Symptom Removal: The Twentieth Century Experience

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The twentieth century hypnosis literature regarding the use of direct symptom removal with hypnosis is in strong contrast with that of the nineteenth. It shows much ambivalence about the use of symptom removal. Objections, largely based on conclusions drawn from psychoanalytic theory, led many twentieth century psychotherapists to reject direct symptom removal. However, a certain amount of empirical evidence, scattered through the literature, has accumulated during the twentieth century to support this rejection. The lack of satisfactory twentieth century statistics and of nineteenth century details concerning hypnotic interventions that were used, makes it impossible to satisfactorily account for the discrepancy in experiences of the nineteenth and twentieth centuries. Although therapists did not altogether abandon working directly with symptoms, many opted instead for modifying and manipulating them by suggestion instead of completely removing them, usually allowing the patient to retain a psychodynamically suitable substitute. Here again a lack of adequate statistics prevents one from being able to properly appraise the effectiveness of this approach which has remained the preferred one for a number of therapists.

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As recently shown (Weitzenhoffer, 2002), a fair number of leading clinicians widely used hypnosis for symptom removal between 1884 and 1900 and apparently did so with remarkable success. This may have been essentially the only way hypnosis was then clinically used. However, as indicated by the literature of the times, and for reasons that are not clear, around 1900 a decline in this use of hypnosis began. By 1910 all clinical uses of hypnosis seem to have essentially vanished. In fact so had all scientific interest in hypnotic phenomena, as is well demonstrated by the demise, in 1910, of the Revue de l’Hypnotisme Expérimental et Thérapeutique [The Review of Experimental and Therapeutic Hypnotism], the only remaining scientific journal devoted to these subjects. Various more or less reasonable speculations have been offered to account for this state of affairs. However, facts have not been included among them. First, considerably earlier than 1910, a division had come about between providers of mental health and providers of physical health. Leading general medical practitioners...
using hypnosis, such as Liébeault, Bernheim, van Eeden, Renterghem, Grassman, Stoll, Bérillon, Schrenck-Notzing, Bramwell, and Tuckey, dealt with purely somatic as well as mental problems. However, by 1900 specialization had begun to take place: psychiatry was evolving as a medical specialty. This is reflected in the fact that the name of the *Revue de l’hypnotisme* was eventually changed to include the words “et de psychothérapie” [and of psychotherapy]. Simultaneously, extensive advances were taking place in the field of somatic medicine. Many physicians, feeling more comfortable with what the state of their art provided, may have had little inclination to use a poorly understood phenomenon such as hypnosis. The diminished need for symptom removal brought about by progress in medicine seems to have contributed to an inevitable decrease in the use of hypnotic symptom removal as a whole.

Relatively little about hypnotherapy appears until nearly the middle of the twentieth century. Research with hypnotic phenomena had not completely ceased, but there was comparatively little of it done, and it was sporadic. Some have credited the appearance of Clark L. Hull’s work (1933) for the renewal of interest in hypnosis. Others have credited the use of hypnosis in World War II with “shell shocked” patients. None of these really explains the resurgence of interest in the study and use of hypnosis that took place around 1945. One can just as well credit the *Zeitgeist* for this.1

**Views Regarding Symptom Removal from Circa 1940 to 1999**

Whatever the reasons may have been, the historical facts seem to be that the resurgence of an interest in hypnotherapy in the nineteen-forties was largely in the United States and on a smaller scale in England. It seems to have appeared first among psychiatrists and some clinical psychologists, although by 1950 some physicians and dentists were also using hypnosis. At that time the only data available regarding symptom removal were those which had come down from the Nineteenth century, and these were highly favorable. The publication of the authoritative texts of Wolberg (1946,1948), Rosen (1953), Watkins (1949) and Schneck (1953)2 marked this revival of interest in the clinical uses of hypnosis. However, they clearly indicated that the use of symptom removal had become a controversial issue. There were psychiatrists who strongly opposed any such use. Others continued to see it as a useful technique, but one to be employed with caution. Some felt that great caution was needed.

The basis for this position is unclear. No solid empirical foundation can be found in the literature of that portion of the twentieth century to support this new position. Many allusions were made to the likelihood of relapses, of symptom substitution, and worse. However, this was opined in the absence of any available statistics comparable to the positive ones inherited from the nineteenth century.3 It

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1 It has recently been suggested (Gravitz, 2002) that the credit for renewed interest in hypnosis should go to the publication of the Bridey Murphy case by Morey Bernstein. There is clear-cut evidence that this resurgence started before the publication of the case.

