An understanding of hypnotic induction: moving from psychoanalysis to a cognitive-analytic perspective

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Abstract: Nowadays there are many theories that have sought to explain hypnotic phenomena. Within psychological theories, psychoanalysis seems to offer a partial explanation on how the hypnotic process works and tries to give an explanation on the relationship between patient and therapist. Since the object relation theory school moved away from the traditional psychoanalytic tradition, new emerging psychological schools are starting to develop an integrative understanding of human experiences, and one of these, namely cognitive analytic theory can be applied, in the purpose of this article, to try and give a possible different explanation to the hypnotic-induction-phomena and the patient-therapist relationship.

Keywords: Hypnotic induction, Authoritarian induction, Permissive induction, Psychoanalysis, Cognitive-analytic therapy
Introduction

Nowadays there are many theories that have sought to explain hypnotic phenomena. They seem to be valid in some circumstances but they fail to give a comprehensive explanation of how hypnotic phenomena work.

Theories of hypnosis are generally divided into physiological and psychological theories. And within the psychological theories of hypnosis we can also sub-divide into psychological theories (that emphasise role definition, expectation, subject motivation; e.g., sleep and waking theories, cerebral inhibition theory, dissociation and neo-dissociation theories, dissociated control and controlled dissociation theories, state theory, informational theory) and psychoanalytical theories (that emphasise hypnosis as a regressive state).

Aim of this article is to try to explain hypnotic induction phenomena, moving from the psychoanalytic perspective to a cognitive-analytic therapy perspective. In particular, will be emphasized, the shift in the way therapist-patient relationships have to be seen: from a subject-centred psychoanalytic mode to an understanding of the true, interactive and dynamic relationship between therapist and patient; as seen by cognitive-analytic theory, derived and developed from the psychoanalytic tradition of the object-relation theory.

Discussion

On therapeutic rapport

Rapport is a specific requisite for hypnotic induction, for utilisation of the hypnotic process, and for production of subsequent behavioural changes.

It is a well recognised fact, that if there is a good relationship between patient and therapist, suggestions from the therapist are more readily followed, and greater attention is paid to the therapist when this rapport exists. This rapport is also enhanced by the prestige of the therapist.

On hypnotic induction

Individuals come to hypnotherapy with different expectations concerning the therapist’s performance, their own experiences and behaviour, and their relationship with the therapist.

By definition, induction phase is the initial stage of hypnotic trance, in which a sequence of double-bind suggestions are given in such a manner that a positive response to a prior suggestion conditions the subject to react with hyper-suggestibility to the next suggestion. This allows the patient to achieve relaxation and encourages the patient to focus awareness inwardly (Lynn & Rhue, 1993).

Induction techniques may be mechanical or ideo-motor (e.g.: eye fixation or hand levitation etc.) or imagery and fantasy in nature, or metaphorical.

The “deepening” phase will follow the induction phase, once the patient has reached a sufficient state of relaxation.

All the hypnotic stages are a patient-centred mechanism rather than a doctor-directed modality, as already emphasised by previous influential authors like Kubie (“Illusion and Reality”, 1972) and Kroger (“It’s indeed a wise hypnotist who knows who is hypnotising whom”, 1962).

The modality in which induction can be delivered varies: according to the preference and attitude of the patient; the nature of the patient’s problem; and to some extent also, the preference and attitude of the therapist. The most common types of induction are as follows:
- **Authoritarian techniques**

These are generally used as a method of inducing hypnotic trance for treating addicting problems and/or poor impulse control (e.g.: alcohol and drug misuse, eating disorders etc.), and they can be also used in emergency situations (Lynn & Rhue, 1993).

They are also used successfully in people who are exposed in life to, and feel comfortable with, authoritarian approaches (e.g.: hierarchical working environment etc).

Authoritarian inductions are a very quick way of inducing a trance state in the patient. In this kind of induction, the confidence, the tone of voice and the gaze of the therapist generally play an important role in the induction process.

