his books, published in English in 1925, he remarked that hypnosis was quite dead-until it would come to life again.

The new life for hypnosis began at the end of World War l. Treatment of soldiers with "shell shock" from trench warfare by English psychologist William McDougall (1871-1944) and Johannes Schultz from the German side with his Autogenic Training (a forerunner of BF Skinners behavior modification) and others brought hypnosis to the attention of scientists. An important milestone in the experimental study of hypnosis was reached when Clark Hull (1884-1952) began experimentation as a professor at the University of Wisconsin, and later at Yale University. Hull published a classic book on *Hypnosis and Suggestibility* in 1933. This work, meticulous in its use of scientific controls and statistical tests, stands even today as a model for scientific method as applied to hypnotic phenomena. Unfortunately Hull, like Freud, abandoned hypnosis once he had worked successfully with it; few of his students followed up this interest, despite his listing more than one hundred studies that needed doing but that he had not gotten around

to. But enough work was done that when Weitzenhoffer reviewed the experimental literature twenty years later, he could cite 508 references, many of them, of course, preceding the date of Hull's book.

A resurgence of interest followed World War II and the Korean War. Psychiatry was more advanced by this time than it had been in World War I; many psychiatrists found advantages in hypnotherapy, in part because it could achieve results more quickly than the methods of psychotherapy in which they had been trained. Dentists, too, found that they were able to use hypnosis when their normal supplies of local anesthetics might not be available. Clinical psychologists, drawn into service, also found hypnosis useful. After the war years, societies related to clinical and experimental hypnosis were established, with journals to publish research findings and case material. Specialty boards were established so patients could be directed to hypnotic practitioners with adequate credentials. Both the British Medical Association and the American Medical Association passed resolutions stating that training in hypnosis might appropriately be given in medical schools. Research laboratories were established at some leading universities, with support from government agencies and private foundations. Hypnosis was now on firmer ground and could advance without the sharp fluctuations of interest that had occurred in the past.

We are now prepared to consider the knowledge about hypnosis that has accumulated through the research efforts of recent decades, following this awakened interest.

Hypnosis has been approved by medical associations for over 115 years
It is my opinion that we even though we are in the year 2012, we, as a society, are still stuck in the 1790's and the 1850's as far as hypnosis is concerned.

2) Basic hypnosis fears

The3 basic fears that drive people away as a standard, knee-jerk reaction from the very term hypnosis is that
#1) people are concerned it is a truth serum and they will spill their secrets
#2) they will loose control of their mind and embarrass themselves or say something foolish.
#3) "It is of the devil", It is somehow "against God", I will boil these concepts down 2 ways.;

#1) It is many times a standard human response for people to equate a new experience or concept with attributes of a negative nature or experience so as to not assimilate same. When people are educated in rote learning style schools such as we have had in the US they may be able to develop a phenomena that is actually a phenomena of hypnosis. It is an unspoken phenomena, yet it is a hypnotic phenomena all the same. "you will pay attention to XXXXXXXXX and not YYYYYYYYY. It is called selective thinking. Now when you endow this attribute with emotion(s) like fear of the unknown, fear of sin, fear of having something unknown take over your mind, body, etc., you now have a hypnotic state going on.

#2) This concept of not being able to experience something new based on a basic fear of the unknown, in my opinion has some basis in the greek definition and term of Daemon VS Demon. You are all aware of the definition of demon (the little devil, black in color, has a tail, beard, maybe red eyes, carries a spear), well this little fellow got mixed in with the nature spirits of ancient Greece and Rome by both the spelling similarity and archetype of himself, and by the basic nature of the new Christian religion from Rome, where people were to now pray to a monotheistic God and ask for help from a saviour who is an intersessor between us and that angry God, for a human (let alone a single human, alone, not in a church) to be involved with pagan personalities like Daemons, who could have direct affect in their lives and that person would have to take responsibility for what happened and not live under the victim status being propogated by the new Christian Church of Rome, was then and is now, simply a task beyond most people. The victim status is a tremendously powerful mindset in the human psyche and is one that I occasionally am able to overcome, and in the event that I do it is because of the full cooperation of the person I am working with.