2The number of practitioners that can be considered to have been leading authorities on the clinical uses of hypnosis in the United States between 1940 and 1955 was quite small. In this context particular mention should additionally be made of Estabrooks, Brenmann, Gill, Kubie, LeCron, Dorcus, Kline, Conn, Spiegel, Kroger, Lindner, Moss, and Erickson.

3Furthermore, there would have been no opportunity to compile like data between the time treatment with hypnosis resumed and such publications as those listed above took place.
appears that psychodynamic speculations had come to dominate the field of mental health and their message was clear: *Symptoms are expressions of various psychopathological needs. Remove them and these needs will seek to express themselves anew*. It is this credo, started by Freud (1938), and not the existence of well established empirical facts, that appears to have been at the bottom of the initial rejection of symptom removal by many psychotherapists during the second quarter of the twentieth century and, indeed, to the end of the Twentieth century (Yates, 1958; Bookbinder, 1958; Szasz, 1949).

**What Are the Facts?**

Of the twentieth century pioneers who resumed using hypnosis in their clinical practices, many continued to use direct symptom removal, others abstained, and still others, as will later be seen, devised ways to get around the alleged problems. In light of the fact that direct symptom removal continued to be done for many more years, one might hope statistics at least comparable with those reported during the nineteenth century would have accumulated during the twentieth century. There is relevant anecdotal clinical material available that is scattered through the literature, but usually it is too vague to allow one to come to definite conclusions. The relatively recent issue of the *International Journal of Clinical and Experimental Hypnosis* (Nash, M. 2000) did not remedy the situation. Using Chambles and Hollon’s (1998) criteria for clinical efficacy of psychotherapies in general, six surveys examining that of hypnotic interventions used in the treatment of 20 conditions were published in this special issue. They failed to note adverse reactions to hypnosis, and the majority of the interventions were not limited to direct symptom suppression, but used indirect hypnosis combined with a variety of non-hypnotic maneuvers. It is simply a fact that to this date no modern data bearing on symptom suppression have been properly gathered, reported and made available for a satisfactory statistical analysis. As early as 1967, writing on the possibility of symptom substitution, Spiegel (1967) expressed his doubts regarding its wide existence, saying, “…case reports that supposedly report this thesis can be better understood on the basis of sequential phenomena despite treatment or on the basis of inept treatment intervention” (p. 1279).

Likewise, Montgomery and Crowder (1972) later make the following points:

There are a number of difficulties, however, that hinder a fair appraisal

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1As he explained in his lectures on psychoanalysis given at the University of Vienna between 1915 and 1917 (Freud, 1938, pp.390-392), Freud had visited Bernheim in 1889 and spent some time with him as a pupil. Returning to Vienna he had made use of the hypnotic techniques he had learned from Bernheim for a number of years. His experience, he stated, had been that the results of hypnotic symptom removal were unreliable, often lacking permanence, with the symptom returning or a new symptom appearing. He explained, on the basis of his psychoanalytic theory of symptom formation, this was because hypnotic symptom removal leaves the processes that have caused the symptom to form unchanged. Actually, there was more to his rejection of hypnosis as a treatment tool than this, but these other reasons are not relevant to the present article.

2Unfortunately, no single article of Erickson describes all of the modifications he used. Instead they are scattered through his various clinical articles to be found in this collection. Some, such as the one that follows, were never published but were described by Erickson in his seminars or in discussions. He would work with almost any feature of a symptom, such as its intensity, the frequency of occurrence, the duration, the time interval between occurrences (when intermittent), the form taken, and its location.
of the empirical evidence for symptom substitution. One difficulty is that there is little agreement on what constitutes a symptom... A second difficulty is the interest of the investigator... A third difficulty is that the symptom substitution may bear no resemblance to the original symptom (p. 98).

A fourth difficulty Montgomery and Crowder (1972) might have listed is that, theoretically speaking, symptom substitution is not the only expected adverse response. It is difficult to find descriptions in the clinical literature of clear-cut cases of symptom substitution. Wolberg (1945, pp.419-421) has published one of the few that is available. In his clinical work the author had only observed two absolutely clear cases of symptom substitution. Other less obvious ones probably have occurred that passed unrecognized as such.

