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HYPNOTHERAPY: A REAPPRAISAL

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Introduction

Throughout the years there have been periodic surges of great interest in hypnosis. Many extraordinary phenomena have been attributed to its effects and great claims made as to its effectiveness in therapy. Yet, in spite of such claims, there still appear to be relatively few therapists using hypnosis as a major tool. Why? Is it because the criticisms usually leveled at hypnosis are true? That it is overrated, actually limited to a small range of problems, unable to produce lasting changes? Will removal of symptoms by hypnosis lead to new symptoms? Is it dangerous? No, there is far too much clinical evidence contradicting these statements. Such evidence can no longer be ignored. It is felt that the major reason behind the rejection of hypnosis has been that for most people it is still virtually an unknown. It seems to be human nature to stay clear of or reject anything that doesn't seem to fit in or be explained rationally, especially when it seems to be something potentially powerful. It is mainly its unknown nature that has led to the many misconceptions surrounding hypnosis and has kept us from making the best use of it.

The purpose of the present paper is to present some of the recent clinical evidence contradicting the common criticisms and misconceptions surrounding hypnotherapy, to provide a good indication of how to make the best use of this tool, and to provide a rational explanation for its hard-to-believe therapeutic effects.

Overview of Recent Literature

There have been 1,018 articles[2] dealing with hypnosis in the past three years (1966 through 1968), approximately forty per cent of which dealt with its use in therapy.
In the same period we find 899 articles on psychoanalytic therapy and 355 on behavior therapy.

1. Formerly at University of California, Los Angeles.
2. According to the National Library of Medicine's Medical Literature Analysis and Retrieval System (MEDLARS) storage of information, based on some 2,400 journals. The number given above does not include the articles on hypnosis in dentistry (64) and anesthesia (59) or those on suggestion (391) or the hypnosis studies done in the European socialist countries (532 in two recently released bibliographies covering the years 1945-1965 – Hoskovec and Svorad, 1966).

Contrary to popular opinion that hypnosis is only effective in certain specific symptom-removal cases, a wide range of diagnostic categories have been successfully treated by hypnotherapy. This includes anxiety reaction, obsessive-compulsive neurosis, hysterical reactions and sociopathic disorders (Hussain, 1964), as well as epilepsy (Stein, 1963), alcoholism (Chong Tong Mun, 1966), frigidity (Richardson, 1963), stammering and homosexuality (Alexander, 1965), various psychosomatic disorders including asthma, spontaneous abortions, dysmenorrhea, allergic rhinitis, ulcers, dermatitis, infertility and essential hypertension (Chong Tong Mun, 1964, 1966). Also in the past few years an increasing number of reports indicate that the psychoses are quite amenable to hypnotherapy (Abrams, 1963, 1964; Biddle, 1967).

Three Large Scale Studies

Three large scale studies in the past five years contain basic findings.
Richardson's (1963) study dealt with seventy-six cases of frigidity. He reports 94.7% of the patients improved. The average number of sessions needed was 1.53. The criterion for judging improvement was increase in percentage of orgasms. The percentage of orgasms rose from a pre-treatment average of 24% to a post-treatment average of 84%. Follow-ups (exact length not given) showed that only two patients were unable to continue realizing climaxes at the same percentages as when treatment terminated. Richardson's method of treatment was a combination of direct symptom removal, uncovering, and removal of underlying causes, since he had found that direct symptom removal alone was not always sufficient. He reports no hypnotic induction failures.

Chong Tong Mun's (1964, 1966) study covered 108 patients suffering from asthma, insomnia, alcoholism, dysmenorrhea, dermatitis, anxiety state, and impotence. The percentage of patients reported improved was 90%. The average number of sessions was five. The criteria for judging improvement were removal or improvement of symptoms. The average follow-up period was nine months. Chong Tong Mun's method of treatment was a three-fold approach. With some patients he would work on reeducating the patient with regard to the behavior patterns immediately underlying the symptoms. With others he would first regress the patient back to the original onset of the symptom. Once regressed, he would reeducate the patient to the fact that the original cause was no longer operative. In addition, he usually used supplementary suggestions of direct symptom removal.

Hussain's (1964) study reports on 105 patients suffering from alcoholism, sexual promiscuity, impotence and frigidity, sociopathic personality disturbance, hysterical reactions, behavior disorders of school children, speech disorders, and a number of different psychosomatic illnesses. The percentage of patients reported improved was 95.2%. The number of sessions needed ranged from four to sixteen. The criteria for judging improvement were complete or almost complete removal of symptoms. In follow-ups ranging from six months to two years no instance of relapse or symptom substitution was noted.

