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Hypnoanalysis and Analytic Psychotherapy: A Comparative Study

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Introduction

In recent years there has been a reawakening of interest in the practical application of hypnosis in the different medical fields. In the realm of psychotherapy, the evidence for such interest can be found in the many specialized works on the subject, as well as in such texts as the *American Handbook of Psychiatry* (1), and the *Comprehensive Textbook of psychiatry* (2).

In spite of this interest, and the claims that hypnoanalysis can accelerate the process of psychotherapy, hypnosis has not been established in the teaching of psychiatric residents, nor is it very widely used in clinical practice. Obviously, it would be desirable to determine the potential advantage offered by the use of hypnosis in psychotherapy. It would then be possible to decide whether hypnosis should be more widely taught and employed in the practice of psychotherapy.

In this paper we shall attempt to compare the process of *psychoanalytically* oriented psychotherapy that uses hypnosis as an adjunct with the same kind of psychotherapy without hypnosis. For the sake of brevity, in this paper, we shall refer to the former treatment as *hypnoanalysis*, and the latter as *analytic psychotherapy*.

The dearth of controlled clinical studies comparing hypnoanalysis with analytic psychotherapy makes it difficult to directly determine the relative merits of either treatment. On the other hand, there is a body of laboratory research on the subject of hypnosis. Some of these data bear directly on clinical considerations, while some suggest clinical possibilities that will need to be confirmed by further clinical studies.

Another difficulty that stands in the way of our proposed comparison is the lack of universal agreement on what measures should be used to assess the efficacy of psychotherapy. In addition there are also wide differences between authors in their conceptualizations of the processes which take place during psychotherapy. In consequence, in order to compare hypnoanalysis with analytic psychotherapy, we shall resort to an operational approach. We shall break each of these partially unknown entities into their procedural elements, and then pair the corresponding elements of the one with those of the other. Each pair will then be examined for overlap or divergence. We shall focus principally on whatever elements, if any, are found in hypnoanalysis that are missing from analytic psychotherapy.

Let us stress that we are not concerned here with the absolute value of either treatment, but only with the possible advantage of hypnoanalysis over analytic psychotherapy. Also, we are not concerned here with the use of hypnosis in non-psychoanalytically oriented psychotherapies.

Breakdown of treatment procedures

Treatment procedures can be viewed under five categories:

(1) *Antecedents of the therapeutic situation.* These include all of the relevant factors that precede the first encounter of patient and therapist: such as the therapist's training, personality and standing in the community; and the patient's distress, personality and place in society.

(2) *The therapeutic contract*, as described by Menninger (3). This includes the understanding which takes place between patient and therapist

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as to their goals, the methods to be employed, and the responsibilities of each. Only part of this contract is explicit, the rest is either implicit or unconscious. It is to be expected that in this unwritten contract the patient's understanding of its content will vary to a greater or lesser degree from that of the therapist.

(3) *The setting for the therapy.* This includes the physical surroundings, as well as the preparation of the patient for therapy.

(4) The *patient's psychological* and *physiological condition* during the treatment.

(5) *Therapeutic techniques proper:* these include those parts of the treatment interaction which, presumably, are directly effective in healing. We shall discuss six techniques: *anamnestic exploration;* and the five techniques described by Bibring (4), *suggestion*, *abreaction*, *manipulation*, *clarification* and *interpretation.**

Comparison of the treatment procedures

(1) *Antecedents*

(a) *Therapist's antecedents:* We know that some psychotherapists use hypnosis, while others, perhaps the majority, do not. Yet we do not know what determines the use of hypnosis by a therapist. It is possible that the reported successes of hypnoanalysis are not only due to the use of this technique but might also reflect other characteristics of the therapist, such as his enthusiasm and faith. Unfortunately there are no studies that compare personalities of therapists, and such a study might be difficult to conduct.

