Comment on Lynn

John G. Watkins
Missoula, MT

When I read the original article my response was “Bravo.” Researchers are now investigating the values to therapists of Hidden Observer phenomena (and incidentally that of Ego States). In his paper, Lynn’s clinical case represents good therapy, and his forensic one shows proper attention to normal safeguards. Furthermore, the three research studies reported demonstrate the increased therapeutic leverage which “hidden observer” suggestions might afford. However, in his recent extension of that paper, Lynn takes it all back.

He seems to have convinced himself that Hidden Observers and Ego States are only “metaphors.” Lynn obviously has not tried Ego State Therapy – which you cannot do with entities you don’t believe even exist. Like multiple personality alters, these personality segments, or “part-persons,” often appear spontaneously, un-suggested, surprising even to a believer, and demonstrating a wide range of behaviors, attitudes, perceptions and affects quite different from the personality patterns found in the overt personality. They show relative stability over long periods of time, often years. Each ego state may have a history of origin and development uniquely its own different from that of the primary personality. They act like DID alters, but seldom become manifest except under hypnosis with a trusted operator.

They covertly influence the behavior, thinking and affects of the overt, conscious personality. Many ego state therapists these days have found their “elicitation” (which does not mean their suggestive creation) offers a new dimension for treatment (Phillips & Frederick, 1996; Frederick & McNeal, 1999).

Sutcliffe (1961) noted that hypnosis workers can be divided into the “credulous” and the “skeptics.” Now which one discovers reality? Are the skeptics more realistic than the credulous ones? Not really. The rose-colored glasses and the mechanism of projection in the most “credulous” ones are equaled in the reverse direction by the dark glasses and mechanism of denial in the “skeptics.” One person’s “reality” is often another’s “metaphor” – since we all wear colored glasses.

Skeptics put much faith in empirical, controlled laboratory experiments to ascertain reality, not recalling that many great scientific discoveries (movements of the planets, the reality of microbes, evolution of species, unconscious processes) were discovered through human observation, not laboratory experiments.

Controversies among hypnotists often lie in the differences between “experimental and clinical hypnosis.”

In experimental hypnosis the purpose of the study is the discovery of verifiable knowledge. The procedures are empirical. Standardization and control are paramount. The scientific approach is nomothetic. Subjects, commonly selected from volunteers in a population of (conveniently available) college students, are usually normal individuals, i.e., not known to be ill or maladjusted. They are motivated to volunteer by curiosity, academic credit, social
pressures and financial rewards, and are recruited to meet the needs of the researcher. Experimenter and subject are strangers to each other with only an hour or so of contact. “Trust” is usually taken for granted. The relationship between experimenter and subject is minimized to avoid influence and contamination. Induction suggestions are verbal and standardized, often recorded. Measurements are objective and quantitative.

In clinical hypnosis the purpose is the cure or alleviation of painful symptoms and behavioral maladjustments. The subjects (called “patients” or “clients”) are drawn from a population of all ages and socio-economic classes who come to meet their own needs. The patient and therapist communicate with each other over many hours. A high level of “trust” is essential and actively sought. The approach is ideographic. The relationship between therapist and patient is maximized. Induction instructions are variable, un-standardized and altered flexibly to meet individual needs. Evaluations (measurements) are subjective and qualitative.

Can any two procedures, called by the same name “hypnosis” be so different? No wonder researchers and therapists argue over what “hypnotic” phenomena are real and what are not.

Another issue: In research, hypnosis is defined as a “process, state, or condition” which inheres in the subject. Many clinicians now regard hypnotherapy, unlike a pathologist examining a tissue under a microscope, as an intense interpersonal relationship to which both are parties, and the relationship is more important than the techniques.

Lynn is right when he says, “the hidden observer” is shaped by “social demands and expectancies,” but by both those of the “skeptic” and the “credulous.” The classic study by Sutcliffe (1961) demonstrated how experimenters covertly influence their subjects. It seems to be forgotten today. Both therapists and researchers may influence human subjects even more through their covert attitudes, beliefs, and biases than their verbal suggestions. This influence involves unconscious resonance (Watkins, 1978) and transferences, ignored by researchers, as also are the crucial findings by Rosenthal (1966).

MPD alters seldom reveal themselves to skeptics. They were usually dissociated years ago, so they think concretely like children, not with the adult, cognitive words employed in research. Having been rejected and victimized over years they often sense disbelief, even if not spoken. Through posture, gestures, word accent and inflexion we covertly transmit our beliefs and biases to others. Cases of dissociation generally come to an empathic therapist only after many un-therapeutic rejections from skeptics. When the unconscious communication to a personality segment by a skeptic is, “I don’t believe you are real,” the entity’s response is, “For you, I’m not.” As one psychiatrist told me. “In 30 years of practice I have never seen a multiple.” My thought: “And he probably never will.”

Lynn states that his studies were “not inspired by the idea that the hidden observer is a tangible personality structure,” but only as a therapeutic “metaphor,” which we must not “reify.” so we and the subject or patient know his beliefs, attitudes and biases before he even begins his studies. With such an approach it would be surprising if real ego states revealed themselves in his hypnotic sessions.

Furthermore, Lynn advocates requiring a signed consent from the patient before applying these procedures, which is a good (paranoid) way to tell the patient that you the therapist don’t have confidence in your technique, and you don’t trust him not to sue you. This could kill any therapy, especially with child states. One wonders if the great risk of “pseudomemories and reifying metaphors” of which Lynn warns, comes from his own
practice or from theory. Therapist “safety” can be better assured by building a trusting relationship and resonating with childlike (concrete) thinking. In many decades of treating, involving hypnosis, ego states and abreacts, we have never had a patient sue us.

In our book (Watkins & Watkins, 1997) I report a follow-up outcome study on all patients my colleague, Helen Watkins, had treated by ego state therapy during the preceding 18 years. Negative comments were almost non-existent, and the superiority of the ego state approach (10-15 hours) was rated (at the .005 level) higher than their psychoanalyses lasting 100s of hours. Yes, subjects can manifest suggested ego state behavior but these are frequently artifacts, designed to please the therapist or researcher. The specific verbalizations reported by Lynn for activating a hidden observer are a good example when he suggests that, “there is a part of yourself that is always present and which is always aware” (which he doesn’t really believe). The subject will sense the insincerity and produce a pleasing artifact, which he can call a “metaphor.” However, there are better ways to activate ego states and minimize demand characteristics, such as: “Is there any part of Jane who knows what is causing her disturbance, but if there is no such separate part that’s okay?” Or, after building a trusting, resonant relationship and inducing hypnosis, the therapist might ask, “What is causing Jane’s severe anxiety?” In one case (Watkins and Watkins, 1988), a childish voice, with a childish vocabulary (who didn’t understand words like “vulnerable”) revealed that a joking remark by a colleague initiated the anxiety. The therapist asked, “Can I call you Jane? Is that your name?” The “metaphor” replied, “No! That’s her name, the Big One. I’m the Little One.” “Little One” then stated, that when “The Big One” is boring and does “that thing with the keys (computer), I give her headaches,” also that “I’m the one who goes into hypnosis. She (Jane) doesn’t know how.” Little One then discussed her toys, her favorite colors, and her teddy bear. The therapist suggested ways of dealing with the offending remark, and “Little One” was ultimately reassured. The disturbance was eliminated and didn’t return. Experienced ego state therapists find these entities as real, tangible and as observable as hypnotic anesthesia.

Expecting laboratory studies alone to answer questions such as, is a therapy effective, or are ego states real when activated, is like asking the question, do violins make good music when played?

References: