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Resistance: Solving Problems During Hypnotic Inductions

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This chapter offers a scientific perspective on the variety of problems that might emerge between a patient and practitioner during hypnotic induction. I hesitate to use the word *resistance* because of its implication that failure in therapy is always the fault of the patient. This term has also become associated with highly speculative assumptions of unconscious sabotage. Using a broader problem-solving perspective, this chapter focuses attention on all members of the dyad to better determine which actions, emotions, or beliefs are interfering with desired outcomes.

Clinical hypnosis is essentially a cooperative endeavor, in which the priming of unconscious associations combines with the creation of a deep expectation that therapeutic change will occur. With this definition, it is apparent that effective hypnotic problem solving remains balanced upon a fulcrum of trust and voluntary consent. This differentiates clinical hypnosis from hypnosis used by entertainers, by cult recruiters (Hassan, 2012), or by Central Intelligence Agency (CIA) interrogators (Ross, 2007). When writing about the subject of resistance in clinical hypnosis, Weitzenhoffer (1989) warned that above all else, “a subject should be willing to be hypnotized, have confidence and trust in the hypnotist, and have a readiness for inner changes, especially changes implemented by an outer agent” (p. 140). For these reasons, expert practitioners seek confirmation that the patient wants to be hypnotized or has a continuing desire to be hypnotized. According to Christenson (1958),

It will be found, even with experienced subjects, that if they are not in the mood to be hypnotized, there is no point in going further. . . . In fact, it is best to concede to the new subject that if he does not wish to be hypnotized, he cannot be forced. (p. 38)

When the patient feels invited to participate in a process that is permissive, collaborative, and founded on a respect for his or her goals, there is a decreased likelihood that problems will occur (Fromm, 1980).

FEAR

Experts agree that fear is one of the most common reasons for resistance to induction (Frauman, Lynn, & Brentar, 1993; Weitzenhoffer, 1989; Yapko, 2013) and the most common fear is of the hypnotic state itself. For those who have never experienced hypnosis or have only seen it demonstrated in comedy clubs, the prospect of being hypnotized may induce panic. Such individuals may fear losing control, revealing embarrassing secrets, developing excessive dependency, or having to comply with the practitioner’s every command. Confidence can be increased by offering the patient the option of maintaining full awareness and control over his or her actions, including the ability to open the eyes or lift a finger to stop the induction. Another possibility is to offer the option of “waking hypnosis,” so that the patient can keep his or her eyes open, or the option of limiting the scope of the trance to one small part of the patient’s body, such as a hand or an arm (Short, Erickson, & Erickson-Klein, 2005), which is easily accomplished using ideomotor signaling or other suggestions for automatic responses that the patient can observe. Another piecemeal approach is to invite the patient to close her eyes and merely imagine what trance will be like, what the practitioner might do to improve the experience, and what suggestions will be most helpful to achieve her goals. This exercise often

reveals fears and misconceptions that inhibit full participation (Frauman, Lynn, & Brentar, 1993). Dedicating some time to this type of preinduction activity helps prepare the patient with the information needed to set his or her mind at ease. It also defines the situation as one in which the patient is an important contributor with power to alter the course of events, if necessary.

Another common fear is the fear of failure. This fear may be felt by the patient, the practitioner, or both. Patients who have tried almost every other method of treatment, without success, may verbalize their doubt that they can go into trance or they may try to avoid failure by seeking to delay the procedure. Performance anxiety is likely to escalate with pressure, for instance, if the patient gets the idea that trance induction is a test of whether therapy, as a whole, will succeed. It is important to honor all of the patient's requests, for instance, stopping the induction if the patient does not feel ready. If this occurs, the therapy can be temporarily shifted to another form of treatment, such as counseling, and returning to hypnosis at a later time. Confidence can also be increased by having hypnotic responding modeled for the patient, a strategy that dates back to Liebault's work in Nancy, France.

