Catalyzing the Therapeutic Process

The Use of Hypnosis

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In therapy much time is consumed in coping with resistances to the yielding of ego-syntonic patterns. It is traditionally assumed that this extended period is inevitable as part of the process of "working-through." There is, however, some evidence that certain expediences may be employed to catalyze progress. One mode has a paradigm in crisis situations during which motivation has been created for change that otherwise would not have developed. Using this idea, some therapists attempt during therapy to create minor crisis situations for the patient by tactics such as aggressive confrontation and other ways of stirring up anxiety. The object is to convince the patient that pursuit of one's usual mode of behaving is offensive to others and unpleasant for oneself. In this way the therapists try to break through resistances to productive change.

In patients who are capable of countenancing challenge and confrontation such methods may prove successful. Unfortunately, where a weak ego structure exists, where the patient is hostile to or excessively defensive with authority, or where negative transference precipitates too readily, the relationship will not sustain the patient during the tumultuous readjustment period. The patient will either leave therapy or show no response to the procedures being used. With such patients it is better to employ an approach oriented around a deliberate maintenance of a positive relationship.

A search for other stratagems that can hasten the therapeutic process has yielded a number of interventions that have, in the opinion of those skilled in their use, proven to be of special merit. Such vaunted catalysts are subject, however, to variables of therapist personality and patient response that can negate and even reverse their influence. Among the most commonly employed techniques utilized to accelerate treatment are hypnosis, narcoanalysis, emotive release strategies, guided imagery, behavior therapy, Gestalt therapy, experiential therapy, dream analysis, family therapy, and introduction of the patient into an active group.[1]

Certain ways of expediting insight have also been helpful, for example, citing specific episodes from the treatment of other patients (of course, anonymity is maintained) that in some respects relate to

the patient's problem. This may serve as a projective technique to cushion the patient's anxiety and help maintain defenses that might otherwise be shattered by direct interpretations of the patient's personal reactions (A. Wolberg, 1973, pp. 185-234). Another method is the use of metaphors through relating stories or anecdotes that illustrate points the therapist wants to get across to the patient (De La Torre, 1972).

Therapists develop personal preferences in the choice of catalyzing techniques. These generally relate to their successes with the majority of patients. In my own experience I have found hypnosis of great value, and I recommend it with no illusion that it can be helpful to all therapists. It should be experimented with to see if it blends with one's style of working therapeutically.

When to Use Hypnosis

Hypnosis is particularly suited for the patient who is paralyzed by resistance. Resistance is embodied in overt or covert behavior patterns. Usually, the patient is unaware of such maneuvers. Resistance is particularly obstructive when it blocks the special techniques that are employed in psychotherapy. Hypnosis may help resolve such resistance and enable the person to respond better to treatment.

Hypnosis may be advantageously employed in the course of psychotherapy under the following conditions:

When the Patient Lacks Motivation for Treatment

Hypnotic techniques may be helpful in convincing an unmotivated patient that he can derive something meaningful from treatment. A patient may feel resentment toward those who insist that he get psychological help; he may be afraid of revealing secret or disgusting aspects of his life; he may feel distrust for the therapist or refuse to recognize an emotional basis for his complaints. These and other obstructions that contribute to the lack of incentive for therapy can usually be handled by a skilled therapist in the initial interviews without recourse to hypnosis. Occasionally, though, even skillful approaches do not resolve the patient's resistance to accepting help. At this point, if the patient permits induction, hypnosis may provide a positive experience that significantly alters recalcitrant attitudes.

For example, a patient who had great resistance to psychotherapy was referred to me by an internist. He suffered from urinary frequency, which had defied all medical intervention and had become so serious that it threatened his livelihood. He resented being sent to a psychiatrist and announced to me that there was no sense in starting what might prove to be a long and costly process when he was not fully convinced that he needed it. I accepted the patient's negative feelings, but I speculated that his tension might be responsible for at least some of his symptoms. I offered to show him how to relax so that he might derive something beneficial out of the present session. He agreed, and I then induced a light trance, in the course of which I suggested a general state of relaxation. After the trance was terminated, the patient spontaneously announced that he had never felt more relaxed in his life and asked if he could have several more sessions of hypnosis. In the course of hypnorelaxation I casually suggested to him that there might be emotional reasons why his bladder had become tense and upset, and I inquired whether he would be interested in finding out whether this was so. When he agreed, I gave him a posthypnotic suggestion to remember any dreams he might have within the next few days.

He responded with a series of dreams in which he saw himself as a frightened person escaping from situations of danger and being blocked in his efforts to achieve freedom. His associations were about the democratic rights of oppressed people throughout the world and the futility of expressing these rights in the face of cruel and uncompromising dictatorships that seemed to be the order of the day. When asked how this affected him personally, living as he did in a democratic regime, he sarcastically replied that one could be a prisoner even in a democracy. Since his father had died, he had been obliged to take over the responsibility of looking after his mother. Not only did she insist that he stay in her home, but she also demanded an account of all of his movements. He realized that she was a sick, frightened woman and that consequently it was his duty to devote himself to her comfort for her few remaining years. These revelations were the turning point at which we were able to convert our sessions into explorations of his needs and conflicts. As he recognized his repressed hostility and his tremendous need for personal freedom, he realized that he himself was largely responsible for the condition that was virtually enslaving him. It was then possible for him to help his mother find new friends and to move into a retirement village. When he resolved some sources of his deep resentments, his bladder symptoms disappeared completely. More significant was a growth in assertiveness and self-esteem that improved

the quality of his social relationships.

When the Patient Refuses to Begin Therapy Unless Assured of Immediate Relief of Symptoms

Symptoms may be so upsetting to the patient that therapy will be refused unless there is first a reduction or removal of symptoms. When symptoms are so severe that they create physical emergencies, as in cases of persistent vomiting, hiccuping, or paralysis, the therapist may be able to restore function through suggestions in hypnosis. After this the therapist may proceed with other psychotherapeutic techniques. In less severe cases, insistence on symptomatic relief may be a tactic for demonstrating the therapist as a sympathetic person concerned with the suffering of the patient. Hypnosis with suggestions aimed at relaxation, tension control, and symptom reduction can create an atmosphere conducive to a therapeutic working relationship. Hypnosis can also expedite the learning of new habit patterns through desensitization and reconditioning (behavior therapy).

A patient who came to me with an obsessional neurosis complained of belching and hiccuping after meals. This caused her great embarrassment and frequently forced her to skip meals. She was so preoccupied with whether or not her symptoms would overwhelm her that she could scarcely enjoy food when invited out to dine. Her symptoms forced her to seek medical help, in the course of which she was referred to me. At the initial interview she testily protested being sent for psychiatric treatments, particularly in view of a past unsuccessful psychotherapeutic experience. What she wanted, she insisted, was sufficient relief from physical distress to enable her to function at work and in her relationship with her family. In light of her disappointment with interview psychotherapy, I suggested hypnosis as a possible way of helping her to achieve some lessening of her trouble. She agreed to give it a trial. The next five sessions were spent in teaching her how to relax and how to control her symptoms. Her response was dramatic, and her attitude toward me changed from suspicion and hostility to friendly cooperativeness. She readily entered into a therapeutic relationship, and once therapy had started, there was no need for further hypnosis.

