HYPNOSIS IN THE PSYCHOSES

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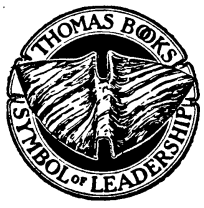

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DEDICATION

To those men and women who
were literally brought to life by
their understanding of my "crazy" theories

INTRODUCTION

HYPNOSIS IS A valuable and effective method of treatment which, even in its periods of popularity, has not been applied as extensively as it might be. The most common reason given for *not* using hypnosis is the possible danger of precipitating a psychosis. A bacteriologist is not afraid of germs. Psychiatrists and clinical psychologists who do hypnotherapy should be as adept in the management of hallucinations as the bacteriologist is in the handling of microbes and viruses. The expert hypnotherapist ought to be as familiar with the treatment of the psychoses as he is with the neuroses. In fact, experience with hypnosis in the psychoses will render the therapist much more effective in the treatment of all functional mental disorders.

Hypnosis in the Psychoses is addressed especially to those who have had some experience with hypnotherapy and wish to extend their therapeutic armamentarium. The approach to the psychotic individual is different from treating the neurotic. The psychotic person's ego strength must be developed before other therapeutic maneuvers can be helpful. Specific dangers occur in hypnosis in the psychoses which are not present in the neuroses. These hazards are discussed in detail, together with the means of avoiding and handling them.

In this monograph we are dealing with all of the functional psychoses and have not broken them down into diagnostic categories because the different diagnostic classifications do not require different hypnotherapeutic techniques.

Involvement in discussion of the nature of the hypnotic phenomena has been avoided. Instead, emphasis has been placed on the practical application of hypnotherapy. Theoretical questions could not be eliminated entirely, however. Some discussion

of psychogenetic development was necessary to provide a structural background for the application of the therapeutic method which I use. The theoretical presentation is supported by examples from experience. Anyone can validate these results by regressing his subjects and asking questions similar to those which are given in the text.

The importance of imagination is emphasized because most psychiatrists do not give it the respect it deserves. An understanding of the formation, storage and reproduction of images is essential if the therapist is to accomplish recoveries. Mental illness is due to distortion and reversal of mental images from past experiences. Recovery requires that the therapist help the patient to reconstruct his images to conform to a healthy objective reality. With hypnosis the introduction and alteration of new images is a relatively simple task. Everyday labors, play, hobbies, and dreams all have an influential part in changing the images by improving objective reality.

Experiences with hypnotic regression have disclosed the importance of a rarely discussed combined Father-Mother image. Melanie Klein (43) described a phallic woman fantasy. John Rosen (56) used to present himself to his patients with the bold statement, "I am your mother!" Both Klein and Rosen were dealing with a pathological fantasy of a fusion of the identities of Father and Mother into one person. However, this fantasy person could not relate to any other person.

The fantasy, combined Father-Mother, is allied to the "primal scene" described by Freud (27). However, in the "primal scene," the parents keep their separate identities. I have found that recovery from mental illness depends, not on the "passing of the Oedipus Complex" as Freud claimed, but upon the ability of the patient to improve his fantasies of the "primal scene" so that he becomes able to imagine that the intimate relationship between his parents is not hurtful, but is healthy and holy.

When the patient is able to picture in his mind a good relationship between his parents, he can trust them, feel safe with them, and not be afraid to grow up like one of them. He can allow himself to be subject to their authority. It is impossible for the patient to relive the experiences of early child-

hood. He must learn to establish a new and stable kind of relationship with the doctor, the nurse, and other interested ancillary people who deal with him in therapy.

When the fantasies of the individual in relation to his original family social group are understood, it is not so difficult to explain some of the cultural aberrations now so prevalent because of the many broken homes which are condoned in our culture. The significance of Social Psychiatry then, is not simply treatment of the community, but the restoration of the image of family solidarity to those individuals who feel that they belong to no one.

Over twenty-five years ago, I was introduced to hypnosis by William Pious, now at Yale. Experience with regression technique was provided by Milton Erickson, esteemed teacher and beloved friend.

