Subconscious Guided Therapy With Hypnosis

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Abstract

Two adolescents were hospitalized with incapacitating symptoms: one with headache, back pain, and an inability to walk, while the other had headache, musculoskeletal pain, nausea, and emesis. Medical evaluation did not reveal an etiology for the symptoms of either patient. Consultation with child psychiatry services yielded recommendations that both patients might benefit from counseling. Both demonstrated an immediate improvement of their symptoms with instruction in self-hypnosis-induced relaxation techniques that included favorite place imagery and progressive relaxation. The patients were told that while in hypnosis their “subconscious” might be able to characterize psychological issues that underlay their symptoms through the medium of automatic word processing (AWP). The information identified through AWP helped guide their subsequent therapy. Thus, instruction in self-hypnosis, as well as helping adolescents develop awareness about the cause of their debilitating symptoms can be associated with rapid improvement of their symptoms.

Keywords: Conversion disorder, emesis, headache, hypnosis, paralysis.

Hypnotherapy has been employed in the treatment of a wide variety of psychological disorders (Udolf, 1992). Insight gained through hypnosis helps patients define some of their psychological conflicts, and can promote the development of a self-reliant therapy (Anbar, 2004; Anbar & Savedoff, 2005/06). This approach is likely to increase patients’ self-esteem, which has a recognized significant therapeutic effect (Stanton, 1979).

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Patients can be instructed that their “subconscious” might be able to define the psychological issues that underlie their presenting symptoms through the hypnosis medium of automatic word processing (AWP; Anbar, 2001). The term “subconscious” was chosen because laypersons commonly understand this term as referring to materials that are out of conscious awareness. In consultation with the therapist, information disclosed by the “subconscious” can help develop strategies for dealing with patients’ psychological conflicts, and can lead to rapid resolution of symptoms in children (Anbar, 2004; Anbar & Savedoff, 2005/06).

“Subconscious guided therapy” may tap into the same source of insights provided by the “hidden observer” (Hilgard, 1978), or by ego-state therapy (Watkins, 1993). A “subconscious” ego-state might be activated by defining it as a part of the mind, of which patients are usually unaware (Anbar, 2001). It is likely that the characteristics of this ego-state are modified by patients’ unstated understanding regarding the nature of their “subconscious,” and thus, may vary significantly between patients (Anbar & Savedoff, 2005/06). “Subconscious guided therapy” is consistent with the Ericksonian technique of utilization, a technique that respects patients’ outlook and meets them “where they are” (Erickson, 1977; Sanders, 1977). Also, this method is consistent with the philosophy of Rogerian therapy, which assumes patients have the ability to improve their own conditions (Udolf, 1992).

As an illustration of “subconscious guided therapy”, the cases of two adolescents are presented. The patients were hospitalized with debilitating symptoms for which there were no identifiable medical causes. They did not improve with medical treatment. Their symptoms included headaches, musculoskeletal pain, nausea, emesis, and inability to walk. After being taught how to use hypnosis to relax, each patient exhibited an immediate improvement in their symptoms. The patients then chose to use AWP in order to allow their “subconscious” to help them through helping to define the stressors that may underlie their symptoms, which subsequently guided their treatment.

Methods

The patients were hospitalized at University Hospital in Syracuse, NY. Hypnosis instruction was offered by a pediatrician who had been trained in hypnosis techniques at 3 workshops sponsored by the Society of Developmental and Behavioral Pediatrics and the American Society of Clinical Hypnosis. The patients were taught how to induce relaxation with self-hypnosis within a 30-minute session, as follows:

(1) The patients were provided a description of hypnosis. It was explained that hypnosis does not involve sleep, or mind control by the therapist. The patients were informed that a hypnotic state was a “normal” state of mind, which might be achieved during activities such as intense absorption in a movie or daydreaming in class.

(2) Instruction in hypnosis induction techniques was provided by explaining that these techniques demonstrated how imagery in the mind could affect the body. The patients learned how to imagine their hands as two giant magnets that attracted each other, and noted how their hands came together apparently “on their own.” Also, the patients were coached to imagine holding a pail full of sand in one hand while holding helium balloons in the other hand. Within several seconds for both patients, one
hand fell slowly and the other hand levitated. They stated it felt as if their hands had moved of their own accord.

(3) The patients were instructed to imagine going to a favorite relaxing place. They were coached to imagine what they might perceive was there with each of their five senses. Subsequently, they were coached to relax successive muscle groups beginning with their foreheads and ending with their feet.

(4) It was suggested to each patient to pick a signal with one hand, such as touching their index finger to their thumb, which would serve as a triggering gesture to remind them how to relax similarly to how they felt while in hypnosis, even when they were not in a state of hypnosis.

Instruction regarding the patients’ “subconscious” expression was provided on the same day as the initial session:

(1) The patients were told that “subconscious” could be defined as a part of their minds of which they were usually unaware. Examples of “subconscious” behaviors cited included the part of the mind that showed the patients’ dreams, and the part of the mind that controlled the “magnetized hands” that had been demonstrated as an induction technique. The patients were told that while consciously it appeared as if their hands moved of their own accord, in actuality it was their “subconscious” mind that moved their hands.

(2) It was suggested that the “subconscious” mind was aware of the reasons for the patients’ symptoms, and could choose whether to disclose this information to the pediatrician or to the patients’ conscious selves. It was emphasized that the patients would have a choice as to whether to be consciously aware of their “subconscious” disclosures.