When the Patient has Such Deep Problems in Relationships with People that Therapy Cannot Get Started

A good working relationship between patient and therapist is mandatory for any kind of

psychotherapy. This is particularly essential in therapy that tries to bring about modification of a personality that is prone to anxiety. This type of personality often feels great stress when the therapist probes for conflicts and challenges habitual defenses. With some sick patients the proper working relationship may never develop or may take many months to appear because of such factors as fear of closeness or intense hostility toward authority. Relaxation during hypnosis may resolve fears, reduce hostility, and cut down the time period required for the development of rapport. The patient often feels an extraordinary warmth and closeness toward the therapist even after only one or two hypnotic sessions. A therapeutic relationship may crystallize under these circumstances, and it will then be possible to proceed with psychotherapy without hypnosis.

One of the most severely disturbed patients I ever treated was a paranoidal man who upbraided me during our first session for my delay in arranging a consultation with him. He was upset, he said, because he was involved in litigious proceedings against his business partners, who had presumably deceived him about their business prospects when they first induced him to buy a share of the company. Another legal case was pending against a neighbor who had in a lot adjoining his house built a garage that the patient considered an eyesore. But what he most desired from the consultation with me was to determine the feasibility of hypnotizing his wife in order to obtain from her the truth of her exact whereabouts during an evening when he was out of town on business. He had carefully examined her tube of contraceptive jelly before his departure and again upon his return. At first he could see no difference, but he compulsively returned to it, ruminating about whether he had not made a mistake in his original conclusion about his wife's innocence. For weeks he had been subjecting her to cross-examinations, carefully tabulating contradictory remarks until he had convinced himself that she was concealing the truth about a rendezvous with her lover. The poor woman, protesting her innocence from the start, had become so confused by his confrontation that she desperately tried to make up stories to cover tiny discrepancies in her minute-by-minute account of activities on the fatal evening. With a sharp eye for her inconsistencies, the patient had seized on her flounderings to trap her into an admission of lying, which then convinced him all the more of her infidelity. A firm believer in the powers of hypnosis, he challenged her to submit to a hypnotic reliving of the evening in question in his presence.

Upon finishing this account, the patient inquired about my methods of trance induction since he had been reading about the subject. I volunteered to demonstrate the hand-levitation technique to him,

and he cautiously agreed to be a subject. Before too long he entered into a trance, during which I suggested that he would soon begin to feel more relaxed, secure, and self-confident. If he visualized a happy scene or had a dream about the most wonderful thing that could happen to a person, he would probably feel free from tension as well as experience a general state of pleasure that would make him happier than he had ever been in his life. After an interval of 10 minutes he was brought out of the trance. Upon opening his eyes, he revealed, with humor, having had a dream of lying on a hammock while lovely slave girls circled around him with baskets of fruit. I suggested that he return in 2 days and bring his wife if she wished to accompany him.

During the second session, which was held jointly with his wife, his wife tearfully proclaimed her innocence, whereupon the patient petulantly asked her to leave my office if she was going to "act like a baby." When she promised to control herself, he requested that she wait for him in the reception room. He then told me he had felt so well since his first visit that he had decided that several more sessions of hypnosis would be valuable for his insomnia. His wife's problem could wait, he claimed, until he had healed his own "nerves." After this initiation into therapy, he underwent a number of sessions of psychotherapy with and without hypnosis, during which we worked on several problems that concerned him. He ended therapy when he had achieved a marked reduction of his symptoms, an easing of his tensions with his partners, and the reestablishment of a satisfactory relationship with his wife.

Another patient spent the first 3 months of treatment with me in fruitless associational explorations. He protested that "nothing was happening" in regard to his symptoms or "anything else." He did not have either a warm or hostile attitude toward psychotherapy. He appeared to resent any continued questioning concerning his feelings about me. There was a consistent denial reaction to my interpretations. After I induced him to try hypnosis, he was able to achieve a medium trance. From the very first hypnotic session his enthusiasm and energy increased. His activity and productivity also improved remarkably, and we were able to achieve a good therapeutic result. Without hypnosis, I am convinced that his detachment could not have been penetrated.

When the Patient is Unable to Verbalize Freely

When communication is blocked, there can be no therapy. Sometimes the usual unblocking

techniques may fail to restore verbal communication. In such an event hypnosis can often be effective, although the way in which it is used will depend on the causes of the difficulty. The mere induction of a trance may uncork explosive emotions against which the patient had defended by refusing to talk in the waking state. Cathartic release in the trance may restore normal verbal expression. If the patient's silence is due to some resistance, it may be possible to explore and resolve it by encouraging the patient to talk during hypnosis. In speech paralysis (aphonia) resulting from hysteria these techniques may not suffice, and direct suggestion may be needed to lessen or eliminate the symptom. Speech disorders may be treated and sometimes helped by lessening tension during the trance, and there may then be a carryover into the waking state. When the speech difficulty is caused by needs that forbid the expression of painful sounds or ideas, an explosive outburst during hypnosis may not only release the capacity to talk freely, but will also open up areas of conflict that can be beneficially explored.

A young woman, a severe stammerer, came for therapy because of incapacitating phobias. Once she had established rapport with me, she expressed herself satisfactorily, but as we began to examine her fantasies and dreams, she experienced so pronounced a relapse in her speech disturbance that she was almost inarticulate. She complained that while she could talk better than ever before with her friends, she could scarcely communicate with me. Since progress had come to a halt, I suggested hypnosis as a way of helping her to relax. She reacted to this suggestion with anxiety but, nevertheless, agreed to try. During the process of deepening the trance she suddenly broke down and cried fitfully. Encouraged to discuss what she felt, she clenched her fists and shrieked, "No, no!" After exploding into a coughing spell, during which she could hardly catch her breath, she gasped over and over that she was choking. At my suggestion that she "bring it up," she broke into a torrent of foul language, pronouncing the word "shit" repeatedly and spitting with angry excitement. A few minutes of this frenzied behavior were followed by complaints of exhaustion. Thereupon she resorted to normal speech, which continued for the remainder of the session, even after she had been aroused. This performance was repeated in subsequent sessions, although the patient responded with diminished fury. The therapeutic process gained great momentum, and the young woman was able to curb her stammer. The experience opened the door to a discussion of her great concern over bowel activities. This was related to extremely rigid toilet training as a child by an obsessive, overdisciplinary mother who made her feel guilty and frightened about toilet activities. Feces, from early childhood on, were equated with poison and destruction. Our therapeutic sessions were

largely concerned with clarifying her misconceptions. As she developed a more wholesome attitude toward her bowel functions, her general feelings about herself improved, and her speech difficulty practically disappeared.

When During Therapy the Patient is Unable to Engage in Unrestricted Exploration

A patient may maintain rigid control when he dreads psychological areas of conflict that may be exposed. He thus cannot permit his ideas to emerge freely and unrestrainedly in the process of exploring unguarded aspects of his psyche. When the patient is blocked because of resistance, hypnosis may be a possible solution. Not only may it bring the patient into contact with repressed emotions and thoughts, but it also may help him to analyze his blocks.