All untrue, as hypnosis is not a truth serum and hypnosis does not cause people to loose control.
In addition, it is not a portal to a world of demons, nor some sort of a start to a process of self destruction fueled from a supernatural source.

3) The vital role of the patients state in the context of hypnosis.

Hypnosis plays a vital role in every dental practitioner's interaction with patients. Fear, tension, apprehensiveness, hostility—these are some of the common attitudes towards dentistry. Anxiety may be free-floating or general—with or without avoidance of specific objects and experiences—or it may be channeled into specific symptom formation, as in dental phobias or pronounced gagging that interferes with treatment. The patient whether calm or scared, walking into the dental treatment room is in a trance state. The dentist with training in hypnosis, from the perspective of acting as a hypnotist, or benefitting from an adjunct or complimentary relationship of the patients hypnotist, can transform the patients fear and fright to a state of inner calm and comfort. Probably the greatest benefit of hypnosis to the dentist is the ability to project or further anchor and apply verbal and non-verbal hypnotic strategies to enhance patient comfort and compliance.
Are sedatives the answer? Sedation can be accomplished chemically, but chemicals cannot reeducate the patient to enable him to respond more positively to dental treatment. Unlike other types of major surgery, dental work needs to be performed again and again, thus negative reactions may be cumulative if not counteracted. Reeducation can be facilitated by hypnosis so as to reduce dental anxiety.
The dental practitioner is able to use hypnosis to help the patient distract and dissociate from their fears and concerns in the dental chair. This state of the subject is dependent on the hypnotic suggestions offered by the dentist operator and members of the dental team. What is said affects what is felt and the actions performed.

From the Dentists words, emotions and attitudes, the suggestions make the difference between not coming in at all, and showing up for a calm relaxed and compliant experience. Hypnosis suggestions also can calm the patient when the work is being performed, stop gagging, stop excess salivation, tongue thrust against the drill, help the patient stop bleeding after surgeries, speed healing and reduce discomfort after the work is done. It can also be used to reduce or eliminate bruxism. When patients reduce or eliminate dental fears they are more likely to come in regularly, so as to add to the income of your operation.

4) Drugs and surgery

The medical aspects of pain reduction center upon two large classes of pains: those brought to the dentist by the patient who is already in pain, and those caused by the dentist in the course of treatment as in the process of surgery and in the postsurgical period. The two classes are not always separable: a broken tooth, which is painful, is relieved by surgery or repair, which is also potentially painful We shall not here be concerned with the alleviation of pain by the removal of a tooth or a source of infection; important as these steps are, they belong to the ordinary practice of dentistry.

Anesthesia in surgery to prevent pains caused by the surgeon's intervention is of interest, however, because the anticipation of surgery has an influence on the drugs that may be required and on the postsurgical recovery. General anesthetics have been a great boon because of their ability to relieve pain in major operations. Their history began only 150 years ago, when ether and chloroform were introduced. These have been supplemented by many other chemical anesthetics, along with local anesthetics that reduce pain but do not produce unconsciousness.

For the relief of nonsurgical pain, and for pains that persist after surgery, the most successful pain-killers have been morphine and other narcotics derived from opium. The success of morphine is blemished by its addictive potential and the severity of withdrawal symptoms following addiction. Just how successful is morphine? The individual differences in pain responses also vary as to the effects of morphine. Investigations with hospitalized patients have shown that, in the relief of postsurgical pain by morphine in doses considered safe to use, the effects are roughly as follows: about one-third of the patients gain relief from morphine beyond that received from a placebo (a nonactive substance, such as saline solution thought to be morphine); another one-third gain the same relief from the placebo as from morphine; and the final one-third get little relief from this dose of morphine or from the placebo.