Common verbal cues used in this kind of induction are: verbal commands, tell the patient how he/she feels/thinks e.g.: “close your eyes ... You feel ... you are more and more relaxed ... you are more in control”, etc. Good examples of authoritarian techniques are: eye-to-eye contact, rhythmic eye movement induction etc.

- **Permissive techniques**

These can facilitate the patient’s active participation and mastery. They are gentle in nature, non-threatening techniques, slower than the authoritarian ones; patients feel generally safe and comfortable (Lynn & Rhue, 1993).

Examples of permissive techniques are: early learning set, eye-closure, eye fixation on hand etc.

The verbal cues that are used in this kind of induction are very permissive, and the therapist gives clues, and suggestions to the patient on how he/she might feel/think (e.g.: “I would like you to....”; “it might be you feel/think....”; “you may wonder....” etc).

Permissive techniques are often used in conditions where patients’ have experienced trauma or abuse such as: PTSD, anxiety, sexual and physical abuse, personality disorder. Such permissive techniques have also been used with children; for detailed descriptions see Gardner and Olness (1981).

- **Confusion induction techniques**

Conceived and developed by Milton Erickson, these involve the presentation of a whole series of individually differing contradictory suggestions, at variance with each other, requiring a constant shift in orientation by the subject. As the subject tries to accommodate himself to the confusing, contradictory responses apparently sought, he finds himself at such loss that he welcomes any positive (familiar) suggestion that will permit to escape this welter of confusion.

Often used with people who are sceptical to hypnotic procedures, or in people that have a very “rational and scientific” mind.

**Psychoanalytic view of hypnotic phenomena**

Psychoanalysis, historically, was born as Freud decided to abandon hypnotic techniques in favour of word association techniques for treating mental disorders that have an unconscious component (Ellenberger, 1970). According to Freud himself, hypnosis can be seen as an adaptive regression in the service of the ego. In other words, hypnosis can be seen as a reversion to a childish state, where ego function is suspended. Freud claimed that in the hypnotic process, the patient is under the pressure of a therapist, and the therapist can be seen as the equivalent to the patient’s father (Freud, 1895).

The work of Freud in this respect has been continued by one of his followers: Ferenczi. He believed that hypnosis recapitulated the Oedipal situation, (Ferenczi, 1909). He also used expression such as “paternal hypnosis” and “maternal hypnosis” to further describe
the nature of the libidinal regression. According to him, in authoritarian induction, the subject would associate the hypnotist with a strong father and in permissive hypnosis, with the mother. Implied in this view is a gender-orientated element in the hypnotic condition that, barring some claims by occasional subjects who experience erotic feeling in their trance, is not borne out by clinical observation.

A Cognitive-Analytic perspective of hypnotic induction

General background of Cognitive-Analytic theory

Cognitive-Analytic Therapy (CAT), and its underlying theory, was developed, in Britain, during the early 70’s by Dr. Ryle. CAT historical roots lie in both the European tradition of psychoanalytic thinking and the North American tradition of cognitive psychology. It is an integrative therapy, which makes use of the theoretical insights, of cognitive-behavioural therapy and, the object relations theorists of the British School, hence the therapy’s name.

According to this model (Ryle, 1997), psychological health and disturbance is conceptualised through the Procedural Sequence Object Relation Model (PSORM). This model explains how people express their intentions as actions in relation to others in repetitive, sequential way and how responses are elicited from these others. This repetitive sequence of thinking, feeling and acting (called procedures) is aimed or goal orientated. Procedures can be enacted. Procedures enacted towards other people usually seek corresponding sequences in reply from those others (Ryle, 2002).

The theory of reciprocal relating is derived from the object relation theory, but CAT theory prefers to describe self and others as processes in action rather then objects in relation.

The notion of the “role” in this model is understood to be the position from which procedural sequences are enacted. Psychological health and psychological disturbances are seen in terms of an individual’s repertoire of functional or dysfunctional internalised reciprocal roles, that perpetuate the shaping of present and future relationships from past internalised “reciprocal roles”.