Assistance in the preparation of the manuscript was generously given by my daughter, Rosemary, and my wife, Catherine.

W. Earl Biddle

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Chapter I

AVOIDING COMMON PITFALLS

IMPORTANCE OF IMAGINATION

Success with hypnosis in the psychoses requires, first of all, that the therapist be willing to work at whatever trance depth the patient is able to attain. Some psychotic patients, who with practice make excellent subjects, are initially unable to go into a trance at all. The effectiveness of therapy is not proportionate to trance depth. Schilder and Kauders (58) observed that a profound emotional response may occur in a light trance, whereas a deep trance does not carry with it the assurance that there will be any emotional involvement. A similar observation has been made by Gill and Brenman (37).

There are other factors which the subject must be willing and able to allow to be brought into operation within himself. It is an interesting fact that the French Commission (17) which reported on mesmerism in 1784 certified that the results claimed by the mesmerists were valid, but were produced by the imagination. Though the power of imagination was recognized at that time, the function of imagination as a factor in hypnosis was not pursued until recent years. In 1956, a brief report of some work I had done in this field was published (11). Arnold's (6) pioneering work appeared earlier, but was not given the attention it deserved. It is now becoming more generally known that the ability to develop a trance is a skill which lies primarily with the subject rather than with the hypnotist. Erickson (23) goes so far as to claim that the patient has the right to success or failure

as he chooses. Alexander (2), too, emphasizes the importance of the freedom of the hypnotized patient.

Since the anxiety of the psychotic subject is more intense and more deeply repressed than neurotic anxiety, the psychotic patient guards his defenses more strongly. The psychotic subject will, therefore, be extremely wary of the therapist who approaches him with an aura of exuberent confidence. The most common pitfall in the use of hypnosis in the psychoses is the attitude that the patient must submit in a relation of slavish subservience to the hypnotist. It need not be explained to the patient that the therapist does not have hidden mystical hypnotic powers, but the therapist himself must realize that he does not, and that he may fail. The hypnotist simply teaches the patient to be a good subject.

CHOICE OF SUBJECTS

The choice of psychotic subjects suitable for hypnotherapy depends upon (a) the intellectual ability of the subject to follow the instructions of the therapist, (b) the ability to exercise a moderate degree of concentration, (c) the presence of some flexibility of imagination, and (d) some confidence in the hypnotist. The experienced hypnotist is guided also by a clarity and sparkle seen in the eye of the subject, indicative of a facile imagination. Those who are aware of occasional nocturnal dreams generally make good subjects. With Klemperer (45), I agree that the most practical and most reliable test of hypnotizability is the actual attempt at trance induction. When hypnotherapy is decided upon, the patient is simply asked to follow the therapist's instructions in trying to produce a trance. If successful on the first attempt, fine! Lack of initial success, however, does not indicate complete failure. Other attempts can be made at later sessions.

TRANCE INDUCTION

Induction by Erickson's hand levitation method (22) is most suitable because it permits the patient to enter the trance at his own pace. Anxiety is kept at a minimum because the patient does not usually experience a fear that he is being dominated.

The burden of proof of success or failure, therefore, lies in the ability of the subject to concentrate in following the instruction of the therapist, and does not depend upon the therapist's power to force the patient into a trance. An authoritarian type of induction invites a "battle of wills."

By pointing out to the patient the sensory phenomena which can be produced by concentration, his self-confidence is enhanced and he will be encouraged to permit himself greater trance depth. Using Erickson's technique, tingling in the tips of the fingers is readily attained. The tingling will spread through the hand and up the arm if the patient persists in his concentration. The lightness is suggested and levitation of the hand occurs. The therapist then suggests that the patient will become drowsy as his hand moves towards his face so that when his hand touches his face he will be sound asleep. It is well to give these suggestions in the form of personal instructions rather than as mechanical, impersonal patter. The tone of voice may be monotonous with repetitive words and phrases, but the hypnotist's manner must be adjusted to the reaction of the subject. Every patient cannot be treated in the same stereotyped manner.