A further word about placebos may be in order. To study the effectiveness of drugs, experiments are commonly performed by the double-blind method; that is, neither the physician nor the patient knows whether the drug or the placebo is being administered. This guards against psychological influence upon the patient's pain attributable not to the effectiveness of the drug, but rather to the physician's manner or the patient's expectations.

Review of a large number of double-blind studies shows that the placebo tends to have about half the effectiveness of the drug, if the drug is a genuine pain reliever. This is a curious finding, because it shows that the placebo has a stronger effect when it is thought to be a strong drug than when it is thought to be a mild drug. This expectation must somehow be communicated to the patient by the physician administering the drug.

The necessity to control for the placebo effect tells us a great deal about psychological influences upon pain. It tells us that even drugs such as morphine that have clear organic effects in relation to pain also act through learned components. Pavlov, the distinguished Russian physiologist and Nobel prize winner, showed a learning effect upon injecting morphine in dogs. When morphine is injected hypodermically into a dog, the result is nausea, followed by vomiting, and then profound sleep. Pavlov found that, after receiving a few repeated injections, a dog would react with all those symptoms to the preliminaries of injection. Even seeing the experimenter come into the laboratory and open the box in which the syringe was kept could be enough to produce all the symptoms-nausea, secretion of saliva, vomiting, and sleep. The fact that these responses can be produced without morphine does not, however, mean that morphine was ineffective in producing them. This is one of the lessons that will have to be learned in connection with hypnosis and other psychological treatments: they work in complex interactions with the anxieties, expectations, and prior experiences of the experimental subject or patient. Because there is a psychological component to the responsiveness of the person does not deny very genuine organic components.

What applies to morphine applies equally well to the milder analgesics such as aspirin, which-although an organic pain reducer whose action is fairly well understood-also has a placebo component. A person who takes aspirin for a headache may find the pain diminishing almost immediately, far too soon for the aspirin to be absorbed into the blood stream. A placebo effect may enhance the drug itself; it need not depend upon a neutral substance substituting for the active agent.

In addition to the general relief that pain-killing drugs can produce, local anesthetics and other chemical agents may be used in more specific ways to relieve pain in local areas of the body or to assist in diagnosis of sources of irritation. A procedure known as a *nerve block* combines the use of anesthetic agents with neuroanatomical knowledge, and may serve as a guide to surgery. Bonica, director of the Pain Clinic at the University of Washington and one of the leaders in the use of nerve blocks, reports on many persons for whom appropriate nerves have been blocked successfully by injecting a local anesthetic or alcohol. With the local anesthetic, the beneficial effect may outlast the transient effect of the drug for hours, days, or even weeks. In some manner, then, the drug must interrupt a self-sustaining activity responsible for the pain.

5) Further definition and discussion of states:

1st and foremost, everyone is in a state.

The patient already has his form of understanding operating (I am calm and serene and am going to get help now, I am terrified and am worried about pain from the procedure I am presently going to experience, etc.) His reason(s) for coming in are important and, in my opinion, should be known, so as to better be able to help and guide them through the sales side of your relationship with him, hence to be able to zero in on motivational issues should those ever need to be addressed. His expectations of what needs to happen and what will happen will be a mix of his/her memory and current experience.

You yourselves are also in a state.

Your form of understanding is basically, i.e, I assume, "here is Mr. X and he needs to have me inspect his teeth and report on their condition and let him know if there is any work needed in order to keep them in excellent repair". I am performing a valuable service for him that will allow him to enjoy good health and live a better quality of life with the service I provide, besides the fact of helping him to avoid dental pain and dental troubles as he gets older.

6) There are 2 ways to go at utilizing hypnosis in your operation.

The 1st is to become a hypnotist and operate as such with your patients, where they would be both your patients and your subjects.