On the other hand, there are some important qualities which will be common to the therapists in both treatments considered here; these include such professional qualifications as are acceptable to the community, and a commitment to treat emotional distress by psychological means.

(b) *Patient antecedents:* The patients, both in the case of hypnoanalysis and in analytic psychotherapy, will be sufferers from emotional distress, seeking relief by psychological means. They will have a certain latitude of choice in the kind of treatment they will submit to. Thus they will be alike in choosing, but will differ in their choice.

What are the factors which determine the patient's choice of treatment? Are there any specific indications for the use of hypnosis? Barber, in a survey of 88 publications relevant to this subject (5), finds that there are contradictory claims concerning the relevance of specific character traits to hypnotizability; and that most research claiming to have established a correlation between personality factors and hypnotizability have not been validated by replication. On the other hand, in his own experiments (5, 6) he found that manipulation of the subject's psychological attitude could turn 'good' hypnotic subjects into 'poor' ones, and vice versa. The variables which were manipulated in these experiments included among other things: instructing the subjects that the chances of their becoming hypnotized were high, or low; that they were being tested for gullibility, or for imagination, and other similar manipulations of their attitudes. The effects of these manipulations on the subject's responses to test suggestions were evident whether or not a hypnotic induction procedure was included in the session.

The above evidence is offered with full realization that laboratory results cannot be applied clinically without discrimination. However, many researchers who claimed to have discovered specific personality traits that made the patient a more likely hypnotic subject, conceded that there was no correlation between the degree of hypnotizability (as measured by the 'depth of hypnosis' obtainable), and the therapeutic results. An example would be the work of Gill and Brenman (7, p. 333).

Based upon these findings, we conclude that no demonstrable differences have been established between the patient antecedents involved in hypnoanalysis, as opposed to those involved in analytic psychotherapy. It also follows that there are no clear indications for the use of hypnosis in psychotherapy.

* This schema does not cover either the changes that occur in the patient during therapy and after its termination; nor the process of termination itself. The last is omitted because few claims seem to have been made about hypnosis in the process of terminating treatment. The changes taking place in the patient are dealt with only where the discussion of the technique demands it; since the technique is the main concern of this paper.

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(2) *Therapeutic Contract*. We have grouped different therapeutic procedures into two types, and for the sake of the comparison we have named them *hypnoanalysis* and *analytic psychotherapy*. In practice, different designations will be used for the treatments, and often the name of the treatment will classify it as hypnotic, or non-hypnotic. Most patients have some conception of the meaning of the term used to name the therapy; this, together with the fame of the therapist as one who uses a certain treatment modality, will affect the patient's understanding of the therapeutic contract; this in turn will determine whether or not he will expect an hypnotic approach during treatment.

To the patient, the therapist is a source of information on the therapeutic contract, and he rightly expects the professional man to know more about it. Even when the therapist has no such intention, the patient will see in the therapist's behaviour cues to his judgement as to the patient's performance; that is: am I a good patient and am I fulfilling my part of the contract? Assuming that the patient's attitude is positive, he will strive to approximate his own conceptions of the ideal patient. From the mutuality of a contract, it follows that a therapist who fulfils his part of the contract encourages the patient to do the same. A hypnotherapist who behaves like a hypnotist will encourage his patient to behave like hypnotized persons. Likewise, a patient who believes that his treatment involves dream interpretation, and who sees in his therapist's behaviour signs of interest in his dreams, will feel encouraged to report dreams; the same reasoning applies to other aspects of the treatment, such as interest in sexuality or hostility.

We have seen that different contracts will promote varying patient behaviour in these therapies. There are also important similarities in the contracts. In both cases, the therapist agrees to help the patient, to be available to him at the designated time, to listen sympathetically, keep confidentiality, and do no harm to him. The patient agrees to talk as unreservedly as he can, keep his appointments, pay his fees, and refrain from harming himself or the therapist. Note that avoidance of harm is a responsibility shared by patient and therapist, with the balance of this burden shifting according to the circumstances.