Hussain's approach is illustrated by the case of a 35 year old woman exhibiting the following symptoms: anxiety, alcoholism, depression with suicidal tendencies, sexual promiscuity, insomnia, and inability to make decisions and future plans.

Prior to treatment, Hussain pinpointed the various fears and negative attitudes which he felt were underlying the symptoms – e.g., the patient feeling unloved and unwanted in regards to her marriage, feelings of inadequacy at being a mother, fear of her own mother, fear of responsibility and making decisions, and guilt over her sexual promiscuity.

Hussain then used a therapeutic technique somewhat similar to Wolpe's (1958) desensitization technique to eliminate these fears and negative attitudes. For example, he would have the patient think of a particular fear-producing situation and recondition her by suggesting she would find herself calm and relaxed in the situation. This particular approach is very often used now in one form or another. Abrams (1963) refers to it as an "artificial situation" technique. Through hypnosis the patient is able to experience his new attitudes in an "artificial situation," an imagined situation. It differs from Wolpe's approach in two respects. First of all, Wolpe does not often use hypnosis. Secondly, Wolpe has the patient go through a *hierarchy* of "imagined situations," going from easiest to deal with to most difficult. (There is no reason, however, why this hierarchy approach cannot be incorporated into hypnotherapy.)

With the above patient Hussain also used direct symptom-removal suggestions. For example, "aversion to the thought and sight of alcohol was also built up by direct suggestion."

This patient was discharged from the hospital after twelve sessions. “No relevant symptoms were left behind and there was no relapse during the six-month follow-up period.”

Current Method of Using Hypnosis

As one can see in the above studies, and this probably comes as a surprise to most therapists, the main use of hypnosis is *not* as a means of direct symptom removal. Nor is its main use as an uncovering device. The current trend is to use hypnosis to remove the negative attitudes, fears, maladaptive behavior patterns, and negative self-images underlying the symptoms. Uncovering and direct symptom removal are still used to a certain extent, but usually in conjunction with this new main function.

In the past, so much emphasis was directed towards symptoms and disease processes that some of us were guilty of forgetting the person in the body. It is incumbent upon us [hypnotherapists] to concentrate on treating the particular patient who presents the symptom rather than the symptom presented by the patient (Mann, 1963).

Psychiatric hypnotherapy, as practiced today by the leading practitioners in the field, has in common with all other forms of modern psychiatric treatment that it concerns itself not only with the presenting symptoms but chiefly with the dynamic impasse in which the patient finds himself and with his character structure (Alexander, 1965).

The objection that the results of symptom removal will seldom be permanent is certainly not valid. This may have been so in the past, when direct symptom removal alone was practiced and nothing was done to strengthen the patients ability to cope with his difficulty or to encourage him to stand on his own two feet (Hartland, 1965).

This change is being stressed in the present paper because it is part of its purpose to fit hypnotherapy into “the scheme of things.” Many therapists have rejected hypnosis
because its direct symptom approach of the past clashed violently with their dynamic approach. Now we see that such a clash need no longer exist.

The A historical vs. the Historical Approach in Therapy

Some hypnotherapists use, in part, a historical approach, going back into the patient’s childhood and changing his attitudes regarding the causes of these patterns (Fromm, 1965; Abrams, 1963; Chong Tong Mun, 1964,1966). However, most hypnotherapy is ahistorical and, it would seem, faster. If we wanted to change the direction of a river it might be much easier to work on the main current directly (once it had been located) rather than going back upstream, locating all the tributaries, and pointing each one in a new direction.

A comment on the Dangers Ascribed to Hypnosis

In the past there have been certain dangers ascribed to the use of hypnosis – for example, the danger of a psychotic break, or the substitution of more damaging symptoms. According to a number of investigators (Kroger, 1963; Abrams, 1964) these dangers have been grossly exaggerated. However, whatever dangers there were have been virtually eliminated by this new approach. The few mishaps that have occurred in the past resulted either from (1) the misuse of hypnosis as an uncovering agent, or (2) its misuse as a direct symptom remover. The first type of mishap was produced by a therapist who would allow, or force, the patient to become aware of repressed information which he was not strong enough to face. The second type of mishap occurred when the therapist wrested away a symptom, which the patient was using as a crutch before he was strong enough to stand on his own.