This was true of a patient who had retreated to a highly structured and rigidly directed form of verbal expression. Attempts to analyze his loss of spontaneity produced little response. After floundering, with no improvement and mere repetition of insignificant items, I induced hypnosis and encouraged the patient to talk about what really was bothering him. He revealed that he had felt guilty in the past few weeks for having masturbated in my office bathroom after one of our sessions. He had not wanted to tell me about this incident because he knew it was not an adult act. He then associated this action with having been caught as a child masturbating in his aunt's bathroom. Not only had he been reprimanded and warned by his aunt, but also his parents had promptly been told, The physician who referred the patient to me also frowned on his masturbatory practices, classifying masturbation as "idiot's delight, which is never indulged in by a mature person." Reassured by my handling of these revelations, the patient was able to continue with his associations in the waking state.

In instances where there is a dearth of dream material the patient may be trained to dream in the trance or through posthypnotic suggestions during normal sleep. General topics of specific topics may be suggested as the dream content. Once this process is started, it may be possible for the patient to continue dreaming without hypnosis. Hypnosis can also be used to restore forgotten elements of dreams, to clarify distortions elaborated to disguise their meaning (secondary elaborations), and to help the patient explore by means of dreams attitudes toward people and disturbing elements in everyday life. During hypnosis spontaneous dreams may occur reflecting unconscious attitudes, memories, emotions, and

conflicts. Sometimes they reveal to the patient the meaning of the immediate hypnotic experience as well as distortions in relationship with the therapist, caused by confusing the therapist with early authority figures.

The improvement shown by one of my patients illustrates how valuable hypnotic dream induction can be. The patient came to me for psychotherapy when he could find no relief for severe rectal itching. He had tried every kind of medicinal oral and injection treatment. Although we soon established a good working relationship, he was unable to remember his dreams. In the trance I suggested that he would have a dream that would explain his rectal itching. He responded with an anxiety dream of a man with a huge penis approaching him from the rear. He was told to forget the dream or recall any part of it that he wished to remember after he had awakened. Upon opening his eyes, he complained of tension, but he did not remember his dream. He admitted some relief in his rectal itching. That same night he had a dream of riding a roller coaster with a male friend. His dream suggested concerns about homosexuality. In later dreams he was able to countenance homosexual impulses and to discuss them during the session. Hypnosis was responsible for opening up a repressed and repudiated area of guilt and conflict.

When the Patient Seems Blocked in Transferring to the Therapist Distorted Attitudes toward Parental and Other Early Figures of Authority

Childhood experiences, particularly relationships with parents and siblings, by their formative influence on attitudes, values, feelings, and behavior leave an indelible imprint and affect the way the adult responds not only to other people but also to oneself. Because some of the most important formative experiences are forgotten, or remain hazy, or are dissociated from the fears and anxieties with which they were originally linked, they subversively influence faulty ways of thinking and acting. Some of the transference distortions may be uncovered by hypnosis, and their interpretation may bring the patient to a realization that he also responds in destructive and unnecessary ways in many other situations. The lesson learned can serve as the basis of new, more wholesome attitudes to present-day authority, attitudes that fortunately will in all likelihood make life more comfortable and productive.

A patient who came for therapy entered easily into the hypnotic state but became more and more recalcitrant to suggestions. He had always been submissive to his father (and later to other male

authorities). Along with this he felt great inner rage, turmoil, and depression, although he was outwardly calm. It seemed to me that his entering hypnosis was a means of pleasing me. This was the customary role with male authority, patterned after the way he reacted to his father. "For years, I hated my father," he said. "He couldn't stand being contradicted. I remember needing to lose at cards deliberately so that father would not get upset over my winning. I am never able to be successful: it makes me too anxious." When I interpreted to him the way that he was reacting to me, he at first denied it. But then he appeared to see the light, with the result that he challenged me first by resisting hypnosis and finally by manifesting a total inability to enter the hypnotic state, I accepted his refusal to comply, even encouraged it. At this phase the patient experienced dreams of triumph. "It's healthier to dream of feeling love rather than hate. For the first time, I realize I loved my father. I cried in my sleep. I felt my father really loved me, but we had this wall between us. I awoke feeling I really loved him." This change in feeling was accompanied by an abatement of symptoms and a capacity to relate more cooperatively. Soon the patient was able to enter hypnosis easily and without resentment, as a means of pleasing himself—not me.

Another patient, experiencing frigidity, was referred to me by her psychoanalyst for some hypnotic work. After the third induction she told me that she felt the need to keep her legs crossed during the entire trance state. So tightly did she squeeze her thighs together that they ached when she emerged from the trance. Before the next induction I instructed her to keep her legs separated. As I proceeded with suggestions, she became flushed, opened her eyes, and exclaimed that she knew what was upsetting her. I reminded her of her grandfather, she said, who, when she was a small child, had tossed her into bed and held her close to his body on several occasions. She had felt his erect penis against her body, and this had both excited and frightened her. It became apparent that the hypnotic experience represented for her an episode during which she hoped for and feared sexual seduction. Her leg crossing was a defense against these fantasies. Continued trance inductions with the patient diminished her fears, and she then revealed being able to have better sexual relations with her husband.

Another patient, who suffered from periodic attacks of nausea, vomiting, and gastrointestinal crises, was referred for hypnosis after two years of traditional psychoanalysis had failed to relieve her symptoms. Because she tended to shield herself from awareness of her problems with strong repressions, I felt that transference, which had not developed significantly during her previous therapy, might be

important in helping her to gain insight into her problems. After she had been trained to enter a medium trance, I suggested that she would dream of her feelings about me. She failed to dream; instead she had a hallucination consisting of a peculiar taste in her mouth, which she described as "bittersweet." This taste persisted for several hours after her session. That evening she had a nightmarish dream in which a woman, whose handbag bore the initials B.S., took a small boy into the bathroom to help him to urinate and wash up. She was unable to interpret the dream. A trance was induced in which she recalled forgotten elements of the dream, namely that the sexes of the two participants had changed as they had entered the bathroom; the adult had been a man, the child a girl. The next few sessions were spent discussing a "reaction" to me that the patient had developed and that made her want to stop treatment. She was positive that I resented her, and she recounted several minor incidents indicating to her that I did not have her best interests at heart. She was positive that I preferred a young man whose sessions preceded hers because I once had kept him late, thus overlapping her time.

In the trance that followed, she broke into hysterical crying, identifying me as her father, whose nickname was Bing. (The initials B.S. in the dream stood for Bing. His last name began with an S. B.S. apparently was linked to the "bittersweet" taste she had in her hallucination.) He had been both father and mother to her (changed from male to female in the dream), had preferred her brother to her (her reaction to the male patient whose hour preceded hers), and had always reminded her that he regretted that she had not been born a boy (her being brought into the bathroom as a boy in the dream possibly indicated that she had finally succeeded in achieving a masculine status). Thereafter, she experienced strong sexual feelings toward me and shamefully asked if I did not have a preference for her among all my other patients. From then on it was possible to analyze the origins of these feelings in her relations with her father and to see that some of her symptoms were associated with fantasies of wanting to be a boy through acquiring a penis. Hypnosis succeeded rapidly in allowing us to understand what was behind her difficulty.