Society is a third party to the therapeutic contract. By custom, and at times by law, it confers upon the contractual relationship certain privileges. These may include the right to confidentiality, a certain license for unconventional behaviour, and some financial privileges in the form of tax benefits or direct subsidy.

We believe that the contract is an extremely important part of the treatments considered here, and that it can account for many aspects of behaviour encountered in therapy. The following evidence will support this contention.

(a) A series of experimental studies by Barber (6) has shown that merely instructing the subjects that they were to be hypnotized, increased the frequency of occurrence of phenomena, usually associated with hypnosis (suggestibility, slowed movements, fixed gaze, etc.). This effect of *naming the procedure* could be observed when other procedural variables (including what is usually regarded as hypnotic induction procedure) were kept constant from experimental group to controls (the group that was not told that they would be hypnotized).

(b) Frank, in clinical experiments without hypnosis (8), found that a 'role induction' session before the beginning of psychotherapy increased both the patient's co-operation during the treatment and his improvement after it. In the 'role induction' session the patient was told what to expect in the course of treatment, and what was expected of him.

(c) In Milgram's well-known experiments (9) the subjects were ordered to administer punishment to 'victims'. The subjects were led to believe that they were administering electrical shocks of increasing severity and degree of dangerousness to victims who were purported to be subjects of a learning experiment. (In fact the 'victims' were confederates of the experimenter, and the electric shocks were sham, but the 'victims' displayed an amount of protestation appropriate to the purported amount of 'punishment'.) The experimenters were surprised to discover that a large proportion of subjects did not desist from 'punishing' the 'victims', even when they believed the

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punishment to be severe enough to endanger the 'victim's' life. The subjects were in no way selected for sadism or for compliance.

Regardless of whatever sadistic impulses or compulsions to obey were released, the fact is that in this specific situation, labelled as 'scientific research', men behaved in a way contrary to their usual behaviour.

Milgram's research has been criticized on the grounds that the punishment was sham, and that the subjects may have realized this (10). The validity of this criticism is questionable, since the design of the experiment seems to have provided adequate control.* However, we may turn to the following research that involved no sham.

(d) Masters and Johnson (11) were able to get 'proper', middle-class people to have sexual relations in a laboratory, in the presence of witnesses and of recording apparatus. This seems a feat unsurpassed by hypnotism.

The *contract* provides the most economical explanation for these phenomena. Calling a procedure 'hypnosis' establishes contractually that the subject will behave as if hypnotized. The description of Frank's 'role induction' almost paraphrases the therapeutic contract. Milgram had a 'scientific research contract' with his subjects that specified explicitly or implicitly that: (1) for the duration of the specified period, the subjects will follow the experimenter's directions, (2) the experimenter knows what he is doing, will keep the subject from being directly or indirectly injured in the experiment, and will remunerate the subject for his time, (3) society, for the sake of scientific advancement, permits rather wide departures from established custom. The same considerations apply to Masters and Johnson's study, but in their case the contract received added sanction from the medical stature of the researchers.*

We may conclude that in hypnoanalysis the contract is effective in preparing the patient to exhibit the appropriate behaviour. However, a well-executed contract in analytic psychotherapy is at least as effective in obtaining the behaviour appropriate to psychotherapy. Note that the 'hypnotic trance' is only a means to the end of freeing the patient in his expression of memories, ideas and feelings. A properly executed contract of analytic psychotherapy, should be as effective in obtaining the desired patient behaviour.

(3) *The setting for the therapy.* The physical setting will be practically identical for both treatments; both will take place in a more or less quiet and private office, with the patient in a reasonably comfortable and relaxed posture. The verbal preparation will differ. In analytic psychotherapy it will be brief, consisting of a simple reinforcement of the contract (e.g. 'you can say anything here'), or otherwise conveying to the patient that the therapist is there, fulfilling his role according to the contract.