Hypnotizability of Patients

Freud abandoned hypnosis because of "the small number of people who could be put into a deep state of hypnosis" at that time and because in the cathartic approach, symptoms would disappear at first, but reappear later if the patient-therapist relationship were disturbed (Freud, 1955, p. 237). In the above studies the only hypnotic induction

failures were reported by Chong Tong Mun (eight failures out of 108 patients.) This can mean one of two things: the hypnotic induction procedures have improved since Freud's day, or that the reconditioning approach used in these studies (as opposed to Freud's cathartic approach) does not require very deep levels of hypnosis. There is evidence that both factors bay be involved.

Although many have thought that hypnotic susceptibility was a set character trait, there are a number of studies which now seem to indicate that this is not the case, and that responsiveness can be increased by certain changes in the hypnotic induction procedure (Pascal and Salzberg, 1959; Sachs and Anderson, 1967; Baykushev, 1969), as well as by means of a pre-induction talk aimed at insuring a positive attitude, an appropriate expectancy and a high motivation toward hypnosis (Dorcus, 1963; Barber, 1969; Barrios, 1969).

With regard to the depth of hypnosis required for the reconditioning approach to work, there are a number of therapists who feel that only a light state of hypnosis is necessary (Van Pelt, 1958; Kline, 1958; Kroger, 1963). A study by Barrios (1969) gives this contention some support; it was found that an increase in the conditioning of the salivary response could be produced almost as effectively by lighter levels of hypnosis as by deeper levels.

The latter point brings us to the question of whether hypnotic induction is necessary at all for the re-conditioning approach to work. Judging from the work of Wolpe (1958) it would appear that hypnosis is not an absolutely necessary requirement. This would also be supported by the work of Barber (1961, 1965) who found that hypnotic phenomena could be produced without a prior hypnotic induction. However, the real question to be answered is not whether hypnotic induction is absolutely necessary, but whether it can further facilitate the conditioning process. Wolpe, himself, concedes the hypnosis apparently does facilitate the conditioning:

"Patients who cannot relax will not make progress with this method. Those who cannot or will not be hypnotized but who can relax will make progress, *although apparently more slowly than when hypnosis is used.*" (Wolpe, 1958, p. 141; italics added).

Also, although Barrios' (1969) study indicated that conditioning could be increased during lighter levels of hypnosis, it was also found that there was no increase in conditioning with those subjects indicating no response to the hypnotic induction.

As pointed out in the theory (Barrios, 1969), hypnotic and waking suggestion are in the same continuum and hypnotic induction should be looked upon as a procedure whereby we can increase the probability of getting a more positive response to suggestion. The next question to be decided now is not so much whether hypnotic induction procedures increase responsiveness (this is fairly well accepted – e.g., Barber, 1969) but what variables in the hypnotic induction are playing the key roles and what can be done to strengthen the effectiveness of these factors.

Comparison with Psychoanalysis and Behavior Therapy

In Wolpe's comparison of his and the psychoanalytic approaches (Wolpe, Salter, and Reyna, 1964), we find the following: Based on all psychoneurotic patients seen, the number of patients cured or much improved by psychoanalysis was 45% in one study involving 534 patients and 31% in the other study involving 595 patients (the only two large scale studies in the literature on psychoanalysis). The average duration of treatment for the improved patients (given only for the first study) was three to four years at an average of three to four sessions per week, or an average of approximately 600 sessions per patient. For Wolpe's approach we find that, based on all patients seen, the recovery rate was 65% in his own study involving 295 patients (usually reported as 90% of 210 patients) and 78% in a study by Lazarus involving 408 patients. The duration of treatment for the improved patients was an average of thirty sessions in the former and fourteen in the latter.

Averaging the above figures, we find that for psychoanalysis we can expect a recovery rate of 38% after approximately 600 sessions. For Wolpian therapy, we can expect a recovery rate of 72% after an average of 22 sessions, and for hypnotherapy we can expect a recovery rate of 93% after an average of 6 sessions.

It is interesting to note the negative correlation between number of sessions and percentage recovery rate. At first sight this seems paradoxical. However, if a form of therapy is truly effective, it should not only increase recovery rate, but also shorten the number of sessions necessary (as well as widen the range of cases treatable).