When the Patient has Forgotten Certain Traumatic Memories Whose Recall May Help the Therapeutic Process

In some emotional states memories may be submerged. Because they constantly threaten to come to the surface, anxiety and defensive symptoms, which bolster repression, affect behavior adversely. The trance can be instrumental in recalling the repressed experience, and the examination of the associated

emotions helps to eliminate debilitating symptoms.

One patient suffered from periodic attacks of shortness of breath, an affliction that resembled asthma. He was given a suggestion in hypnosis that he would return (regress) to his first attack. In a scene in which he saw himself as a child of 3 standing in a snowdrift on a back porch, he described how he slipped and fell into a high snowdrift, gasping for breath as the snow filled his nose and throat. With panic, choking as he talked, he told of being rescued by his mother and father. This story was verified by his parents as a true experience. They were amazed that the patient remembered the exact details of the accident, and they confirmed that "asthmatic" attacks had begun soon after this incident. It was then established in therapy that interpersonal situations in which the patient felt trapped caused him to respond with the symptom of choking for breath. This pattern had originally been established when he actually had been physically trapped. With this recognition, the symptom was markedly alleviated.

When the Patient Seems to "Dry Up" in Conversations, Being Unable to Produce Any More Significant Material

Periods of resistance may develop during the course of therapy characterized by an almost complete cessation of activity. The patient will spend many sessions in fruitless attempts at conversation; he seems to be up against a barrier that he cannot break through. Attitudes of disappointment and hopelessness contribute to his inertia until he resigns himself to making no further efforts. He may even decide to abandon therapy. When such circumstances threaten, hypnosis may be tried to mobilize productivity. A variety of techniques may be used, including verbalizing one's thoughts without restraint (free association) in the trance, dream and fantasy stimulation, mirror gazing, automatic writing, play therapy, dramatic acting, regression and reliving (revivification), and the production of experimental conflicts (Wolberg, 1964). The specific method employed is usually determined by the therapist's experience and preference as well as by the patient's aptitudes in working with one or another technique.

A patient who had been working satisfactorily with me began to develop silences that greatly puzzled her since she had up to this time been quite garrulous in her ramblings. "When I try to think, my mind goes blank," she said. "Nothing comes to me." After several frustrating sessions, hypnosis was induced, and she was encouraged to talk about her mental meanderings. She began to moan and cry.

"Grief, grief. It's all death—as if it's all over. It's my father; he died of cancer, and I took care of him. He keeps coming back. It chokes me up. It's as if it's all happening again." The patient then revealed, expressing great feelings of guilt, that while she had nursed her father during his illness, she had experienced tender and then voluptuous feelings for him. During his illness she was able to have him all to herself for the first time. Her mother was only too willing to let her take care of him. Sexual excitement was strong during this period, and she harbored guilt feelings during and after her father's death, scarcely daring to think about it. "I'm frightened. I know I felt guilty about my desire to be close to my father. After he died, I felt cold and detached. Maybe that is why I can't feel anything for men now. I realize I do this with all men, that is, I want to baby them, take care of them. I had been taking care of one man I know who got sick with the flu. I sponge-bathed him and got so sexually excited I could hardly stand it. The thought occurs to me that I would like to take care of you too. I'm so ashamed to talk about this." From this the patient stated she understood the reason for her guilt feelings and why they were causing resistance to therapy. She herself was able to interpret the transference to me of her feelings for her father. From then on she progressed satisfactorily in treatment.

When the Patient is Unable to Deal with Forces that Block the Transformation of Insight into Action

The mere development of insight is not enough to insure the correction of neurotic attitudes and patterns; it must be employed toward constructive action. Unfortunately, there are often anxieties and resistances that obstruct this process and bring therapy to an incomplete end. Hypnosis is sometimes useful in converting insightful perception into action, and it can achieve this goal in a number of ways. First, one may attempt by various techniques to explore resistance to change, the patient associating to fantasies or the dramatic acting-out of certain healthy courses of action. Second, posthypnotic suggestions can be made to the effect that the patient will want more and more to engage in actions that are necessary and that are being resisted. Third, role playing can be used, the patient dramatizing various situations in the present or future and verbalizing insights or fears to the therapist. Fourth, in somnambulistic subjects experimental conflicts may be set up to test the patient's readiness to execute necessary and desirable acts and to investigate reactions to their completion.

One of my patients, a man with a passive personality, had gained insight into some of the roots of his problem during therapy; he also realized the destructive consequences of his failure to be self-

assertive. He wanted to change but was paralyzed at knowing how to begin. The best he could do was to fantasize walking into his employer's office and boldly asking for a promotion. In his fantasy he was rewarded with a higher position and a handsome raise in salary. But, he could not muster the courage to face his employer in real life, and he expressed fears of being turned down. In hypnotic role playing he took the part both of himself and his employer and vehemently discussed the pros and cons of his position. However, he still could not get himself to act. Since he was able to develop posthypnotic amnesia, I decided to try to set up an experimental conflict. I suggested that he imagine himself asking for a promotion. Then I told him to forget the suggestion but, upon emerging from the trance, to feel as if he had actually made the request. The first two attempts were followed by tension, headaches, and discouragement. This indicated that the patient was not yet prepared to take the necessary step forward. We, nonetheless, continued discussion and role playing, and a third experimental situation resulted in a feeling of elation and accomplishment. The next day the patient spontaneously approached his employer and was rewarded with success. Thereafter the patient began to act with more assurance, and his progress in therapy helped him to become more positive in his general behavior.

When the Patient has Problems in Terminating Therapy

Difficulties in ending therapy are sometimes experienced by patients who, having been freed of neurotic symptoms, are afraid of losing what they have gained and suffering a relapse. Patients with dependent personalities may resist ending treatment with astounding stubbornness. Contrary to what might be expected, the adroit application of hypnosis can help some of these patients toward self-reliance by relieving their tension at points where they try to act independently. The patient may also be taught self-hypnosis for purposes of relaxation and shown how to investigate spontaneously— through dreams, fantasies, and associations— the problems that arise daily from demands to adjust to specific situations. In this way responsibility is transferred to the patient toward becoming more capable of self-determination. Intervals between visits with the therapist are gradually prolonged. In the beginning the patient may resort to daily sessions of self-hypnosis because of anxiety. But as more confidence is developed in the ability to survive alone, self-hypnosis exercises become irregular, and finally they are resorted to only when tensions cry for relief. In many patients, however, regular relaxation exercises are an important part of adjustment and may be prolonged indefinitely with beneficial effect. In this respect

a relaxing and ego-building cassette tape may be of help.