THE UNSUITABLE PATIENT

Inability of the patient to cooperate with the therapist may be demonstrated in several ways: (a) There may be a lack of any response and the patient will explain that he noticed no alteration in sensory phenomena, (b) the patient may show a beginning response, but as soon as he is aware that he is developing a trance, he suddenly arouses himself to regain voluntary controls, or (c) the patient may flop into an apparently deep trance, but contact with the therapist is lost.

FURTHER INSTRUCTION

Before induction is attempted, the patient should be asked about his prior experiences, opinions, and attitudes towards hypnosis. A simple explanation of what the therapist expects should be given. It is helpful to stimulate the patient's curiosity about the discovery of hidden resources and powers within himself. The phenomenon of hand levitation might be explained to

the patient as the result of learning to gain control over nerve fibers which are ordinarily involved in reflex action. When one's hand touches a hot stove, it is pulled away without ideo-volitional action. Training in developing a trance allows the patient to exercise control over his reflexes and autonomic nervous system, and also opens up a fascinating potential of unconscious resources. With hypnosis the patient may be trained to make use of these resources in a positive way for self-advancement instead of the self-defeat he is inflicting upon himself by his psychosis. However, the patient should be warned against practicing autohypnosis, at least until the therapist considers him adequately prepared.

Some authorities *do* train their patients in autohypnosis, but there is a risk for the novice because the patient may be inadvertently overwhelmed by traumatic material which surges up from the unconscious. Should this occur, the patient would be in the same predicament as the child awakened by a nightmare with no one present to help him control the frightening dream material.

During trance induction, some resistance is to be expected. In fact, if there is no obvious resistance, the trance will be very light. In a successful trance induced by the hand levitation method the subject is often able to allow his hand to come within a small fraction of an inch of his face and to hold it in this position for a relatively long period of time before permitting it to touch his face. If the patient were not in a trance, such a feat would be impossible. The skeptical subject will be encouraged by experiencing sensory changes such as glove anesthesia and temperature changes which are relatively easy to induce.

When the patient abruptly stops the induction process or comes out of the trance unexpectedly, the therapist should ask what occurred to interfere. There may be a number of reasons for the interruption. Disturbing thoughts may be running through the patient's mind. Outside noises may be annoying. There may be a fear of failure, a fear of loss of personal identity, distortion of body image, dismemberment, or other changes in sensory experience. Should the patient awaken abruptly, he is asked for

the reason and is given reassurance. The difficulty usually lies in the inability of the subject to focus his concentration on the sensations in the hand as the therapist directs. The subject, instead, allows his imagination to wander. After reassurance and encouragement the patient may be asked whether he wishes to try again immediately or to wait until another session.

During the learning process, the subject should be kept as comfortable as possible, and not given suggestions which will produce anxiety or discomfort. The psychotic patient who is told "your arm is becoming stiff, so stiff you cannot bend it" or "you can't open your eyes," may become frantic if he notices these phenomena occurring, and he will doubt the credibility of the hypnotist if there are no noticeable sensory changes immediately.

Painful suggestions, such as handling a red hot coin or touching a hot radiator also interfere with the willingness of the patient to be cooperative. Painful situations which are acceptable to the neurotic subject may not be tolerated by the psychotic patient. For example, Wolberg's technique (63) of having the subject visualize a theatrical stage on which he sees first the most wonderful scene and then the most terrible, is very helpful in the treatment of neurotic patients, but attempts to visualize horrible experiences often prove too terrifying for psychotic subjects. Special care has to be exercised, also, in avoiding any act which might be considered degrading, such as snapping the fingers as if the patient were a performing animal. Also, a patient will have difficulty cooperating if he thinks that the therapist is lying to him or attempting to delude him. It is important to keep the session on a scientific level, and to avoid anything which might be construed as occultism or entertainment.