Finally, even more confounding is the high probability of untoward reactions to having been being hypnotized. These can be misperceived as contrary reactions to symptom removal. According to MacHovec (1988) there had been at least six studies concerned with the first of these effects published between 1962 and 1986. Of particular interest here are two based on data obtained from college students who had been hypnotized for research purposes and who had been exposed to the presumably innocuous items of the Stanford Scales, Forms A and B (Weitzenhoffer & Hilgard, 1959), and C (Weitzenhoffer & Hilgard, 1962). In one case 120 subjects were involved; in the other, 209. An average 38.5 percent reported minor to relatively severe sequelae. This happened with presumably reasonably healthy individuals. What might one expect with persons being hypnotized for the treatment of a pathology? Three other relevant studies, also reviewed by MacHovec, offer a potential answer. He included reports from surveys of groups of health providers ranging from 102 to 866 regarding the incidence of sequelae in patients following hypnosis. An average 31.7% of these professionals reported observing some 48 kinds of adverse effects; some were quite severe. MacHovec assumes these were merely reactions to being hypnotized. This may or may not have been the case. No information is available regarding what else may have been done by the clinicians besides inducing hypnosis. It is possible that they followed this up with symptom removal. Again, there is no information about how many patients were involved and what percentage had these reactions. In any event, some of the reported reactions were the same as those that have been mentioned as following symptom removals. While nothing conclusive can be drawn from the MacHovec survey, it does raise the serious question of how many cases of observed adverse effects following symptom removal may have been confounded with adverse reactions to hypnosis.

At least three reviews favorable to symptom removal have been published (Pulver & Pulver, 1975; Barios, 1970; Conn, 1968). They fail to make a case for it because they are reporting on removals done in conjunction with other psychotherapeutic interventions, such as exploration, ego strengthening procedures, re-education, and still others. Under such conditions little can be said concerning the results of only directly removing a symptom.

Similarly, Frank’s (1946) report on the United States armed forces experience with symptom removal in wartime using various instrumentalities (hypnosis is not mentioned) appears to make a particularly good case for it. Unfortunately, Frank does
not provide any details or statistics. Several other features detract from the value of the document: There are indications in the report that in many cases treatment was not limited to symptom removal. Also Frank’s criterion for therapeutic success appears to have been solely the ability to quickly return service men to combat, and no follow-up data are available. However, going by Watkins’ (1949) more extensive writing on the hypnotherapy of the war neuroses, it would appear that symptom removal alone was far from being successful in a fair number of cases, and for those soldiers who received further treatment other hypnotic techniques had to be used when hypnosis was involved in their treatment. Some of the better evidence that direct symptom removal can be done with impunity actually comes from the behavior modification literature. A summary of pertinent results can be found in the article of Montgomery and Crowder (1972).

On the negative side of symptom removal, Browning and Houseworth (1953) reported a well-designed and controlled study on the use of gastrectomies in the treatment of 30 ulcer cases. They found that most patients who lost their ulcers developed new ones. Twenty-four percent also developed other psychosomatic disturbances, 50% showing various psychoneurotic symptoms not present earlier, and 3% showing characterological symptoms. Some of these disturbances were quite severe. A follow-up done 12 to 18 months later showed that this situation had generally worsened. Some of the patients had become incapacitated. The control group of 30 patients received only conventional medical treatment without surgery. This group showed no improvement ulcer-wise, but also did not develop new and additional problems. Szasz (1949) has similarly reported on 25 vagotomized patients suffering from duodenal ulcers. Paneth (1959) also reports symptom substitution taking place in a small number of patients treated for various gastric disorders.

Some of the more telling negative data available can be found in the reported outcome of Seitz’s (1953) experimental attempt to serially remove a symptom and its substitutes in a patient who finally decompensated. This was part of a series of 29 experiments done with three patients. These experiments were aimed at determining whether or not satisfactory symptom substitutions are possible in the case of conversion reactions. The experiments involved both naturally occurring and suggested substitutions. Actually Seitz’s results were not all negative. While he did show that symptom substitutions do naturally take place he also was able to show that some can be dynamically satisfactory alternatives. In an article discussing Seitz’s experiments, Rosen (1953) reported having done more limited experiments of the same kind with like results and also concluded that symptom substitution is not necessarily a scourge.

Discussion

What Can Be Concluded?

The facts then are that the twentieth century has no clinical statistics to offer that are comparable to those which have come down from the nineteenth century. It is most often difficult to determine how much of reported success can be attributed to symptom removal. Data on the incidence of adverse effects with direct symptom removals are also unclear. In most cases the best one can say is that yes, some, possibly many, direct symptom removals done in the twentieth century have been found associated with such effects, but a direct, causal, connection between the two events has not been
well demonstrated in most cases. If such a relation existed, its exact nature is not clear. On the other hand reports such as those of Seitz, Rosen, Browning and Houseworth and of Szasz do not allow us to ignore the possibility of symptom substitution, particularly with adverse consequences. One can only wish that more of these reports had included data regarding the dynamics that were presumably involved as this would have greatly strengthened their case against symptom removal.