The situations just described are no more than brief outlines of how hypnosis may be effective in psychotherapy and only suggest the various ways in which the trance can be used as an adjunctive catalyzing procedure. Since all psychotherapy is a blend of the therapist's inpidual personality and techniques, no two therapists will operate identically. Each therapist has a particular philosophy about how people become neurotically ill and how they get well again. If a therapist believes that unconscious memories and conflicts are the basis for all neurotic ailments, digging will be indulged to uncover the emotional conflictual poison that has accumulated. Once it is released, the psyche will presumably heal. Freud and Breuer originally used hypnosis in this way and scored occasional success with some patients. They recorded their findings in *Studien uber Hystene*, the revolutionary book that was a precursor of psychoanalytic theories and methods. Although hypnosis used in this way may be instrumental in releasing repressed memories, we now know that the majority of patients are not helped by this process alone. Interesting and dramatic as are the results, additional techniques are necessary if we are to achieve lasting benefit.

There are other therapists whose theories about how people become emotionally ill involve the concepts of faulty learning and conditioning. They use hypnosis to reinforce their stratagems of teaching their patients new patterns of habit formation, thinking, and action. Although these "behavioral" methods are responsible for considerable progress in the treatment of some ailments, they are not successful in dealing with all problems. But neither is any other technique.

One of the most important points to be made about hypnosis is that it can be helpful as a catalyst irrespective of the method of psychotherapy. Some therapists are not able to use hypnosis with any measure of success, either for personality reasons or because of unresolvable prejudices. This does not invalidate hypnosis as a procedure. Hypnosis, like any other area of specialization, requires particular abilities and skills. Not every therapist is able to amalgamate hypnosis with one's personality and technical training.

It should be stressed again that hypnosis and any other catalyzing technique must be used intelligently within the context of a comprehensive treatment plan and with due regard for limitations.

Applied indiscriminately such techniques not only fail to serve a therapeutic purpose, but their ineffectiveness tends to discredit them as worthwhile procedures and to impede their acceptance. Used at strategic points in psychotherapy, catalyzing methods may facilitate progress. In this way they can add an important dimension to the technical skills of the psychotherapist.

Case Illustration

The following is the fourth therapeutic session with a male patient who came to treatment because of work problems and terrifying nightmares of which the patient had no memory. These conditions had existed for several years, and after a period of psychotherapy with a psychoanalyst in the Midwest, he had derived some benefit from the sessions. However, he was unable to remember any dreams or to associate freely. The session that follows is the first one during which hypnosis was employed. It illustrates the use of various techniques in hypnoanalysis for the purpose of exposing a dynamic focus.

Pt. I am in good shape today, really, for no particular reason that I can think of, and yesterday I didn't feel so good. I had a fight with my wife where I came off very badly.

Th. Shall we go into that?

Pt. I was thinking the last time that this has degenerated into one session after another, my complaining about my wife. You know, I mean the material is all the same. When I think about it, I am really convinced the trouble is with me, not with her. Not that she doesn't have her troubles, don't mistake me; but I am really convinced if she had married a man, in every sense of the word, who really behaved as one, that many of her difficulties and hostilities would be erased.

Th. If she married a man? [*Obviously the patient has doubts about his masculinity.*]

Pt. If she had married a man—you know what I mean—a forceful guy who really ran the roost and her, who, well (*pause*).

Th. You mean, she would then straighten out?

Pt. Yes

Th. So that the emphasis would be on whether you would like to be this kind of guy. Would you?

Pt. Yes. Yes. Yes.

Th. Do you think you would like to be a forceful guy?

Pt. Certainly. Well, I don't say that a man has to be—I don't mean he has to be brutish or stubborn or insensitive or

unintelligent or dull. I don't think any of those things are necessary just to be a well-adjusted man. Don't you agree?

Th. Mm. All right, if you sense that there is a certain lack in you, that should be where we direct our therapeutic effort.

Pt. Right, I should say so; I agree a hundred percent. That is exactly my point, that, you know, I felt not much was accomplished last time, that I had spent all this time talking about my wife, what I said and what she said. What she said is not as important as what I did about it, or why the situation ever got to the point where she would say such a thing. She is not the patient, (*pause*)

Th. All right, then what would you like to talk about?

Pt. Well, I had a nightmare Tuesday night, that was the night. I had no memory of it, except when I woke up I thought I was choking; not exactly choking, but my throat was full of phlegm, or something. I had never had that one before, although, as you know, I have never been able to remember a nightmare. [*It is quite possible, I feel at this point, that the nightmare contains a core problem that he is repressing.*]

Th. It may be possible to catch it, to have it repeat itself and remember it in hypnosis.

Pt. That would be fascinating.

Th. We might be able to revive it so that you will be able to see the kind of nightmare that you repress, and maybe get some clues as to what these nightmares are all about. Now what was this fight all about? Just tell me very rapidly.

Pt. Very rapidly, last night, as you know, our house is in a big turmoil, without a kitchen really; we have a temporary kitchen, and so forth. I took a nap before dinner, before we went out to dinner last night. We go out to dinner almost every night because we have no kitchen. I said, "I actually am afraid that I am getting anemic again," because I was, and she said, "Are you taking your medicine?"—this is pills and stuff—and I said to her, "No, I am not, because I don't have enough for lunch." The point of it is, when I take this medicine, these pills, I have a ravenous appetite; I have to have for lunch a complete meal with potatoes and vegetables, the whole damned thing. This was a criticism of her and she blew sky- high, and I felt lousy anyway, and I did not come up to scratch at all. That is what it was all about. We went to dinner. Well, no, we had a fight a half hour later. We came home. She wanted to make love. I felt so lousy, I was really so tired, sick, tired.

Th. What day was this?

Pt. Oh, that was yesterday.

Th. That was yesterday?

Pt. That was yesterday, that was last night.

Th. Thursday?

Pt. Yes.

Th. What events happened on the day preceding your nightmare?

Pt. Well, I came here.

Th. You were here?

Pt. Yes

Th. Anything else?

Pt. No. I haven't even done much work. I tried it. I have a very difficult time working. I tried reading, a romantic story, actually in romantic terms. It is about a woman who never thought she had any charm but plenty of character, and a guy with tremendous charm who thought he had no character. This, as I say, in fictional, dramatic, romantic terms are my wife and I. Now, my wife, she had done a tremendous lot for me, in many, many ways, tremendous therapy, and I actually have done a lot for her. She looks different. She walks into a room differently. She is an assured, attractive, charming woman. She is very well liked and admired, and she wasn't this when I met her.

Th. You have really helped her a great deal in this area.

Pt. Yes, and she helped me tremendously.

Th. Does she realize how much you have helped her?

Pt. Yes, sure she does.

Th. She realizes then this marriage has to go on?

Pt. Oh, yes; oh, yes. Actually this marriage will go on, no matter what I say. This marriage basically, basically is a good marriage. We need each other; we need each other very much. We give a lot to each other. It has been going to pieces a lot lately, but basically the foundation is good, I think; I am not sure. (*laughs*) I think I am sure, (*pause*)

Th. All right. Do you want to relax now?

Pt. Yes. Do you mind if I take my coat off? It's hot; it's tight; and I think I'll do better with it off. (*takes off coat*.)

The hypnotic induction process I will use is hand levitation. There are many methods of trance induction and a therapist may employ any of these, usually perfecting one technique. The relaxation method described in the chapter dealing with the making of a relaxing and ego-building cassette tape I find is the most suitable technique for most patients.