For the practitioner, it is important to be able to tolerate fear of failure and to accept the possibility of making small mistakes. Other fears that interfere with a confident induction procedure include the practitioner's fear of power, fear of the unexpected, or fear of disapproval from others. Ironically, overfocusing on the nuances of hypnotic induction or the depth of trance tends to increase anxiety while distracting attention from the more important question of how hypnosis is going to support the needs and goals of the patient. For these reasons, it is advisable not to worry about the intricacies of a technique or to become overly concerned with flawless execution. As long as patients know that the clinician is entirely focused on their well-being, they are generally forgiving of small mistakes and just as eager to see treatment methods succeed.

PROBLEMATIC EXPECTATIONS

As with fearful feelings, unrealistic expectations of what will occur during hypnosis (e.g., the loss of all awareness, a complete amnesia for the experience,

or the loss of all volitional control) should be addressed prior to induction so that unfulfilled expectancies do not result in the patient inferring that he or she cannot be hypnotized (Overholser, 1988). Failure to correct erroneous beliefs often results in the patient declaring, "I must not have been hypnotized. I heard every word you said!" If magical expectations are not addressed, it is less likely that the patient will be able to recognize or appreciate small gains achieved during trance.

Before induction, it is important to carefully assess the patient's history of hypnotic experiences and subsequent attitudes. Relevant details include patients' perceptions of how deeply they were hypnotized, whether the experience was enjoyable, how the patients responded to various suggestions, what was most helpful or what was not helpful, and what sensations were experienced (Frauman, Lynn, & Brentar, 1993). This knowledge enables the practitioner to select inductions and hypnotic techniques that are compatible with the patient's expectancies. Experienced practitioners have long known that if a subject truly believes a method will hypnotize him, then a surprisingly wide variety of methods can serve as effective induction (Weitzenhoffer, 1989). During the first hypnotic session, it is advisable to allow the patient to succeed with easy suggestions, such as imagery, changes in skin temperature, and psychomotor movement, before moving to more complex experiences such as glove anesthesia, positive or negative hallucinations, and hypnotic amnesia. Success with early responsiveness to suggestion strengthens expectations, thereby ensuring greater responsiveness to subsequent suggestions (Kirsch, 1990).

Ironically, a problem can be defined as any discrepancy between what is expected and what is occurring. Thus, the more flexible and open-minded the practitioner, the fewer the problems that are likely to be encountered. Perhaps the most common problematic expectation held by practitioners of hypnosis is that a favored induction technique should work equally well with all patients. However, dating back to the earliest research on hypnosis, luminaries such as Bernheim (1889/1947) and Janet (1925) have argued that methods, which work very well with some subjects, may not work equally well with others, and that even those who have responded well to a particular technique may prefer a different technique on a different occasion.

Also, both the therapist and patient should have realistic expectations for the experience of hypnosis. For example, expectations such as that hypnosis requires absolute compliance to be effective can be problematic. Realistic expectations come from recognizing that the hypnotic state does not involve sleep or a loss of consciousness. According to Erickson (1948), “Hypnosis does not change the person, nor does it alter his past experiential life. It serves to permit him to learn more about himself and to express himself more adequately” (p. 514). And as stated by Wolberg (1948), “It has many values; but it does have limitations in terms of the individual’s existing motivations and his capacities for change. Therapeutic failures occur with hypnosis as with any other form of therapy” (p. 418).

MISCOMMUNICATION

Perhaps one of the most hapless problems that can occur during hypnotic induction is that of *miscommunication*. In some instances, the patient is trying to cooperate but does not understand what the practitioner is requesting, because the suggestion was either too vague or stated in too narrow terms. During trance, suggestions should be simple and repeated more than once. The more complicated a suggestion, the more difficult it will be for the patient to carry it out. Another possibility is that the patient is responding in a very literal and circumscribed manner. For instance, a patient who is told to watch her arm levitate may watch a hallucinated arm movement without any physical changes to the position of her arm. Or a person who is told to “feel more and more sleepy” may not close his eyes until being told specifically to do so. This is especially likely to happen during hypnosis with children (Short, 1999). It would be a serious mistake to interpret these behaviors as unconscious resistance when what is actually occurring is unexpected compliance with a miscommunication by the practitioner. For these reasons, suggestions should be brief, precise, and worded as close as possible to the known habits and thoughts of the patient, thereby reducing the likelihood of miscommunication.