On the other hand, the verbal preparation for hypnoanalysis is an elaborate ritual, namely the hypnotic induction. Typically, the hypnotherapist will ask the patient to fix his gaze on some object, he will repeat his instructions over and over again in a droning voice, telling the patient to relax, and suggesting to him that he is getting drowsy and going into an 'hypnotic trance'. The patient may be told that his hands are light, or that his feet are heavy, or that other changes in body sensations are taking place. Then will come the statement that the patient is hypnotized. The therapist usually examines the patient for 'hypnotic trance' by test suggestions such as: 'when I count to three, you will be unable to open your eyes'; if the patient behaves as instructed he is

* For example, the experiment was repeated with the subjects in varying degrees of proximity to the 'victims'. With increased proximity, the subjects refused to go on with the experiment at lower levels of 'electric shocks'. This is consistent with the hypothesis that the subjects actually believed that their 'victims' were in distress, and the proximity to this distress acted as a deterrent to continued participation in the experiment. On the other hand, if we assume that the subjects saw through the sham, closer proximity to the 'victim' should have made it easier to see through the sham, and closer proximity between subject and 'victim' should have allowed the subject to continue with the experiment to higher levels of 'electric shock'.

* The contract has also a profound effect on what the therapist, or the experimenter, may do. Thus, for instance, Gill and Brenman observed that most therapists who participated in their studies showed greater emotional boldness when acting as hypnoanalysts than they did when functioning as psychotherapists without hypnosis. (7, p. 336).

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considered properly hypnotized, and the treatment can proceed.

Any perusal of the literature on hypnosis will reveal a great variability in the techniques of induction. It has been theorized that both limitation of sensory input and relaxation play a role in hypnotic induction. A consideration of the physical conditions under which most psychotherapy takes place will show that relaxation and limitation of sensory input are practically ubiquitous.

What the hypnotic induction does seem to do is to offer a ritual that gives the patient a tangible token of expectation and hope; in this it acts like a placebo. The induction procedure also reinforces the contract in two ways: (a) The therapist fulfils part of his side of the contract, by behaving as a hypnotist is expected to; this in turn encourages the patient to fulfil his own part of the contract, and he will then respond as he believes a hypnotized person should. (b) The therapist makes direct attempts to motivate the patient; he exhorts him to follow the instructions, tells him that this can easily be done, and conveys to the patient the notion that if he does not act hypnotized he is not a good hypnotic subject, and therefore not a good patient for hypnoanalysis.

Experimentally (5, 6), appropriate motivational instructions alone have been shown to be effective in enhancing hypnotic behaviour. These seem to be equally as effective in obtaining the appropriate behaviour as is the full induction procedure. Thus the hypnotic induction is in part analogous to the 'role induction' of Frank.

Finally, the hypnotic induction serves as a screening procedure: patients who do not keep their part of the contract, those who are 'unhypnotizable', are deemed unsuitable for hypnoanalysis. Similarly, though in a less clear-cut fashion, patients who are too resistive and unco-operative are discontinued from analytic psychotherapy.

(4) *The patient's psychological and physiological condition during the treatment*

(a) *The psychological condition.* The emotional position of the patient regarding his therapist is widely documented in the literature and is mostly referred to as *transference*. This is not an exclusive feature of hypnoanalysis by any means. Whether hypnosis can produce a kind of 'instant transference' is at present impossible to prove or disprove in the absence of objectively quantifiable measures of transference. Qualitative differences in the transferences occurring in the two modes of treatment seem likely. Examination of these would go beyond the scope of a paper concerned merely with comparison of the techniques.

Another aspect of the patient's emotional position is the placebo-like effect of expectation and hope. Within limits, expectations are self-fulfilling. (A patient given a placebo and told that it is a stimulant will tend to become alert, if told that it is a sedative he will tend to become drowsy.) And any attitude of hope, in itself, will relieve anxiety to a certain extent.

