DELIBERATE RE-HYPNOTIZATION AFTER THE PATIENT'S REFUSAL

By

IAN OSWALD, M.A., M.D.

Beit Memorial Research Fellow, Institute of Experimental Psychology, University of Oxford

A CASE closely comparable with that reported below does not appear to have been described, possibly because of the ethical problems involved. Watkins (1947, 1951), in the description of two cases, has made the most nearly related contribution to the old debate as to whether an unwilling subject can be hypnotized. His cases were both trained subjects who were offered money rewards to attempt to resist the formal induction of hypnosis before an audience. They were both successfully hypnotized. The fear-inspired unwillingness of the patient to be described would appear to have been in a rather different category.

CASE HISTORY

The patient was a 21-year-old female typist of average intelligence. She had suffered from habitual nocturnal enuresis till the age of eight and occasionally thereafter. Her chief complaint, however, was of a liability to incontinence of urine by day under conditions of excitement or under emotional tension of any kind—an extreme form of a common symptom. Her admission for psychiatric treatment was precipitated by an unfortunate example of this incontinence. She was playing table-tennis in mixed company, and during a brief break in play was lightly springing about on her toes. One of the men present asked, jestingly, "What's the matter with you? Can't you hold your water?" Such was her embarrassment that she was immediately incontinent of urine, a fact which was obvious to those present.

It was thought that she might benefit from a technique for giving increased control of urgency, using hypnosis. With this object she was interviewed by the writer, and, after a discussion of "emotional tension", it was proposed that she could be taught to relax and, by this means, control her disability. The emphasis was on relaxation and no mention of hypnotism was made.

Suggestions of relaxation were made and gradually a fairly deep trance achieved with the successful production of rigidity of limbs, analgesia of the hand and deafness. The demonstration of the control of sensation was used to explain to her how "relaxation" could help to control sensations and would be used to control bladder sensation. In order to facilitate subsequent re-hypnosis the suggestion was made that, "Whenever you sit in a chair and look at me and I clap my hands, you will immediately return to the state in which you are now". Amnesia for this suggestion was then induced to increase its likelihood of success (Erickson and Erickson, 1941). The trance was then terminated and the patient returned, after further brief discussion, to the ward.

In the course of the evening of that day the patient fell into conversation with another patient. The latter had lately been hypnotized by another psychiatrist and mentioned this fact, whereupon the other realized that she too had been hypnotized. Furthermore, the amnesia which had been intended to cover one specific suggestion, in fact covered almost the whole of the session. The patient, having only the lay person's knowledge of hypnotism, was greatly alarmed and distressed to find that she was unable to recall what had happened between the time of the initial conversation with the writer and the end of the interview. She confided her fears to the ward sister.

The next morning the patient refused to have any further treatment. She was interviewed by the writer in the presence of the ward sister and the nature of hypnotism simply explained in an attempt to reassure her. She remained quite unmoved in her attitude however, despite assurances that it was impossible to make a hypnotized person do anything if she was not willing (this is interesting in view of the subsequent happenings). She did not respond to a request to ask any questions she liked. She showed marked hostility, and when asked why, replied, "I'm frightened of you."

A considerable practical and ethical problem was obviously present. If her refusal

https://doi.org/10.1192/bjp.105.440.795 Published online by Cambridge University Press

of hypnosis was respected, her amnesia would remain. If however, despite the ethical objections to such a course, a successful attempt to re-hypnotize her were made, her amnesia could be removed, her fears and distress relieved, and the treatment originally planned could be continued. The decision taken, rightly or wrongly, was that to leave her with a patch of amnesia associated with a fear of something unknown could have so adverse an effect upon her as to justify an attempt at re-hypnotization.

The patient was therefore interviewed later that day by another psychiatrist with the ward sister present, and a few moments after this began, the writer entered the room on the pretext of discussing an electroencephalogram. On the way out of the room the writer casually asked the patient, "Can you still not remember?" As she replied she looked at the writer, who was carrying his hands lightly together before him and who then very quietly and unobtrusively clapped his hands. The patient suddenly diverted her gaze, and continued to reply that she couldn't remember. Then she hesitated and became glassy-eyed. She said, "My mind's going all queer." A second hand-clap then accompanied the instruction, "Close your eyes and try and remember", after which a third hand-clap was made. The patient had by now entered an obvious trance.