Th. Supposing you just lean back; stretch yourself out, and, for a moment, close your eyes and begin relaxing. Relax your forehead; purposely concentrate on your forehead, and your eyes, and your face, and your neck, and your shoulders. Let your arms relax. Relax your body. Then bring your hands, the palms of your hands, down on your thighs. Open your eyes; watch your hands. Just observe your hands. Concentrate on everything your hands do; sort of focus all your attention on your hands and keep all other sensations in the periphery. You may notice that your hands feel heavy as they press down on your thighs. Perhaps you notice the roughness of the texture of your trousers on your fingertips and palms. You may notice the warmth of your hands, or a little tingling in your

hands. Notice whatever sensations there may be. Concentrate your attention on your hands; watch your hands. The next thing you will notice as you observe this over here, this right hand, is that very slowly your fingers will begin to spread, the spaces between the fingers will be wider and wider.

The spaces between fingers grow wider, and wider, and wider, just like that. And then you begin to notice that there will be a lifting of the fingers, slowly. One of the fingers will start lifting from your thigh, and then the rest of the fingers will follow, and then the hands will slowly begin to lift and move straight up in the air, moving, moving, and as they move, you will watch them, fascinated, as they move, slowly, automatically, without any effort on your part. Then your hand moves up, up. It moves toward your face; eventually it will touch your face, but only when it touches your face will you be asleep. [*The word "sleep" is used only because it signifies the deepest kind of relaxation. Obviously the patient will not be asleep*]. You will get drowsier and drowsier, but you will not fall asleep, and you must not fall asleep until your hand touches your face. And as your hand moves toward your face, you get drowsier, and drowsier, and drowsier, and just as soon as your hand touches your face, you will feel yourself dozing off and going to sleep, deeply asleep. You are getting very tired now, very, very drowsy; your eyes are getting heavier and heavier; your breathing is getting deeper and automatic; you feel yourself getting very, very tired, very drowsy; your hand is moving up, up, up toward your face. As soon as it touches your face, you will be asleep, deeply asleep. You will be very, very tired. Everything is floating off in the distance. You are getting very drowsy, very drowsy, drowsier, drowsier, drowsier. Your hand is moving up, up, up, up, toward your face; it approaches your face. Your eyes will soon close, and you will go deeply to sleep; but do not fall asleep until your hand touches your face. Your breathing is getting deep; you are getting very tired; everything is slipping away into the distance. Your eyes are shutting. You are going into a deep, deep, deep sleep; you are very drowsy now. You are very tired, very sleepy. Your hand is coming toward your face; now it touches your face. Now you are going to sleep, and you are going to stay asleep until I give the command to wake up. Your sleep is getting deeper, and deeper, and deeper. [*The patient's hand touches his face; his eyes close; and he is breathing deeply and regularly.*]

I am going to take your hand over here and bring it down to your thigh, just like this. You keep getting drowsier, and drowsier, and drowsier. Listen carefully to me. I am going to stroke your left arm, and your forearm and your hand, and as I stroke them, I am going to count from one to five. You will notice that as I count, you get the feeling as if your arm has become just as stiff and heavy as a board. As I stroke it, the arm gets heavier, and heavier, and heavier. Your arm is getting heavy and stiff, heavy and stiff, heavy and stiff, just like a board. The arm is getting heavier, heavier, stiff, stiff, stiff, stiff. One, it gets stiff and heavy like a board. Two, just as stiff as a board. Three, stiffer and stiffer; the arm is getting stiff. Four, stiff and heavy. Five, stiff, heavy; when I try to bend it, it will resist motion. The harder you try to move it, the heavier and stiffer it becomes. It will be impossible to raise it no matter how hard you try. However, when I snap my fingers, when I snap my fingers, your arm will relax, (*pause, then sound of fingers snapping*) Now you can raise your arm, if you wish. (*The patient lifts his arm slightly.*)

Now, relax yourself all over and fall asleep, even deeper. Your eyes are glued together, very, very, very tightly glued together, as if little steel bands bind them together. They are very tightly bound together. The harder you try to open your eyes, the heavier your lids are. Finally together, and you feel yourself dozing off, going into an even deeper sleep. You are getting drowsier, drowsier, very tired, very, very sleepy, (*long pause*)

Listen carefully to me. I am going to stroke your hand, and your forearm, and your arm, and as I do that, it will become just as light as a feather. As a matter of fact, it may start swinging up in the air spontaneously; it will become so light that it will almost automatically swing straight up in the air, just as light as a feather, straight up. It floats around in the air now, floats around in the air, just as light as a feather. It floats around in the air, just as light as a feather, until I snap my fingers. (*The patient easily lifts his arm and waves it.*) Then it will slowly come down, slowly down. Now it slowly comes down, right down to your thigh, and you slip off into a deeper sleep, a deeper sleep. (*The arm comes down.*) When I talk to you next, you will be still more deeply asleep. (*long pause*)

Now, I want you to imagine yourself walking outdoors. As soon as you see yourself walking outdoors, raise your left

hand about 6 inches. (*Hand rises.*) Now bring it down. Again visualize yourself walking outdoors, raise your left hand about 6 inches. (*Hand rises.*) Now bring it down. Again visualize yourself walking outdoors on the street, and see yourself entering an alley between two buildings. You turn into the alleyway and you walk slowly, and, as you do, on the right-hand side of the alleyway you notice a pail of water, steaming hot water. As soon as you see that, raise your hand about 6 inches. (*Hand rises.*) Good. Now bring it down. Listen carefully to me. Try now to test how hot that water is. See yourself walking over to the pail of water. You take your right hand and plunge it into the water, and as you do, you get a sensation of scalding, of heat. As soon as you feel that, indicate it to me by your hand rising about 6 inches. (*Hand rises.*) The hand feels tingly and sensitive and tender. I am going to show you how tender. I am going to show you how tender it is by poking it with a pin.

As soon as I poke your hand with a pin, it may feel very, very painful and tender. I will show you. Very, very painful, just like that. (*Patient withdraws hand.*) In contrast, this other hand is normal. (*Touched with a pin,the hand does not withdraw.*) Now your hand returns to normal sensation. Now the left hand is going to start getting numb. It is going to have a feeling, a peculiar feeling, almost as if I had injected novocaine all the way around the wrist. This gives you a sensation of numbness that increases to a point where you get the feeling you are wearing a stiff, heavy, leather glove. There is a sense of feeling, but no real sense of pain, a sense of feeling, but no real sense of pain, a sense of feeling, but no real sense of pain. As soon as you feel your hand growing numb and you have a sensation as if you are wearing a stiff, heavy, leather glove, indicate it to me by raising your hand about 6 inches. (*Hand rises.*) Good. Now bring it down.

I am going to poke this hand with a pin, and you will notice, in contrast to your right hand, which is rather tender, that this left hand will be numb; there will be no real pain. You will have a sensation of feeling, but no real pain. I will show you, no pain even when I poke it very deeply, no pain. You notice the difference when I touch this hand over here and the hand here. You notice that, don't you?

Pt. Yes.