The nineteenth century data now sticks out as somewhat of an anomaly. Some symptoms that were treated during the nineteenth century would probably be considered today to have been psychogenic. Surely, then at least some cases of symptom substitutions should have been observed and reported! But none was. Possibly this is because when they occurred they were not recognized. “Relapses” that are subsequently also treated are often mentioned. These cases also possibly became part of the small number of reported failures of treatment. Had we modern statistics to compare with the older ones one might find congruence in this regard. Finally, Spiegel’s (1967) article had a great deal to say about the influence of the therapists’ expectations on the outcome of symptom removal, and we should note that in general the nineteenth century physicians listed looked positively on this type of intervention. Other speculations are possible.

What Can and Should One Do About Symptoms?

Let us begin by recognizing that there are many medical situations in which the symptoms are entirely somatogenic. In such cases, if the symptom is of no particular medical usefulness, there should be no reasons for allowing it to persist. This is also true when the etiology is unknown or if no cure is available. Giving relief to a patient is probably the most frequent treason for removing a symptom. Frank (1946) lists four other important benefits to consider: (1) In some situations symptomatic treatment may also constitute a direct treatment of the cause; (2) The symptom may impede other needed treatment and its alleviation will facilitate the latter; (3) It eliminates or reduces emotional reaction caused by the symptom itself; and (4) It can create a more favorable attitude of the patient toward the therapist and the overall treatment. These four benefits, it should be remarked, apply equally well in the treatment of functional as well as purely somatic disorders. More often than not partial or conditional removal may be the more desirable action because, for instance, totally free of a symptom the patient may be led to carry out contraindicated actions. Or the patient will not proceed with important adjunctive treatment, believing now that he no longer needs it. Other reasons for allowing a symptom to minimally remain can be listed. There can thus be value in having a symptom remain even be it in a vestigial form. That is to say that even if one has not to be concerned about psychodynamics in these cases, removal of somatogenic symptoms still needs to be done with some care. Weitzenhoffer (2000) treats this in some detail.

When removing symptoms it is important to remember that all symptoms do not necessarily involve complex psychodynamics. Some can be directly removed with impunity, being merely the result of strong emotional reactions induced by a situation. To be on the safe side, the following rules of thumb are offered:

1. Assuming the patient was sufficiently suggestible, a persistent symptom is a warning that it may have a function.
2. If it vanishes but shortly comes back it may also be a warning. In this latter case it is usually safe to attempt one other removal, but
if there is another recurrence this should be given serious consideration.

3. The appearance of a new symptom should always be viewed as a strong warning to desist. In such cases a quick, simple exploration can often be done using hypnosis that will often allow the therapist to then proceed accordingly. Techniques for doing this have been detailed by the author elsewhere (Weitzenhoffer, 2000).

4. Remember Seitz’s (1953) finding that some substitutions are psychodynamically as good as the original symptom when the substituted symptom is acceptable to the patient and allows him/her to keep functioning.

One of the interesting results of Seitz’s (1953) experiments was that he found some suggested substitutions also constituted psychodynamically acceptable alternatives. This observation opens the way to other approaches in the treatment of potential psychogenic symptoms.

It may have occurred to others, too, but it was Milton Erickson whom the author first heard propose in one of his early seminars that symptoms might be overdone. If this were the case, Erickson proposed that possibly a smaller edition or some other altered version of the symptom—one that was less of a problem for the patient—might still serve the same purpose. Symptoms have many features, some making the symptom more of a problem than others. Are all these features equally psychodynamically essential? Perhaps not. Other kinds of helpful alterations might then be possible. One of Erickson’s early application of these considerations was in the case of a man suffering from an hysterical paralysis of the right arm. Erickson proceeded to hypnotically transfer the symptom to the right wrist converting it to a stiffness. There was of course no cure of the neurosis, but the man was once more able to function normally, apparently without further difficulties (Erickson, 1954, pp.150f).