Here are the 3 general categories for this:
#1) Direct suggestion of pain reduction
#2) Altering the experience of pain, even though the pain may persist
#3) Directing the attention away from the pain and its source

All of you here in this room are already performing these hypnotic inductions.
How do I know this?

Because as you perform dental work you HAVE TO GIVE THESE SUGGESTIONS AS A NORMAL PART OF YOUR PRACTISE!

Perhaps you are holding this subject of hypnosis at arms length? Of course I do not know because my small talk this evening may not as of yet had that quality or response as an epiphany to you just yet, by your understanding that the quality of your success in hypnosis is directly affected by your belief, understanding and experience of it, so as all of you have different backgrounds, I am unable to make a blanket statement that fits all of you in this room.

I am sure all of you do the following:

You have a calm and quiet environment, clean and tidy with soft music that plays in the background.

You all have nice receptionists and nice hygienists, all are pleasant and respectful.

You are already telling people "this will only hurt a little bit", "you will only feel a small amount of discomfort when I do this, it will feel like a mosquito bite", etc.

By describing the effect of the anesthetic in detail, it will react as such in the patients experience, as it is a natural process. It is congenial to the highly hypnotizable and helpful to the less hypnotizable as a way of directing his effort towards control.

You may say, “These modern drills are nice and quiet, aren’t they?”

When you give people the laughing gas you tell them something too I am sure, although I don’t know what.

When we give suggestions to people and they perform or react as we suggest, technically this is hypnosis. It may be covert or unintentional, it is hypnosis just the same.

As all of you are already hypnotists, I suspect there is nothing new here for you!

Where the hypnosis part comes in that has to be done with practice by the client and understanding is with is something such as glove anesthesia, where a person already in pain or anticipating pain is taught to reduce sensitivity to pain in some part of the body not now in pain, normally a hand. If the pain sensitivity can be reduced in a normal hand, he may be convinced he has some control over his normal pain sensitivity. Hence the 1st step may be to suggest that this hand will feel numb and insensitive. The success of the glove anesthesia in a non-pained hand can be appropriately tested by stimulating the hand by pinching or pricking the hand with a pointed instrument. When numbness has been achieved and the patient is convinced that he has some control over his body sensations, he is ready for the next step of transference, and he transfers the numbness and insensitivity from the anesthetized hand to the part of the body where the pain is felt by rubbing or touching the painful part, symbolically (or not) transferring the anesthetized feeling.

Another way you can help with pain is to displace it or convert it to something nonpainful. Disturbing pain may not be well localized, diffuse pain may be difficult to manage. Sometimes you can get the pain concentrated in 1 area or a smaller area, and then move it somewhere else in the body. Sometimes it can be converted to something else, like fingers tingling.

Amnesia is an opportunity with highly hypnotizable subjects where the pain is absent for some stretches. They can be trained to forget the pain in the past and the pain to come, to make the pain a transient experience. This is really helpful where there is anticipation and

dread of future pain. Because the pain is neither remembered nor anticipated, the experience itself will seem to have no applicable duration and hence be readily tolerated. The pain can even be experienced as a momentary flash of sensation which may go unrecognized as a painful experience.

A twist on this is to temporarily deny the existence of a bodily member. For example the subject is told, think for a moment that you have no arm, for just a bit see your arm as just an empty sleeve, an arm that does not exist does not feel anything, you will find it amusing, not alarming for a while that you have no arm, then the suggestion that his arm is numb from being in a bucket of icewater. Then put the arm in a bucket of icewater. This will eliminate or severely reduce the pain experienced.

My guess is this is where most Dentists remain refractory to dealing with hypnosis as illustrated in the preceeding 4 scenarios is because it takes you from the role of Dentist to one of Magician.

The concern of loss of status, or confusion of status, or fear of failure is important.