Th. All right, now go to sleep, more deeply asleep. When I talk to you again, you will be even more deeply asleep, more deeply asleep, (*long pause*)

Now listen carefully to me. Even though you are asleep, it will be possible for you to talk to me just like a person talks in his sleep. You will be able to talk loudly and distinctly, but you will not wake up. I want you to imagine yourself walking outdoors again, but this time you walk out into a courtyard and you see a church, a beautiful church, steeple, spire, and a bell. As soon as you see the church, indicate it by your hand rising. (*Hand rises.*) Good. Now bring it down. Next you see the bell; the bell begins to move; the bell moves, and it starts clanging. You hear the clang clearly. As soon as you hear the bell clanging, indicate it to me by your hand rising about 6 inches. (*Hand rises.*) Now bring your hand down.

You turn around from the courtyard, and you go back to your home. You walk into the living room. You go over to the radio. You turn your radio on, and you hear a symphony orchestra Beautiful music comes from the radio. As soon as you hear it, indicate this to me by your hand rising about 6 inches. (*Hand rises.*) Good. Now bring it down. Can you recognize the music?

Pt. Uh-huh.

Th. What was the music?

Pt. It is something by Bach.

Th. Good. Next, you decide to go to the theater. You walk along the street. Then you notice a theater; you have a

hunch that you want to see something in this particular theater, but you don't know exactly what it is you want to see. You don't even look at the billboard to see what may be playing. You walk right into the theater, down to the fourth row orchestra and sit down. You look up and notice that the curtain is down. There are very few people in the theater. You are rather curious as to what is behind that curtain.

Pt. Uh-huh.

Th. As soon as you observe yourself sitting in the theater, indicate it to me by your hand rising about 6 inches. (*Hand rises.*) Good. Now bring it down.

In your curiosity you notice that there is a man with a gray suit, a tall young man, up there on the platform. [*To enhance identification, this person is of the same sex and attire as the patient.*] He seems to be peering behind the curtain as if his patience has almost come to an end and he would like to see what is going on backstage. But as he turns around, you notice that he has a horrified expression on his face as if he has seen something horrible, about the most horrible thing that could happen to a person. As you observe that, you begin to absorb some of that feeling. [*This is a technique of imagery evocation often useful in many ways.*) And you wonder what is behind that scene. I am going to count from one to five, and then snap my fingers. At the count of five, as I snap my fingers, the curtain will suddenly rise and you will see a scene that is what this man saw, the most horrible thing that can happen to a person, (*counting to five, then sound of fingers snapping*) Tell me about it as soon as you see it.

Pt. No, no (*crying*)-, no, no, no (*crying*)-, no, no, no, no, no; I don't know; I don't know (*screams with anguish*).

Th. Tell me.

Pt. I don't know; I don't know.

Th. What has frightened you?

Pt. Oh (*crying*), oh, no, no, no.

Th. The curtain is down.

Pt. Yes.

Th. Something frightened you.

Pt. Yes. (*crying*)

Th. The curtain goes down.

Pt. (*crying*) Oh, oh, oh.

Th. You saw something that frightened you.

Pt. I don't know; I don't know what I saw.

Th. All right, now listen carefully to me. I am going to help you. Something frightened you; something continues to frighten you all the time, and we have got to liberate you from that. You want to be liberated from that fright,

don't you?

Pt. Yes, yes, yes.

Th. You would like to get over that fright. That fright makes you insecure. That fright may hold the key to your trouble.

Pt. Yes, yes, yes, yes, to the nightmare.

Th. And when we uncover that fright and see what it is and get it out of your system, get rid of it, we'll solve your nightmares.

Pt. Yes, that will be good.

Th. Now listen carefully to me. You don't know when this is going to happen. I am going to help you. You want to be helped?

Pt. Yes, yes.

Th. All right, now listen to me. As you sit there, the scene is going to change completely. Instead of being a horrible scene, it will change to a happy scene. You are going to notice the same man peering behind the curtain again, but this time when he turns around, he has a happy expression on his face. The whole atmosphere has changed. He feels very happy, very contented. As you see this wonderful expression on his face, you too feel a part of it.

You realize he has seen the most wonderful thing that can happen to a person. You feel as if it is about to happen to you. You watch that curtain very closely. At the count of five, I will snap my fingers and you will see the most wonderful thing that can happen to a person. (*counting to five, then sound of fingers snapping*) As soon as you do, I want you to tell me about it without waking up.

Pt. It is a play. No, no. (*crying*)

Th. It is a play?

Pt. No. It is a play (*crying in an agitated way*).

Th. It is a play?

Pt. I am not happy—oh, oh. [*Apparently the nightmarish image is still with the patient, neutralizing the happy scene.*]

Th. You are not happy. The other thing bothers you, doesn't it?

Pt. I don't know what is behind that curtain. I don't know. I don't want to know. (*crying in anguish*)

Th. You don't know?

Pt. No

Th. Listen carefully to me. You don't know what is behind it, but you would like to know and get rid of it?

Pt. Yes.

Th. I am going to try to help you now so you will get rid of it once and for all. (*Patient continues crying.*) Listen.

Pt. Yes, yes.

Th. I am going to count from one to five. At the count of five, suddenly a number is going to flash into your mind.

Th. The number will be the number of letters in the word that holds the clue to what is behind the curtain that frightens you. It may hold the clue to what is behind the nightmare that frightens you. As I count from one to five, a number will suddenly flash into your mind as if it has been etched out. That number will be the number of letters in the word, the key word, which contains a clue to this whole thing.

Pt. Uh-huh.

Th. And the letters all taken together, unscrambled, will give us the clue to the word that is so significant, that has within it the core of your problem. Do you understand me?

Pt. Yes, yes.

Th. Give me the first number that flashes in your mind when I count to five. One, two, three, four, five.

Pt. Eleven.

Th. Eleven. All right, now rapidly from one to five, when I reach the count of five, a letter will flash into your mind. Give me the letters, regardless of the order. One, two, three, four, five.

Pt. H.

Th. One, two, three, four, five.

Pt. P.

Th. One, two, three, four, five.

Pt. R.

Th. One, two, three, four, five.

Pt. M

Th. One, two, three, four, five.

Pt. I.

Th. One, two, three, four, five.

Pt. L.

Th. One, two, three, four, five.

Pt. E.

Th. One, two, three, four, five.

Pt. H

Th. One, two, three, four, five.

Pt. O.

Th. One, two, three, four, five.

Pt. A, m, n—I don't know.

Th. I will do it again. One, two, three, four, five.

Pt. A. O.

Th. All right, now listen carefully to me. I am going to count from one to five, and this time when I reach the count of five, all these letters will just scramble together and make a word that will give you a clue. You understand me?

Pt. Yes.

Th. One, two, three, four, five.

Pt. Oh, oh, homophrile, homophrile.

Th. Homophrile? [*The word, it was determined later, was "friend and lover of men, " a designation of "homosexual." The patient's concern of his wife not being married to a man is somehow related to the fear that he is a homosexual.*]

Th. Now, you have a clue. You are going to have a dream. The dream will not be too scary a dream, but it will be a first step in coming to an understanding of what this fear is. Do you understand me? The dream will be the first step.

Pt. Yes.