In Erickson’s hands symptom modification and manipulation took on many forms. It is beyond the scope of this article to review all of those he used (Erickson, 1980). One however is so elegant and is of such wide application as to call for special mention. It is one this author has called the iterative symptom fractionation method. It consists of suggesting to the patient that the symptom or some feature of it will decrease by a certain fraction, say, one-half, during the ensuing week (assuming weekly visits by the patient). If such a decrease takes place, the suggestion is given of a further decrease by one-half. If this succeeds, the patient may then be told at this point (or in a later session depending on circumstances), and while in hypnosis, that hereafter the symptom can continue each succeeding week to decrease by one half. Nothing more is said or done. As Erickson would often point out in discussing this technique, this repetitive halving must necessarily lead to an infinitesimal, vanishingly small bit of symptom. Actually, one reason why this method may be particularly effective is that it allows the patient to gradually adjusting to the loss of the symptom. As Bookbinder (1962) suggested, some of the adverse reactions of patients may come from their having insufficient time to adjust to a symptom-free situation.

How well does symptom modification and manipulation work? Once again no satisfactory statistics are available. In most cases one has at best anecdotal accounts of an application, such as Erickson’s case of the arm paralysis. Also, when one carefully
examines the psychodynamics that may be involved, some of the modifications proposed by Erickson tend to lose some of their reasonableness. They may work. However, if they do, some might attribute this to psychodynamic unconscious factors, or other reasons rather than simply conceptualizing them as satisfactory substitutes for the original symptom. Erickson offers no set rules one can follow in choosing a modification, this apparently being largely up to the therapist’s intuition. Even Erickson at times depended on a trial and error approach. On the other hand, Seitz (1953) does offer some limited guidelines, and he and Rosen (1953a) strongly suggest that other guidelines can be obtained from a careful exploration of the psychodynamics underlying the original symptom. One of Rosen’s (1953a, 1953b) preferred methods is that of chronologically regressing the patient to the time when the symptom first appeared and introducing a more satisfactory substitute through suggestion at that time, one that is a more mature solution and which is chosen on the basis of the dynamics that are uncovered.

In the middle nineteen-fifties Cheek and LeCron (1968) introduced a radically different approach for dealing with psychogenic symptoms. They argued that if forcibly removing a symptom is working against and in spite of the patient’s so-called unconscious, why not instead try to get the cooperation of this unconscious? By then LeCron (1954) had developed the technique which eventually came to be called ideomotor signaling as an exploration method. Although both Cheek and LeCron (1968) borrowed their original notion of an unconscious from Freud’s (1938) system UCS, they soon moved away from it, evolving the conception of an “unconscious” not unlike the one Erickson referred to from at least 1960 on. Accordingly it is an intelligent, relatively benevolent, mental entity within every person with which one can communicate using plain, ordinary, English (or whatever language the patient speaks) and essentially work out deals with it with regard to the removal of symptoms. Details regarding the technique will be found in two works (Cheek & LeCron, 1968; Cheek, 1994). Also Weitzenhoffer (1960a, 1960b, 1996).

Since then there have been variations on this theme. Professionals practicing Neuro-Linguistic Programming (Bandler & Grinder, 1979) have made references to communication with a variety of mental “parts”, and have proceeded accordingly. Practitioners of Ego State Therapy (Watkins & Watkins, 1997) work with various numbers of “ego states.” The basic idea in all these approaches seems to be to strike some kind of compromise with these various “unconsciouses” that will bring about symptomatic improvement without doing violence to the underlying psychodynamics.

Based on personal clinical experience, that of other twentieth century therapists, as well as the available data, it appears that both symptom substitution and even more undesirable experiences can appear when symptoms are directly removed by suggestion. Never to do so, however, does not appear reasonable. However, it should be done with care, rationally, and with as much understanding of the likely underlying psychodynamics as possible, taking the latter into account in the removal process. To be on the safe side, one might routinely start with only modifications, moving on to a full removal only later, if indicated. Often merely telling the patient “You will have only as much pain (anxiety, etc.) as is necessary (or as you need)” can be quite effective. The author has

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6The majority of patients seem to have some sort of personal understanding of what a person’s “unconscious” is. The author has found it to be useful to explain to the patient early in the therapy that he uses this expression in a reference to their ability to effortlessly do constructive thinking outside of their awareness.
made very limited use of ideomotor signaling but can conceive that combining it with symptom modification may make for greater effectiveness and security. However, one might think twice regarding its use with severely disturbed individuals. One technique the author has routinely used over the years has been to terminate treatment sessions by suggesting to the patient that in the days that will follow, his/her “unconscious” may keep on working on his/her problem and may find different and more satisfactory solutions than the ones that have been considered during the therapeutic sessions. Frequently, too, it seems useful to propose the possibility of more than one symptom modification being available, using an “and/or” clause. Most successful symptom removal appears to be done in the context of other forms of adjunctive therapy, the latter possibly having largely contributed to this success.

References