TRANCE DEPTH

For practical purposes the numerous gradations in estimating trance depth are not necessary. The depth may be graded as (a) light, (b) moderate, and (c) deep. The light trance begins as soon as any hypnotic phenomena occurs and includes the level in which it is possible to dream. The patient in a light trance may awaken with the feeling that he has not been in a trance

because he had not lost awareness of what was going on around him. In a moderate trance the subject can dream and awaken with an amnesia. A deep or somnambulistic trance makes it possible for the subject to act out a "waking dream" in which objective reality is blotted out completely. Regression and revivification techniques are possible only in a deep trance. Supportive therapy can be done in a light or moderate trance. Uncovering therapy should be done only in the moderate or deep trance where the patient's defenses are protected by the amnesia.

Rarely, a patient will go so deeply in a trance that he will not awaken when instructed to do so. Should this occur, the patient is simply told that the trance will change over to a natural sleep and he will awaken when he is ready to do so. Refusal to awaken might occur when the trance experience is too pleasant to abandon, or when the continuation of the trance serves some other purpose for the patient.

> Inability to awaken a patient at the specified time occurred only once in my experience. The patient was a young man whom I saw during a short period after his lunch and before mine. One day he would not awaken at the end of the treatment session. I told him that the trance would change into a natural sleep, and that he would continue sleeping until I returned from my lunch. When I returned, he was still sleeping. I then told him that I would be in the office down the corridor for only ten minutes longer because I had another appointment elsewhere. I left him and went into the other office. Within a few minutes he awakened very startled and was very angry with me because he was late for his assignment in the hospital laundry. I later learned that in the absence of one of the employees in the laundry that day, the patient would be given a more responsible assignment in the afternoon. The patient told the laundry supervisor that he was sorry he did not get there in time to do the job, but his lateness was due to the fact that the doctor could not bring him out of the trance in time.

AWAKENING THE PATIENT

Before a patient is awakened from a trance, the hypnotist must remember to restore sensory changes to normal, remove or reinforce amnesias, and see that the patient is correctly

oriented. After the patient awakens, it is well to talk with him for at least a few minutes about the trance experience to be sure that he is in good reality contact.

ADVANTAGES OF CO-THERAPIST

The treatment of psychotic patients is facilitated by having a co-therapist of the sex opposite that of the therapist. According to Federn (25), a good result cannot be achieved without the help of a motherly nurse. The psychotic patient is confused about parental sexual roles, and since the therapist is a parental surrogate, the patient usually casts the male therapist in a maternal role. The co-therapist need not play an active part, but simply should be present as a reassuring protective mother. Without a co-therapist, additional time is needed to untangle the confused sexual identity of the parental surrogate.

PHYSICAL CONTROLS

The psychotic patient cannot tolerate abreaction in the same way as the neurotic patient. For this reason it may be necessary to treat the psychotic individual in the controlled environment of an institution. Without physical controls the patient will be apt to discontinue treatment when emotionally traumatic material is being reached, or act out in a dangerous manner.

CONTROL OF FREE ASSOCIATION

The therapist can avoid some serious untoward reactions if he always keeps a close watch upon the patient's fantasies and the direction of their movement. It is unwise to allow uncontrolled free association in the trance. Free association permits the patient to uncover repressed material too rapidly, and usually results in dangerous acting out. It is for this reason that many psychoanalysts are reluctant to use hypnosis. Free association is essential to the psychoanalytic method. When an untoward reaction occurs during hypnotherapy, the analysts are inclined to attribute it to the hypnosis rather than to the use of a modified psychoanalytic method which encourages free association.

CONTROL OF TRANSFERENCE

Severe transference problems will arise as another complication if the patient is permitted to use free association while visualizing the therapist in hypnotic fantasy. The personal feelings of the patient towards the therapist and *vice versa* cannot be handled overtly with hynosis. Hostile, aggressive, or erotic feelings are inevitable hazards unless the therapist assumes some control and management over the patient's fantasies, preserving the doctor-patient relationship. Gill and Brenman (37) warn against the transference dangers which frequently follow from what they have called the "hypnotic relationship." Strong transference sometimes makes continuance of therapy impossible. A negative transference is frequently mistaken to be a positive relationship. The patient who falls desperately "in love" with the therapist is not showing a positive transference. Instead, the patient is attempting to undermine the authority of the therapist and gain power over him. This occurs as a defense mechanism when the therapist is getting close to the core of the psychosis.