Because communication works best as a two-way street, it is helpful to invite the patient to talk during trance induction so that you have a

better understanding of his or her subjective experiences and emerging hypnotic realities. Similarly, increased observation results in greater sensitivity to the needs of the patient and increased responsiveness. When seeking to understand an individual’s emotional experience, it is particularly important to study the movements of the eyes and face, which yield more information than spoken language (Ekman, 2003; Hess, 1965). A sudden look of concern may indicate problems with word choice. For instance, some patients will respond violently to the idea of being “hypnotized” but they do not mind the thought of “going into a trance” just as some patients are terrified of being labeled as “crazy” but do not mind being identified as “mentally ill” (Short, Erickson, & Erickson-Klien, 2005). The primary solution for any problem with communication is to gather more information with the hope of increasing empathic understanding.

POWER STRUGGLES

According to Erickson (1956), apparent resistance is often no more than an unconscious test of the hypnotherapist’s willingness to meet patients halfway rather than forcing them to act entirely in accord with his ideas. Similarly, Christenson (1958) noted that some patients are more resistant to hypnotic induction during the second attempt than on the first, a temporary condition that disappears once they demonstrate that they can resist the process, if they wish. Orne (1965) points out that hypnosis can increase problems of countertransference, leading to a power struggle as the practitioner seeks to gratify his or her needs rather than the needs of the patient. If the patient has a history of being harshly dominated by others, then an unfortunate transference-countertransference dynamic is likely to result in a failure to go into trance or a failure to awaken. Because the practitioner is not likely to recognize his or her unconscious needs, evidence of a two-way power struggle is more easily identified through the patient’s reactions. For example, if the patient begins to tense up as the practitioner offers suggestions for relaxation, then that patient’s needs should be given more careful consideration. Other subtle indicators of an emerging power struggle include a loud cough or the patient needing to blow his nose just as each suggestion is spoken, as well as any other behavior

that interrupts the process and demonstrates that the suggestions have failed to produce their intended effect. Under these conditions, the practitioner needs to find a way to increase the patient's ability to act independently and in accord with his or her personal will.

In response to the problem of power struggles, Erickson (1958, p. 92) developed "permissive suggestion." He illustrated this technique with a sample dialogue, filled with options:

"Shortly your right hand, or it may be your left hand, will begin to lift up, or it may press down, or it may not move at all, but we will wait to see just what happens. Maybe the thumb will be first, or you may feel something happening in your little finger, but the really important thing is not whether your hand lifts up or presses down or just remains still; rather, it is your ability to sense fully whatever feelings may develop in your hand."

Anytime a person feels trapped in a situation that threatens loss of control, the instinctual response is to resist. No sensible person wishes to surrender basic rights and personal freedoms, such as the right to talk or not talk, the right to keep one's eyes open, the right to listen or not listen, the right to sit or stand, and the right to refuse external manipulation. With this in mind, the practitioner uses permissive suggestion, asking leading questions such as *"Would you like to go into trance now or later? . . . Would you like to go into trance standing up or sitting?"* or offering options, such as *"You can listen to my voice or replace it with the sound of your own inner wisdom."* When there is obvious concern for the freedom and needs of the patient, power struggles are less likely to emerge. Even more importantly, as stated by Fromm (1980, p. 426),

The clinical objective is to strengthen patient autonomy and self-pride in mastering a problem situation. This process begins with an induction procedure that permits the patient to decide how and when he or she will manifest the various phenomena of hypnosis.