Coordination in the hypnotist knowing the exact procedure and setting the subject up for same, to act and react in such and such a way when so and so happens AND for the Dentist and his staff to use key words and key phrases at the same time to make the process congruent for all parties involved (Hypnotist, subject, Dentist, Dentists helper, clerks, hygienists, etc) makes for not only a seamless procedure but an opportunity to be unique and have something new to talk about and get new referrals from as hypnosis can be used as a draw or enticement for new marketing strategies.

Common sense dictates that people want to be healthy, strong and look good.

The fact of the matter is that using the rule of 100, 10 % don't care about some or all of the issues surrounding and involved with good dental hygiene, 10% are driven to do everything possible, and 80% fall somewhere in the middle.
I suspect that all of you are leaving money on the table by not having the fraidy cats and scaredy cats know about how hypnosis can help them.

7) Specific uses of hypnosis in dentistry

1. *To reach patients who do not submit to dental treatment readily.*
2. *To overcome fear and tension, perhaps based on previous unpleasant experiences in the dental situation.*
3. *For premedication, either in addition to or instead of chemical medication.*
4. *To allow for reduction of chemical anesthetic agents and to reduce the unpleasant after effects of chemical anesthesia.*
5. *To replace chemical anesthesia where the administration of such anesthesia is contraindicated for medical reasons, such as allergies, heart disease, and others.*
6. *To overcome handicaps such as gagging and such infantile habit patterns as tongue-thrust swallowing and thumb sucking.*

7. To overcome lack of proper cooperation during such procedures as bite registration or in the wearing of appliances-provided, of course, that this lack of cooperation is not due to faulty construction of the appliance.

8 .For the control of flow of salvia and capillary bleeding (although the latter effect has been questioned).

9. To minimize objections to noise and vibration from the dental drill.

10. In the form of posthypnotic suggestion for the control of postoperative situations such as pain and bleeding.

11. To aid in the correction of habits with negative effect on the teeth, soft tissues of the mouth, or on dental appliances.

8) An Example of hypnosis in the chair:

Much of the use of hypnosis in dentistry is for hypnoanesthesia or hypnoanalgesia (Bartlett, 1970; Kroll, 1962). The case that follows is a good example of such application. Our patient, a 32-year-old woman, was conditioned for about one-half hour prior to her first procedure in the office of her dentist. She was told,

Close your eyes and begin to allow your body to relax .... Just concentrate on feeling like a rag doll ... limp as a dish rag ... just void of tightness.... Very good....Now you will note that your eyelids feel glued together and even though you try hard you cannot open them. . . . All right. . . you tried and could not open them and now just a very deep level, your right arm is going to extend itself in front of you .... Good ... it is becoming very rigid ... like steel. ... Nothing can bend it ... it is tight and rigid .... Excellent.... Now relax it, and you will experience a much deeper state of relaxation.... Hypnosis is working very well .... Now the right forefinger .... Concentrate on this finger ....I give you the suggestion. . . that it will feel like a thick leather glove is on it. ... As you are aware of this, nod your head .... Good.... Now you have no feeling in the finger ... only pressure .... Now open your eyes and notice that I am stimulating your finger with this nail file severely but with no discomfort .... Good ... excellent ... absolutely no discomfort. Now close your eyes. Please open your mouth and place your anesthetized finger in this part of your mouth. We are going to transfer this anesthesia to your mouth ... to the teeth, to the gums. These parts will be numb and insensitive to any dental work being done in your mouth. As you feel this anesthesia in your mouth, nod your head, yes ....Good. Now remove your finger .... Now you are going to have a very pleasant thought ... one or more of your choosing, and as this occurs ... nod your head, yes .... While the doctor is examining you and correcting your month ... you will have no discomfort, and these pleasant thoughts will be uppermost in your mind. You will be secure and unafraid ... hearing my voice consistently while the doctor is working with you."