Th. It will have within it the essence of the word that you just spelled out for me. As soon as you have this dream, which may or may not be like the nightmares you have, you will open your eyes and wake up. As soon as you awaken, everything will be blotted out of your mind. It will be as if you are waking from a sound sleep. Then what I will do is tap three times on the side of the desk, like this. (*three taps*) With the third tap you will suddenly remember the dream that caused you to wake up. Do you understand me?

Pt. Yes.

Th. You will have a dream. The dream will contain a clue, and then, as soon as you have had the dream, you will wake up. But you will blot the dream from you mind, or it will be very vague in your mind. You won't remember, but on the third tap the whole thing will pop into your mind. Do you understand me?

Pt. Yes.

Th. Go to sleep and have a dream, and then wake up. [*The object in having the patient repress the dreams is to protect him from any associated anxiety. The tapping signal may release the dream if the anxiety is not too great.*]

Th. (*After several minutes the patient awakens.*) How do you feel?

Pt. A little tired.

Th. A little tired. What are you thinking about?

Pt. Well, well, I know I cried. But . . .

Th. Anything else? (*pause and three taps*)

Pt. Oh, yes, I was on that stage.

Th. Yes.

Pt. And only I came into—it was—there was a woman seated at a desk and she had her hair tied on top of her head, and the whole thing was so red, damask, a red house on the stage, a sort of a whorehouse. This woman I guess was sort of a madame; and there is a painting by Toulouse-Lautrec, that is who her face was. She had a very sharp nose. Maybe it was one of the entertainers. Anyway, she was seated at her desk, and this is on the stage, red lights, and I walked in and she gets up and greets me; and she is an older woman, sort of, and she begins to caress me. Only it gets too much, clutching at my clothes. And then about five girls come out, and they begin caressing me, but then after their caresses started, they start to bite me, to attack me, to tear off my clothes. I am surprised, a little frightened, turn almost into harpies actually, in the classical sense of the word. I back away from them and back away from them, and I fall over the footlights into the orchestra pit. That was the dream I just had.

Th. I see.

Pt. The whole thing is red. Oh, boy, what did I go through today?

Th. You seemed to go through plenty.

Pt. I remember crying, and I couldn't stop. I remember what I went through, actually. I remember you told me to look behind that curtain, and, you know, I couldn't see behind it. I don't know why I cried though. I was scared.

Th. Something scared you. You have gotten a clue as to what the essence of your nightmares might be. It is just the first clue, the first breaking down of your repression. As we keep at this, you should gradually be able to lift your repressions and become liberated from this monster that has you by the throat.

Pt. I can't explain it to you. I don't know what made me cry because I didn't see anything. I know you said it was pleasant as I approached that curtain again. What made me cry, I have no idea.

Th. Mm, hmm.

Pt. I certainly had a strange experience.

Th. Do you feel you were in a trance?

Pt. I must have been. It is a funny thing, I could hear you, I knew what was happening. I can remember. I am sure I recall the thing, and yet there is no question that I was hardly myself, like in the crying.

Th. I am sorry that it had to be as painful as it was.

Pt. Strangely enough, I can't explain it to you. I can't remember. It was almost a release.

Th. Yes.

Pt. And that is true.

Th. Uh-huh.

Pt. The crying, and it wasn't (*pause*).

Th. It should make you feel better, and it should possibly enable you to remember your dreams or nightmares. How do you think you would feel if a thing like your dream happened in reality? Supposing you were to walk into a house and were greeted by these clawing harpies who came at you and started tearing at your skin? How do you think you would feel in a situation like that?

Pt. I was frightened, frightened; I wanted to get out of the whorehouse.

Th. There is a sexual tinge to this?

Pt. Oh, yes, very definitely; yes, very definitely.

Th. Do you remember anything about letters?

Pt. I remember all the letters, but it didn't come out with anything, did it?

Th. You came out with a group of letters that start with h-o-m-o.

Pt. I didn't use all the letters, did I?

Th. Not all.

Pt. I am not very good at anagrams, but I will try to figure out what this means.

At the next session the patient reported another dream that he actually remembered, the hypnotic experience apparently having resolved the resistance to dreaming. A woman wearing a red gown descended a flight of stairs. He noticed with terror her exposed pubic area, which consisted of an open

gaping mouth. As he watched, the woman changed into a threatening tiger with a fierce open mouth. At this point the patient began to discuss his feelings about his mother, whom he remembered as wearing a red gown. He was overprotected by his mother, his father having been an extremely passive person who died when the patient was young. He remembered with guilt having some vague sexual feelings toward her. When he married, there were some problems with impotence and sexual indifference, but his wife wooed him out of his apathy. But this seduction apparently opened up a pocket of oedipal anxieties. Occasional homosexual fantasies were not acted out. It is interesting that he began to remember his nightmares which were patterned after the hypnotic dream and dealt with his fears of women. Soon he identified his wife in his dreams. After a quarrel he would almost always have a nightmare that evening. At around the fifteenth session he started complaining that his symptoms were not being relieved as rapidly as he wished, and he associated this with the fact that his father did not help him much. The transference elements were exposed in his dreaming about me as being ineffectual like his father. I interpreted his transference feelings, and the interpretations had a dramatic effect on him, enabling him to see how he was translating what had happened before in the here and now. From this point on we were able to establish excellent rapport. He was able to relate splendidly to his wife and his children, his work block disappeared, and his nightmares vanished.

Hypnotic induction techniques are illustrated in Chapter 15, which deals with the making of a cassette tape, as well as in the case illustration in this chapter. Other techniques may be found elsewhere (Wolberg, 1948).

Conclusion

In most cases interview psychotherapy will proceed satisfactorily without needing to resort to catalyzing techniques. However, when certain blocks to treatment develop or when it is difficult to define a dynamic focus, measures to resolve resistance or to accelerate progress may be of value. Here a wide range of methods is available, including confrontations, hypnosis, narcoanalysis, behavior therapy, Gestalt therapy, guided imagery, emotive release strategies, experiential therapy, dream analysis, family therapy, and analytic group therapy. Preference for techniques is generally determined by the therapist's training and experience with certain modalities. Resistance, of course, can also develop with these catalyzing interventions, and the manifestations of resistance may serve as a dynamic focus, the

understanding and working through of which may be of consequence for both symptom relief and personality change.

Certain advantages accrue to the use of hypnosis as an accelerating technique where (1) incentives for interview therapy are lacking,(2) symptom relief is an exclusive motivation, (3) rapport is delayed in developing, (4) verbalization is blocked or impoverished, (5) dreams and fantasies are forgotten, (6) transference arousal is deemed essential, (6) repressed memories require recall, (7) greater activity is essential in the interview, (8) little material is forthcoming, (9) insight is not being converted into action, and (10) when there are problems in termination. Hypnosis also enhances the placebo effect in therapy, intensifies the force of suggestion, and opens the floodgates of emotional catharsis. Some therapists may not be able to utilize hypnosis as an adjunct in therapy because they fear its effects or are skeptical of its value. In such cases they may be more amenable to other accelerating techniques (Wolberg, 1977, pp. 761-833).

1 See Wolberg pp. 245-250, 685-740, and 761-823 for a full description of these methods.