AMBIVALENCE

Clinical ambivalence is defined as a discrepancy between deliberate intention and automatic

behaviors, resulting in self-contradictory actions. It is an approach-avoid conflict that remains hidden beneath conscious awareness. For instance, a request for hypnosis from a patient who subsequently seeks to dominate the conversation, never allowing any time for the practitioner to respond as requested, is a sign of ambivalence. Erickson (1958) believed that the very fact that a patient requests hypnosis and then offers resistance indicates a state of ambivalence. Haley (1958) observed such a situation when an individual from the audience stood with crossed arms and challenged Erickson to hypnotize him. Erickson invited the participant to join him on the lecture platform, asked him to sit down, and then said to him, "I want you to stay awake, wider and wider awake, wider and wider awake." At that point, the subject closed his eyes and entered into a hypnotic sleep state.

When dealing with the problem of resistance, Erickson often talked of "displacing" and "discharging" the resistance. Though he did not specify the circumstances in which this approach is needed, he listed numerous case examples, each containing indications of ambivalence. For example, one such patient announced that he wanted to be treated with hypnosis but then insisted that he could not be hypnotized (Erickson, Rossi, & Rossi, 1976, p. 221). This seemingly paradoxical position represents a contradictory attitude not only to hypnosis but to the whole of therapy; otherwise, the patient would have requested a form of therapy that he thought would work well. For this reason, Erickson's problem solving was not limited to the process of induction but to the patient's responsiveness to therapy as a whole.

With this particular patient, Erickson commented that there were three additional chairs in the office and that if hypnosis were attempted in each of these chairs, the induction would probably fail more times than it succeeded. After trying three chairs, unsuccessfully, the patient was readily hypnotized in the fourth chair. Though this process might seem mysterious, the core principle is fairly simple. If the patient is ambivalent, it means that he wishes to have hypnosis fail and he wishes to have it succeed. Thus, the practitioner needs to provide some opportunity for failure and at least one opportunity for success (remember the man from the audience; he "failed" to keep his eyes open). When offering posthypnotic

suggestions to such a patient, it would be reasonable to expect that some of the suggestions will fail. Using Erickson's method, the resistance is dealt with first, so the resistance is "used up and discharged." Once the need for failure is addressed, the patient is nicely positioned to end with a success experience.

As with every other method described in this chapter, it should not be assumed that the induction is the only place where this type of problem will be encountered. The patient may be highly ambivalent about a large number of things, including trusting others, making changes to behavior, or whether or not to remain in therapy. When the practitioner understands the process of disambiguation (Short, 2014), then presumably refractory patients readily cooperate as their needs are met and their goals achieved.

CONCLUSION

Before ending this discussion, it is important to note that the principles discussed in this chapter have application not only to hypnotic induction but to the whole of any therapeutic endeavor. As stated by Bates (1993), "Patients' fears, ambivalences, and dynamic conflicts influence their responses to hypnotic treatment, as do considerations such as secondary gain" (pp. 25–26). When considering the broader interpersonal dynamics that surround therapy, it is helpful to recognize that the preconditions for the induction of hypnosis are very similar to the preconditions required for a successful therapeutic relationship (Orne & Dinges, 1989). As argued by Zeig (2014), the lessons learned from differences in response to the induction procedure can provide valuable information for planning the course of treatment and for avoiding costly ruptures to the overall therapeutic alliance.

Even when the initial induction proceeds with relative ease, there are certain circumstances in which successful trance induction is a problem. For example, prepsychotic patients have been known to decompensate during hypnosis (Gill & Brenman, 1959) as well as those with a paranoid level of resistance to being manipulated or controlled (Orne, 1965; Spiegel, 1978). A procedure that produces alterations in conscious awareness

is also risky with those who perceive themselves as victims of sudden, intrusive, and unwanted intimacy (Frauman, Lynn, & Brentar, 1993). This brings us back to the central thesis of the opening section, which is that clinical hypnosis should always be built on a solid base of trust and voluntary consent. The practitioner who assumes an overly rigid, authoritarian, coercive, or insensitive stance toward the patient will understandably encounter problems with induction (Fromm, 1980; Lazar & Dempster, 1984; Yapko, 2013). The expert hypnotherapist has an expectation of discovery and a curiosity about the patient's reality. When the practitioner is flexible, caring, and open-minded, there is a greater likelihood of success with hypnotic inductions and therapy as a whole.

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