> This was illustrated in the case of a young woman whom I was treating with hypnotherapy. She had been showing predominent catatonic features. Suddenly she became hebephrenic, referring to me (old enough to be her father) as her "boy friend" and behaving toward me in a girlish, flirtatious manner. When I insisted that our relationship was a professional one, she became very paranoidal toward me, and it seemed that progress in therapy had come to a dead halt. She wanted nothing more to do with me. I told her that, in spite of her antagonism, I would continue to keep my appointments, and if she refused to come out to the office to see me, I would go to the ward to see her, but I would not insist that she talk to me. I would simply be there. The period of tenseness in our relationship lasted for several weeks. She never became so paranoidal as to refuse to come to see me in the office, and treatment progressed to a satisfactory conclusion several months later.
>
> After she became well, she thanked me many times for not acceding to her expressed wish to be left alone during her paranoidal phase. It would have been easy to fall into the trap

> she was setting for me in the hebephrenic phase of her illness and to mistake her negative transference as a positive one. Her "falling in love" with me was a defense which was made necessary because we were getting close to the core of the psychosis. She wished to make me a peer instead of a person with authority over her.

Transference conflicts are also inevitable when the hypnotist allows the patient to consider himself as a helpless child and the doctor as an omnipotent parental surrogate. However, when the hypnotist understands that he is dealing with the imagination of the subject, rather than with an imagined power over the subject, these pitfalls can be avoided.

Freud is frequently quoted as an authority opposed to hypnotherapy. His attitude was based upon several factors. He found that symptom removal was not always successful because new symptoms often occurred. Not all of his patients were readily hypnotizable, and he also had transference problems. Still, Freud did not lose his interest in hypnosis, and expressed the hope that it might find a place in psychoanalysis (33).

The dangers inherent in the use of hypnosis cannot be treated lightly, but it is imperative that psychiatrists and clinical psychologists doing psychotherapy alert themselves to the prevention and management of these dangers. The complications which sometimes occur are not irreparable. Yet, many patients who could be helped promptly by hypnotherapy are deprived of this form of treatment simply because of the anxiety of the therapist. A survey of the use of hypnosis in California was made by Auerback (7) who found that 46 per cent of psychiatrists had some experience with hypnosis, but only 13 per cent still used it. The commonest complaint was the danger of precipitating a psychosis. Results of hypnotherapy were found to be temporary, induction was difficult for some, and the doctor-patient relationship was impaired. Every one of these complaints, however, can be overcome with training and experience.

Rosen (55) and Wolberg (62) have warned of the dangers associated with hypnotherapy, and yet these psychiatrists continue to use it extensively. Rosen is the Chairman of the

Committee on Hypnosis, Council on Mental Health of the American Medical Association. The comprehensive reports of this committee are historic documents which express the official position of the American Medical Association regarding hypnosis. These reports are available in the *Journal of the American Medical Association* (18, 19).

Chapter II

HYPNOTHERAPEUTIC TECHNIQUES

CHOICE OF TECHNIQUE

Brenman and Gill (16) describe a number of techniques available to the hypnotherapist. The choice of technique depends not only upon the strategy the therapist wishes to use, but also upon the experience which the subject has had with hypnosis, and the trance depth attainable. Such techniques as simple relaxation and dream induction are useful in beginning therapy because they are applicable even in a light trance. Regression and revivification require a deep trance. The use of uncovering techniques will produce anxiety which the patient will not be able to tolerate until suitable trance depth has been attained. Once the patient has experienced intolerable anxiety it will be difficult to persuade him to go into a trance again. The therapist will save considerable time if he devotes the first several sessions to familiarizing the patient with the trance phenomena rather than starting too soon with treatment. After the patient learns to be comfortable in the trance, the therapist can adapt his technique to whatever depth the patient can reach at the time.