"You can remember now."

"My arm is all stiff." Pause. "My hand" (she pinched it as in the first session).

Further explanations and suggestions were now made. "You are not frightened now are you?" "No." Asked if she would continue the treatment she assented readily. Suggestions were then made to the effect that she would have no more fear, and would indeed look forward to the treatment sessions with happiness because her disability was to be relieved. The trance was then ended, after which she appeared confused as if some further spontaneous amnesia was present.

When seen the next day she was happy, smiling and co-operative, and remained so whenever seen in the seven months which followed, except that four weeks after the original episode she stated that she still felt apprehensive before being seen. Hypnotic suggestions rectified this.

TREATMENT

She was discharged from hospital, as she could easily be seen as an out-patient. She was seen weekly for the next six weeks and every three or four weeks thereafter.

Post-hypnotic suggestions were used to bring about analgesia of any part of the body when she said aloud, "No pain in my (hand, etc.)." Then when she just "thought" the words and finally when she "wanted" it without actually saying any words to herself. Similarly she was taught to render the analgesic part normal again at will. This removal and return of sensation was repeated many scores of times, and practised by the patient during each day till full voluntary control of the perception of discomfort in the superficial tissues was attained. After three weeks of this, post-hypnotic suggestions were given to the effect that later that day, whenever she felt the need to pass urine, she would at once voluntarily abolish the sensation causing that need, so that she would only go to the toilet at tea-time and bed-time. She was instructed not to attempt this except on that one day.

When seen the next week she reported success and further hypnotic suggestions were given—that she would be able voluntarily to abolish her sensations of urgency, and so control the desire to micturate, on all days, and at all times, in the future.

She was seen at intervals for another five months, and throughout this period reported that she now regularly micturated only three times per day, instead of a dozen times or more. Her voluntary control of pain perception also continued. She expressed herself delighted. She became engaged, got married, and left the district. An attempt to contact her later was not successful.

COMMENT

The patient was a particularly good hypnotic subject. The present case would lend support to the view that if such a person can once be hypnotized, providing appropriate suggestions have been made during that initial trance,

then subsequent re-hypnosis can be achieved despite strongly motivated refusal by the subject. This would also probably be true with an unscrupulous hypnotist.

The eventual successful treatment of this patient justified, it can be argued, the decision deliberately to re-hypnotize her after her refusal. It is very doubtful if a successful courtship, culminating in marriage, would have been compatible with the patient's previous disability.

The achievement of voluntary control of perception of discomfort, in the writer's experience, is only occasionally as stable as in this case. It is entirely compatible with the view that to perceive is as much an active, constructive response as is a motor act which is subject to voluntary control.

The case is similar in some respects to that of a patient described by Jones (1956), whose urinary frequency and incontinence were successfully treated by a conditioning procedure. The method adopted in the present case, however, avoided the disadvantages attendant upon repeated catheterization.

SUMMARY

A case is described which contributes to the debate whether an unwilling subject can be hypnotized. The patient was a female who suffered from embarrassing urgency and incontinence of urine with excitement or emotional tension. She was hypnotized by explanations about "relaxation". Suggestions were given for re-entering a trance at a hand clap.

Amnesia for the trance appeared. Discovery, later, that she had been hypnotized caused great fear and despite all reassurances she refused further treatment. The ethical problem being fully considered, she was re-hypnotized, despite her refusal, by a hand clap. Suggestions dispelled her fear.

Hypnotic suggestions were used to teach voluntary control of perception of discomfort, including bladder sensations. Her disability was completely relieved during a seven month follow-up during which she pursued a successful courtship, culminating in marriage, after which contact with her was lost.

REFERENCES

ERICKSON, M. H., and ERICKSON, E. M., *J. gen. Psychol.*, 1941, **24**, 95.
JONES, H. G., *J. abnorm. soc. Psychol.*, 1956, **52**, 414.
WATKINS, J. G., *J. abnorm. soc. Psychol.*, 1947, **42**, 256.
Idem, Brit. J. med. Hypnot., 1951, **2**, 26.