The suggestions were reinforced throughout the procedure. At the end of surgery the patient was told,

"Your fears and tensions concerning dental procedures will be replaced by a secure feeling that your mouth is being restored without discomfort. You can, in the future, use

self-hypnosis during dental procedures, giving yourself the suggestion that '1 will be free of all discomfort in my mouth while the doctor is working with me. . .. My teeth and gums will be numb in the areas being treated and time will go by quickly and I'll have pleasant and secure thoughts throughout the procedures. I can awaken by counting from ten to one.' "

Upon completion of her dental work, the following hypnotic suggestions were given:

•'The surgery went very well and normal sensation will return to your finger and mouth. You will sleep well tonight. . . . You will care for your mouth as the doctor will instruct, and you can use self-hypnosis during sessions with your dentist. As I count from ten to one, you will be fully awake."

Self-hypnosis has also been used by some (Smith, 1970). One psychiatrist, Meares, has recorded his subjective experience while one of his molars was extracted under self-hypnosis as the sole analgesia (McCay, 1963). Petrov, Trailkov, and Kalendgiev (1964) reported the successful use of hypnotic analgesia in 49 outpatients.

As in any surgical procedure, hypnosis may be effective when there are special indications for its use. Chief among these indications are those cases in which the patient is allergic to available chemical anesthetics. One such case (Crasilneck, McCranie, and Jenkins, 1956) was of a woman sensitive to procaine who objected to the use of any local anesthetic and had for three years insisted on a general anesthetic for any dental procedures. Since it was impractical to administer general anesthesia as frequently as she needed dental procedures, difficulty arose, and she refused to return to her dentist for needed treatment. Most of her teeth developed caries. Her personality evaluation indicated an individual relatively free of emotional symptoms other than extreme fear of dental procedures. After a trial of hypnosis she became an excellent somnambulistic subject. Five separate dental procedures were successfully performed with the patient under hypnosis. During these procedures she was free of pain and apprehensiveness. As her fears diminished, she gradually became capable of allowing minor dental procedures to be done even without the induction of hypnosis.

Another patient had a problem with gagging. Each time the patient, who was a woman in her forties, tried to eat wearing her new complete dentures she gagged.

This woman had for several years refused to wear her partial dentures as she almost invariably experienced gagging several minutes after eating with them in place. Psychological interviews had failed to reveal any deep underlying fantasy or remembered trauma that might explain her symptom. When her last teeth were extracted, and full dentures prepared, her situation became critical, since she was then in a position of either overcoming her gagging or feeling embarassed at her condition. She responded quite well to the initial hypnotic induction, responded readily to suggestions, and was able to begin wearing the dentures without gagging after six hypnotic sessions. No further inductions of underlying psychodynamics were elicited, and the symptom had not returned at the time of writing.

An exaggerated gag reflex may interfere with performance of dental work. Although this may be a symptom of anxiety and may reflect a deeply repressed conflict from the oral state of psychosexual development, it can often be handled by the dentist in his office by simple reassurance. It is well to remember that persons with psychogenic symptoms have

not only conflicts but also strengths, and a change in the emotional climate of the situation, as can be sometimes effected by reassurance, may bring into play defenses that overcome the symptoms of the conflict (Marcus, 1966). When this is not successful, hypnosis may be indicated.

Bruxism is a common reason for dental referrals for hypnotic treatment. **It** may occur at any time but frequently happens only during sleep.