Application of Cognitive-Analytic concepts towards an understanding of hypnotic phenomena

In the light of what has been illustrated above, we can move forward from the psychoanalytic “subject-centred” way of seeing hypnotic induction, to a “relational model” of hypnotic induction (as emphasised in cognitive analytic theory), in which the understanding of the patients’ internalised reciprocal roles, is an important element that might help the therapist to be aware of what is going on in the room between patient and therapist. Such approach to hypnotic induction can also help the therapist in providing rational guidance, when he/she has to select which hypnotic induction technique has to be used for a certain patient.

With reference to the already mentioned different types of inductions, we can also explore, in a cognitive analytic framework, the meaning of the patient-therapist relationship and the most common pattern of reciprocal role procedures that might be commonly present for each of the above modalities of hypnotic inductions.

Authoritarian induction: the “remissive-type” patients

It sounds as if patients who prefer this type
of induction, and feel comfortable about it, are people who have internalised since their early life a controlling versus controlled, or dominating versus dominated, reciprocal role; such role, where they were controlled or partially dominated, has been useful and healthy. This kind of way of relating to people might have provided patients with a feeling of safety and security. For them, being in the dominated and controlled role in the therapeutic induction can make them re-live, the already experienced and past benign kind of controlling/dominating relationship, and in doing so, it might be they ‘ll anticipate the good therapeutic alliance and result in hypnotherapy.

Permissive induction: the “mastering-type” patients

For patients where they experienced and internalised the controlling/controlled and domineering/dominated reciprocal role in a negative way, and for patients who have been in the abusing/abused reciprocal role in their past, the authoritarian induction would re-create in the “here and now” situation in the room with therapist the traumatic past, for the above reason authoritarian induction is not advisable.

For these kind of patients a permissive induction will be used. In permissive induction the patient can go at his/her own pace in the process of the hypnotic induction and deepening, and this would allow them to have a feeling of mastery of the situation and themselves. It appears that this process ‘per se’ is therapeutic by nature because it reinforces the positive strengths of the patients, in regards to being able to perform tasks and in being able to master their own feelings. The relation with the therapist is one of re-enactment of positive internalised reciprocal roles; such as the patient been listened to and understood, and the therapist being in the listening and understanding position.

Confusion techniques: the “dismissive-type” patients

Confusion techniques allow the therapist to “defeat” the dismissive attitude of the patient who, in the beginning, mistrusts the therapist, and at the end allows the reinforcement of the therapeutic alliance between patient and therapist.

Confusion techniques allow the patient to switch from the dismissive role (therapist being in the dismissed role) to the adoring role (with therapist being in the adored role). When the patient is allowed to have this switch from one role to the other, the therapeutic alliance will become stronger, and that will have a positive result in terms of therapeutic outcome.

In psychoanalytic terms this process is described as a regression to early experiences in relation to important authoritarian figures (e.g.: teachers, parents, leaders etc). Permissive induction would be not advisable for these types of patients because of their fundamental unconscious or conscious disbelief towards hypnotherapy; which would cause a resistance to hypnotic suggestions starting from the very beginning of therapy. In this way the patient becomes the “saboteur” of their own therapy. Also authoritarian induction would be not advisable because the patient’s dismissive attitude wouldn’t allow him/her to form a therapeutic alliance and acceptance of the therapist as such.

Conclusion and implication for therapy

It sounds as if CAT principles can be applied to assess and identify, through the history taking, the patient’s reciprocal role, and according to that, to also ascertain which method of induction is more appropriate for that particular patient.

Method of induction, as already emphasised
depends on the personal history of the patient, individual temperament, and vulnerability factors. CAT principles can provide a useful framework for the hypno-psychotherapists and can help them to understand better, and to be more aware of, some practical aspects of the therapist-patients relationship, and some therapeutic issues such as compliance and resistance to therapy.

From the theoretical point of view, CAT understanding of hypnotic induction is also a step forward from psychoanalysis: hypnotic phenomena can be seen not just as a patient’s internal world phenomena and representation, but as a real dynamic interaction between patient and therapist; as a “dyad in dialogue”, where enactment of internalised reciprocal roles are played in the room between patient and therapist, and the above reciprocal role can be used to initiate and facilitate the hypnotic process.

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