The expectations and hopes that the patient brings with him to any kind of treatment get modified by the therapeutic contract first, and continue to be affected by the vicissitudes of the treatment, and to a certain extent also by events outside the treatment situation.

How does this relate to our examination? Hypnosis no doubt may have a placebo effect. But, as Frank shows (8), the placebo effect is at work in all psychotherapies to a greater or lesser extent. This effect can be enhanced by appropriate techniques, which are not necessarily hypnosis. There is no evidence that hypnosis is more effective as a placebo than any other technique. It could be argued that in certain cases the patient will have more faith in hypnoanalysis than in other therapies, and in these cases hypnosis will give rise to more hope. Research should provide us with more data on this last question before we can form any permanent conclusions.

(b) *The physiological condition:* Early investigators classified hypnosis as a special kind of sleep, which would have made it a physiologically distinct state. With the advent of techniques such as the EEG and the polygraph it became possible to test the hypothesis. A review of the pertinent literature by Barber tends to disprove this earlier conception (6, 12); for instance, the EEG in hypnosis can be slowed if the subject is relaxed and drowsy, or be acti-

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vated when he executes a task while still in 'hypnosis'. Moreover, the same physiological changes that can be elicited in hypnosis can be brought about by simply asking the co-operative subject to do the appropriate thing: relax, execute a task, imagine something, and so on. We may conclude that there is no need to postulate a physiologically distinct hypnotic state in order to account for the observable facts.

(5) *The therapeutic technique proper*

(a) *Anamnestic exploration*, especially of the traumatic neuroses of war, has been specifically claimed to be facilitated by hypnosis. Unfortunately, no controls were used in the studies of hypnotic treatment of war neurosis. Apparently, no attempts were made on a comparable number of patients to simply sit down and patiently and emphatically ask the patients to tell what happened, without any prior attempt at hypnotic induction. It might have been quite as effective. Other non-hypnotic techniques are effective too. For instance, F. Deutsch's (13) technique of associative anamnesis seems to be rather effective in anamnestic exploration.

In one study on the effect of hypnosis on the psychiatric interview, the hypnotized patients gave *less* information than the non-hypnotized patients (14). A survey by Barber of the literature on the effect of hypnosis on recall (15) concludes that hypnosis without specific suggestions for high recall does not enhance recall. On the other hand, task-motivating suggestions or suggestions for improved performance are at times effective in enhancing recall. These suggestions are about as effective with hypnotized subjects as with non-hypnotized ones. Other studies have cast doubts on the factual reliability of material obtained through hypnosis (16). It has been shown that hypnotic subjects will lie to tell the hypnotist what they think he wants to hear. Of course, the same cannot be ruled out in other methods of treatment, but we may say that as far as *anamnestic exploration* is concerned, hypnoanalysis should not offer any advantage over any well conducted analytic psychotherapy.

(b) *Suggestion* seems to be more widely used in hypnoanalysis, yet there is nothing to prevent a therapist from using more suggestion in analytic psychotherapy, if he deems it advisable. As for the efficacy of the suggestions, this can be enhanced by: (a) having the therapeutic contract cover suggestions, in effect saying, 'the therapist will help the patient by giving him instructions'; and (b) periodically reinforcing this with appropriate motivational instructions. It has been shown that the exhortations to the subject, plus the reassurance that he can easily follow the suggestions, are generally as effective as the complete hypnotic induction procedure in heightening suggestibility (5, 6).

(c) *Abreaction* can be facilitated by an appropriate invitation to abreact. We judge the intensity of the emotional abreaction by the accompanying physiological signs: tears, fast breathing, tachycardia, flushing, etc. Research on the physiological effects of hypnosis (12) shows that though we can elicit the physiological concomitants of emotions by instructing a hypnotized subject to 'go back' to an emotionally charged situation we can obtain the same effect without hypnosis by instructing an appropriately motivated subject to think back and vividly imagine such a situation. We may therefore conclude that intense abreaction is obtainable in suitable cases by suitable techniques; also that the intensity of any abreaction will depend on factors such as the patient's motivation, resistance, and external factors such as the presence of an audience. Traditionally, to further abreaction, rituals are often resorted to, as in religion, hypnosis and mourning rites. They are probably all effective by proclaiming a contract and establishing expectations, but there is no evidence that they have any action beyond that.