A young man in his early twenties was referred to us for severe bruxism that was causing malocclusion and excessive wearing of the enamel surfaces of his teeth. Careful anamnesis revealed (I) that the patient's father, who had been a strong, authoritarian *paterfamilias,* had frequently told the children to "keep your mouth shut" when they talked excessively, and (2) that the severe symptoms of bruxism did not begin until after the patient's father was accidentally killed in a motor accident. Some abreaction of emotion followed this clarification of the history of his symptom.
The patient was hypnotized and entered a medium level of trance. He was told the following: "Because you want your mouth to function normally, you can respond to the hypnotic suggestion. . .. Your mouth will be much more relaxed during sleep. . .. You are not going to grind down on your teeth any longer. . . . Should you attempt to do so ... your sleep will be momentarily disturbed. . .. You will awaken and go right back to sleep. .. You do not want to damage your mouth and because of the power of the unconscious mind, your mouth will be relaxed during your sleep ... free from tension, tightness, and grinding of your teeth. . .. Starting tonight, if you attempt to grind your teeth, you will immediately awaken and then go right back to sleep.... In this way your mouth is going to get well. . .. Do you understand these instructions?
... Good ... as I slowly count from ten to one, you will be fully awake."

Following three more reinforcement sessions his symptoms abated and have not returned one year following his treatment.

Many problem dental patients may respond well to hypnosis (Moss, 1963) with modifications of induction techniques (such as written suggestions); even deaf mute patients have been able to benefit from hypnosis for dental work. If a simple induction of hypnosis, using relaxation technique, does not suffice to remove the presenting dental problem when the direct suggestion for such improvement is given, there may be a more major unconscious conflict than is apparent on the surface of the situation. More specialized help may then be indicated, and further hypnotic exploration would best be done by a clinical psychologist or a psychiatrist, who are trained to delve into the unconscious meaning of symptoms and to adequately deal with any upset occasioned by such exploration. Excessive salivation may respond to hypnotic suggestion (Koster, 1957). Although dental procedures under hypnosis have been successfully accomplished in schizophrenics (Marcus and Bowers, 1961) and paranoid patients (Secter, 1964) work with such complicated patients should only be considered in close cooperation with a psychiatrist or clinical psychologist.

CONCLUSION

The dental practitioner familiar with the principles of psychodynamics will find hypnosis useful and effective in making many patients more at ease, less apprehensive, and free of excessive pain.

9) Precautions in the Use of Hypnosis

Hypnosis is fortunately a powerful tool; but unfortunately it can be learned by virtually anyone who takes the trouble to read enough books and practice induction on unsuspecting friends. Some persons try self-hypnosis, which can also be used inappropriately as a "crutch" (Oetting, 1964). Managing the complications that can arise from hypnosis, however, requires sophisticated understanding of the workings of the mind. A good basic rule to follow if deciding to use hypnosis or not is this-if a person cannot treat a problem with nonhypnotic techniques, he cannot treat it with hypnosis.

POSSIBLE DANGERS OF HYPNOSIS

It is important to recognize the potential dangers of hypnosis as well as its useful applications (Cheek and LeCron, 1968; Scott. 1969). West and Deckert (1965) divide the dangers into four categories;
#1) dangers to the subject (patient)
#2) dangers to the operator
#3) dangers to medicine
#4) dangers to hypnosis itself.

Dangers to the patient include:

1. The possibility of precipitating a psychiatric illness, such as dissociative neurosis, schizophrenia, paranoid states, and homosexual panics.
2. The danger of making an existing disorder worse, particularly by indiscriminate removal of symptoms that may then recur.
3. The danger of causing regression.
4. The danger of prolonging treatment in patients with passive-dependent and hysterical character disorder.
5. The danger of masking illness.
6. The danger of superficial relief.
7. The danger of excessive dependence.
8. The danger of fantasized seduction.
9. The danger of criminal activity.

All of these dangers can be eliminated or modified by proper screening and the use of hypnosis only by trained persons aware of the complexity of psychological symptoms.

In speaking of dangers to the operator West and Deckert (1965) cite grandiosity, narrowing one's practice to hypnosis alone, and the danger of psychopathological disturbances in the operator, citing one amateur hypnotist who became obsessed with

supposed telepathy experiences. As dangers to medicine they report the dangers of failures when hypnosis is used inappropriately, which may lead to failure to use it when it is indicated; the danger of success leading to hypnosis being oversold, with disappointments as to its realistic limitations; and the danger of untrained "hypnotists" being given the status of de facto psychotherapists to the discredit of psychiatry and psychology as specialities and to medicine as a profession. The dangers to hypnosis itself are the lingering aura of criticism that may be attributed by some to anyone using hypnosis, and the danger of cultism.