SIMPLE RELAXATION

The Aesculapian Temple sleep is one of the earliest applications of hypnosis to produce simple relaxation. This technique is used frequently without actually calling it hypnosis. The calming "bedside manner" of the physician is therapeutic though the doctor may not be aware that he is using a modification of a hypnotic technique.

The relaxation described by Janet (41), Jacobson (40), and Read (53) is, as Kroger (46) has pointed out, similar to that produced by hypnosis. Some therapists have found the simple relaxation technique to be so effective that they have abandoned the dynamic unconscious approach customarily employed in the treatment of the functional psychiatric disorders. Haugen, Dixon, and Dickel (39) have devised a modified Jacobson method of relaxation without reference to hypnosis, and claim success in the treatment of anxiety. Reardon (54) frankly hypnotizes psychiatric patients, using simple relaxation, and has good results even in the psychoses without delving into unconscious dynamics. These therapists and others who use this technique are successful because they have a beneficent authoritarian approach which promotes the patient's confidence. The depth of the trance may be light, moderate, or deep, depending upon the patient's ability. The induction of the trance is the only necessary part of this type of therapy. Suggestion is generally used to reinforce the relaxation, but is not essentially a part of the technique. Ambrose (3) coined the word *detensionize* to explain how the relaxation treatment works.

SUGGESTION

Suggestion is generally defined as a means of introducing an idea into the mind of another, either by direct implantation or by stirring up appropriate associations. For example, relaxation may be induced by the following type of suggestion:

> As you sit comfortably in the chair, you may picture yourself as being on the beach gazing out over the ocean. The sea is calm. As you listen, you may hear the quiet, peaceful rippling of tiny waves, and the cry of the sea gulls as they fly about.

Suggestion is not always the *uncritical* acceptance of an idea; there may be reservations. In the above example, if unpleasant associations are connected with memories of the beach, relaxation will be difficult. Suggestion operates on both conscious and unconscious levels. In hypnosis it is a dynamic process similar to suggestion without hypnosis, except that in the trance,

associations are produced more rapidly, and repressed material is more accessible. It is for this reason that the subject in the trance is considered to be more suggestible. Hypnosis and hypnotherapy are not dependent upon heightened suggestibility. Actually, extremely suggestible people do not make good subjects, and suggestion is the least effective form of hypnotherapy. At best it is palliative and temporary. Symptom removal by suggestion is rapid and generally successful, but there is the hazard that the patient may develop a new symptom for the one which is given up. The symptom, as the therapist knows, is an unconscious defense against anxiety. Removal of a symptom without treating the underlying cause of the symptom leaves the patient in a vulnerable position.

Many therapists, believing that they are using "suggestion," are actually applying a commanding directive technique. Intonation can change an intended suggestion into a direction. "You *will* be more relaxed" is not a suggestion, but a command. Gill and Brenman (37) describe a form of direct suggestion by "magic gesture" which appears to be a directive rather than a suggestive approach. They report spectacular results in symptom removal by this method. However, failure occurred when they attempted to produce a positive interpersonal relationship between a schizophrenic girl and her hated sister. Forcing a patient into what is considered an untenable position is bound to increase anxiety and result in failure. A commanding, directive technique certainly has a place in hypnotherapy, but it should not be confused with suggestion technique.

DREAM INDUCTION

Dreams are readily induced in psychotic patients by hypnosis. Patients who are not aware of nocturnal dreams can be instructed to produce dreams even in a light trance. Occasionally, waking hallucinations occur in attempted dream induction, but these, too, can be therapeutic. A patient who insisted that he never dreamed was able to attain a light trance. I directed him to picture in his mind a good meal. He thought of bacon and eggs, but could not visualize the meal in the trance. Upon awakening from the trance, however, he exclaimed, "There! I