The Need for a Rational Explanation

In spite of all the encouraging reports, there continues to be considerable hesitation on the part of psychotherapists to use hypnosis. Hypnosis is still looked upon as an "unknown" by most therapists. They are as yet not aware of any reasonable rational explanation for hypnotic phenomena that would satisfy them, one that would tie these phenomena down to observable facts and laws. As long as hypnosis continues to exude an air of mysticism and charlatanism, it will continue to be rejected by many, no matter how great the claims on its behalf.

An Explanation Based on Principles of Conditioning

The experienced therapist really should not be so surprised at the effectiveness of hypnosis in facilitating therapy. Hypnotic induction can be looked upon as a technique for establishing a very strong rapport, for establishing a greater confidence, a greater belief in the therapist, whereby the latter's words will be much more effective. As Sundberg and Tyler (1962) point out, one of the common features among all methods of psychotherapy is the attempt to "create *a strong personal relationship that can be used as a vehicle for constructive change…* It is a significant fact that many theoretical writers, as their experience increases, come to place much more emphasis on this variable" (pp.293-294).

The question still remains, however – what exactly is the process whereby "mere words" can produce such great changes in personality.

As pointed out in Barrios' (1969) theory of hypnosis, the ability of words to produce behavior changes is really not so difficult to understand if we are familiar with the principles of higher-order conditioning. First of all, we know that words can act as conditioned stimuli.

Pavlov recognized this fact:

Obviously for man speech provides conditioned stimuli, which are just as real as any other stimuli… Speech, on account of the whole preceding life of the adult, is connected up with all the internal and external stimuli which can reach the cortex, signaling all of them and replacing all of them, and therefore it can call forth all those reactions of the organism which are normally determined by the actual stimuli themselves (Pavlov, 1960, p. 407).

Now, according to principles of high-order conditioning we know that by paring word B with word A we should transfer the response produced by word B to word A and consequently anything that would evoke word A. Thus, for example, if we wanted to condition a person to be more relaxed in the presence of people, we would pair the words "people" (A) and "relaxed" (B), using a sentence or suggestion such as, "From now on you will find yourself more *relaxed* in the presence of *people*." Mower's theoretical formulations on the sentence as a conditioning device (Mowrer, 1960) tend to support this contention.
Of course, we know that under ordinary circumstances suggestions are not always accepted (and thus conditioning doesn't always result when an appropriate suggestion is given). Why is this? Osgood (1963) holds that a suggestion will tend to be rejected if it is incongruent with the subject's previously held beliefs and attitudes or his present perceptions. It would seem that if there were some means of eliminating the latter we should be able to have a suggestion more readily accepted and thus facilitate the higher-order conditioning. Hypnosis is such a means.

Thus we come to the reason hypnosis is so effective in facilitating therapy: the incongruent perceptions, beliefs, and attitudes are kept from interfering with the suggestion (and thus with the conditioning). As put by Pavlov:

The command of the hypnotist, in correspondence with the general law, concentrates the excitation in the subject (which is in a condition of partial inhibition) in some definite narrow region, at the same time intensifying (by negative induction) the inhibition of the rest of the cortex and *so abolishing all competing effects of contemporary stimuli* [present perceptions] *and traces left by previously received ones* [previously held beliefs and attitudes]. This accounts for the large and practically insurmountable influence of suggestions as a stimulus during hypnosis as well as shortly after it (Pavlov, 1960, p. 407; italics added).

As an illustration, let us say we wanted to change a patient's self-image from that of an inadequate person to a more self-confident one. If under ordinary circumstances we suggested that he would no longer feel inadequate, it would most likely accomplish little. This is because the patient's negative self-image, usually ever-present and quite dominant, would quickly suppress any positive image suggested, or at least keep it from being too vivid or real. But in the hypersuggestible hypnotic state conditions are different. The patient's negative self-image is now more easily inhibited and should therefore be less likely to interfere when we attempt to evoke the positive self-image through suggestion. As a result, the conditioning can take place and new associations can be made. The person can truly picture himself feeling self-confident in various situations and these new conditioned associations in turn can lead to new behavior. This new attitude can now become permanent by means of self-reinforcement, just as his old negative attitude had been kept permanent by self-reinforcement. As long as the patient has negative attitudes, these are self-reinforcing. They lead to his tensing up, acting awkward and making numerous mistakes. Also, he is unlikely to believe any praise or any positive occurrences should they chance his way. But if this negative self-image has been replaced by a positive one, the opposite cycle can result. Being more confident and relaxed he will naturally be more likely to be accepted. Also, he will now be more open to believing and accepting praise and positive outcomes.

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