McCartney (1961) in discussing his half-century of personal experience with hypnosis concluded, "I have become increasingly convinced of its [hypnosis'] therapeutic value, when properly used, and of its potential destructiveness when misused. It should be put under legal restrictions and scientific control, and only qualified persons should be allowed to apply the technique. " Nesbitt (1964) considered the general physician to be competent to use hypnosis, though he stressed that physicians should carefully evaluate their own motives for choosing hypnosis as a treatment method. Tyson (1962) called hypnosis a "calculated risk,"; however, he proposed its use in spite of some dangers. Shaw (1961) referred to hypnosis metaphorically as "the mental hyperdermic" and considered it to be a valuable dental instrument when properly used. Rosen (1961), however, has expressed the opinion that hypnosis "must be considered a specialized psychiatric procedure regardless of the purpose for which it is used. " Many authorities, among them Conn (1959, 1972) and Friedman (1961), find that there is no danger specifically unique to hypnosis. Instead, the dangers of hypnosis are the dangers that accompany every psychotherapeutic relationship, notably the dangers of transference and countertransference. Among the causes of difficulties with hypnosis are ignorance, overzealousness, lack of understanding of the basis of interpersonal relationships, and irresponsible use of hypnosis for entertainment (Kost, 1965).

Much of the past criticism of hypnosis has come as a result of those rare and unqualified' 'hypnotists" who indiscriminately remove neurotic symptoms which have strong psychodynamic meanings (Gherardi, 1967). For example, if a nondrinking alcoholic is treated with hypnosis for a smoking addiction without simultaneously handling in a psychotherapeutic manner his desire to drink, it is possible that a recurrence of a serious drinking problem may be an undesirable result. Similarly, if pain of organic origin is suppressed with hypnosis, the diagnostic picture may be obscured, a situation that could well lead to the physician being unaware of signs or symptoms that could cause early detection and cure of an otherwise serious condition. If the therapist is well trained, however, even resistances may be put to psychotherapeutic use to benefit lives (Schneck, 1953).

Another inherent safeguard is the ability of the patient to leave treatment or to refuse to enter hypnotic state even though undergoing the induction procedure. The patient with excessive defenses will usually prove to be unhypnotizable.

Some dangers may arise in the treatment of organic conditions by hypnosis if the hypnotherapist is unaware of the complexities of the patients' condition or if there is inadequate communication with other physicians who are in charge of specialized areas of treatment. An example of this potential is the induction of hypnoanesthesia in a burned

extremity for purposes of skin debridement. If the anesthesia is not clearly limited to the time of removal of burned tissue, it may allow the patient to use the arm is an abrasive way, adding to the injury after the surgery.

I am able to go off into left field here and describe details of scenarios that are not applicable to this talk or to you folks in my status to you as an adjunct or complimentary therapy. How I work with any professional in any field is to understand exactly what you will do with your patient, line-by-line and section-by-section, so I am able to make that subject (your patient is my hypnosis subject) act, react and perform in such a way as to do exactly what it takes to have a safe, peaceful and successful outcome before, during and after the visit to your dental operation.

Screening to determine acceptability for hypnosis
I use a modified test that was developed by Stanford University and the US Air Force in 1962 and have done very well with it. It allows people to experience 13 common hypnotic phenomena and to grade themselves so as to determine their own, native ability and competency. I also do an intake and screen them to make certain hypnosis will be helpful and healthful for them. From there they can decide if they care to proceed to the next step, as I have my business segmented in such a way as to teach the subject their own self-hypnosis technique, based on their own needs and abilities, as quickly and efficiently as possible.