(d) *Manipulation* has been defined as the use of the therapist's skills to 'redirect' some of the patient's emotional attitudes in the service of the treatment. For example, the therapist may 'manipulate' the patient into making his own decision whether to stay in therapy or not, thereby making him assume a more independent role. In this regard, hypnosis can be seen as a special kind of manipulation. We may assume that the hypnotic manipulation orientates the patient in a more passive role, relinquishing more responsibilities to the therapist; and more

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weight will be accorded to non-rational, magic elements in the therapy. Again, different manipulations can be used and are resorted to in non-hypnotic therapies.

(e) *Clarification* is a rational elaboration of psychological elements that are already conscious. This is a term taken from Roger's Non-Directive Therapy, and seems to exclude hypnosis by definition, since hypnosis depends so much on a directive and non-rational approach.

(f) *Interpretation* has been claimed to become more effective under hypnosis. This is a difficult claim to test; no two interpretations are ever alike, since the interpretation and the resistance that it will meet depend so much on the momentary constellation of the patient's emotional state, his train of thought, and his relationship with the therapist. As this constellation is in a continuous state of flux, it is hard to compare the effectiveness of one interpretation with that of another. Moreover, the patient's acceptance of the therapist's words is implicit in the contract of the hypnoanalysis. This will make it even more difficult to gauge the actual amount of resistance that an interpretation encounters.

It is, therefore, unlikely that any of the six listed therapeutic techniques will be more effective in the course of hypnoanalysis than they would be in the course of analytic psychotherapy that does not resort to hypnosis.

Summary and Conclusions

A comparison of the procedures of analytic psychotherapy with the procedures of hypnoanalysis reveals that they share many qualities and that most of the operatively important features of hypnoanalysis can also be found in *non-hypnotic* analytic therapy. Though there is no proof that hypnoanalysis offers any distinct advantage over analytic psychotherapy, the possibility that some such advantage might occur under specific circumstances cannot be excluded. One such possibility is that for some patient-therapist combinations it could be more expedient to establish such a working therapeutic contract based on hypnoanalysis, while they might be unable to form a contract of analytic psychotherapy. This should be the subject of further investigation.

The therapeutic contract is most important in determining the subsequent behaviour of the patient (and the therapist) in treatment. Much of the characteristic behaviour of the hypnotized subject can be attributed to the contract and its concomitant effects.

Both treatments under consideration here are conducted in circumstances that minimize external distracting stimuli.

The hypnotic induction procedure serves as a symbol of the patient-therapist contract, a token of the therapist's involvement, and as direct reinforcement of the patient's motivation. It also serves to select the more co-operative patients. All these goals can be reached by alternative techniques.

Psychophysiological data tend to show no special state of consciousness characteristic of hypnosis.

The therapeutic techniques of anamnestic exploration, suggestion, abreaction, manipulation, clarification, and interpretation can be used effectively in any well-conducted psychotherapy. Hypnosis does not offer any special advantage in this respect.

The conclusion that most of the therapeutically useful ground covered by hypnoanalysis is adequately covered by analytic psychotherapy should not be surprising. Since both psychoanalysis and analytic psychotherapy grew out of hypnotic therapy, it is conceivable that in the course of their development they retained the clinically useful features of hypnotherapy, while discarding some of its redundant aspects. This process of selection seems to have been acting on the techniques of psychotherapy, sometimes deliberately but often unwittingly. This would account for the fact that in spite of theoretical interest hypnosis is not very widely used in the practice of psychotherapy.

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