(3) Both patients were told that their “subconscious” could express itself through typing during hypnosis, and both said they were interested in learning how to use this method. Therefore, they were instructed in the technique of AWP. They were seated along side the pediatrician in front of a computer screen attached to two keyboards. The patients were instructed to enter a state of self-hypnosis in their imagined relaxing place, with their eyes closed. Once they indicated they were in hypnosis, patients were instructed as follows, “When your subconscious is ready to type, your eyes will open by themselves. Your subconscious will be able to read the computer screen and will be able to operate your hands. In the meantime, your job is to remain in your relaxing place. If you are aware of what we are typing, that is fine. It may seem as if you are observing an interaction between two other individuals.” The patients were told that they would be allowed to read a copy of the typed interaction following the session, if they so desired.
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The typed interaction lasted approximately 60 minutes for each. During this time, non-verbal responses, such as changes in breathing pattern, were observed and in some instances commented on through typing.

As the cases in this report represent information derived from a chart review, without identification of the patients, this report was exempt from and received waiver from review by the SUNY Upstate Medical University Institutional Review Board. The patients’ names and some of their biographical information were changed in order to protect their privacy.

Case 1 - Chief complaints: Headache, back pain, and inability to walk.

The patient was a 17-year-old previously healthy boy who was hit on the right temple with a basketball. His head hit the wall and he lost consciousness for a few minutes. He reported that his next recollection was waking up at an emergency department with headache, lower back discomfort, and inability to walk. He said his legs felt numb. His physical examination and head CT scan were normal.

The patient’s parents were separated when he was 7-years-old. When he was 15, his custodial mother gave him short notice that she would be leaving town for a new job. At that time, he arranged for himself to live with a family friend and his wife. The patient was in 11th grade and was an “A” student. He was a star on his high-school basketball team. He had a girlfriend. He denied feeling depressed, angry, or anxious before his basketball accident.

He denied previous episodes of headaches, paralysis, paresthesia, blindness or seizures. He denied prior psychological difficulties, substance abuse, or learning issues. He appeared guarded and indifferent about his inability to walk.

The patient was evaluated by the psychiatry service after being unable to ambulate for 4 days. The diagnosis was an adjustment disorder, and possible conversion disorder. It was recommended that the patient be offered counseling. The patient said he was certain there was a physical cause of his symptoms because of his lower back discomfort. After some discussion, in view of the medical evaluation that revealed no abnormalities, he agreed that there may be a psychological component to his presentation. However, he thought this possibility was unlikely as he explained, “Why would I want to stop walking? Basketball is my life.” The patient said he was interested in learning how to use self-hypnosis techniques in order to help himself.

The patient was taught how to use self-hypnosis for relaxation, as described in the methods section. Immediately thereafter, while employing his triggering gesture (touching his right index finger to his right thumb), he was able to walk up and down the hospital corridor. At first he said his legs were “burning”, and then said they felt better. He indicated an interest in utilizing AWP in order to gain insight into his stressors. At his request, the patient walked down a hospital corridor, up two flights of stairs, and down a second hospital corridor to the site of the computer and keyboards. He was instructed in AWP as described in the methods.

In the following transcript excerpt the patient explains a possible psychological reason for his symptoms. Excerpts of the AWP session are presented verbatim. The pediatrician’s typed statements are in italics.

Hello, are you Connor’s subconscious?
Yes
How are you?
Good
Anbar

*How is Connor?*
Not so good
*What’s the matter?*
His life is going downhill
*How is that?*
When his mom left he began to fade away
*She was an important part of his life?*
No someone he trusted
*He trusted her?*
Yes
*Did he trust anyone else?*
Barb
*Who’s that?*
The girl that he likes
*So when his mom left, what happened to his trust?*
He lost it
*And did something happen recently that rekindled his old fears about losing trust in someone?*
Yes
*What happened?*
Barb seemed to fade away
*And what does the inability to walk have to do with it?*
He needs her strength and comfort and encouragement
*So when he couldn’t walk she started giving him some of those things?*
Not really but showed concern
*Did that concern feel good to Connor?*
No it scared him
*Why?*
Because he wanted her to feel safe and he could not do that
*That must feel very bad to him.*
When he does not hide it or try to deal with it on his own
*Do you have some ideas of how he can start feeling better?*
He needs to be secure in his self and also know that its alright to trust
*Do you know how he can start feeling secure in himself and know that it’s all right to trust?*
A little
*Tell me.*
He loves to play bb
*And?*
He likes when he feels that he is good at what he does
*So that’s why basketball is so important to him!*
Yea it was even more important than barb and others
*How do you feel about yourself?*
Secure
*Do you know how to trust?*
Yes
*How do you know?*
Because I taught him

*How were you able to get him to trust me enough to engage in this typing?*

By addressing his love for barb and bb

*Good... So you helped him by working with his strength. This is a good strategy. Let him feel you and your strength and ability to trust. And then tell me what happens to him.*

He feels his legs again and his trust grows stronger

*Good.*

He will place all his comfort once again in sports but he will gain his glory but in turn he is risking losing all he ever wanted

*That's what I will tell him when the time is right*

*Why do you think he is risking all he ever wanted?*

Because he is caught between his safety in sports and the will to do the best and love

*As in his relationship with Barb?*

Yes I think I told him too soon about her

*What did you tell him?*

That that was the girl for him but that he would have to not try and Impress her but just be himself

*He's 17. That's normal for someone his age.*

Thats why I told him too soon and he is looking for glory from man

*Hmm... Imagine, for a moment, that he never developed the problems with security and trust. How would he be different now?*

He would not look for his acknowledgement from people that don't matter but from his true friends and would still love sports but they would not be first

*And would that be better for him?*

Yes

*Do you need to tell me something else?*

Just a little more

*Go ahead.*

He will soon lose his ability to walk with ur help and mine but he will get stronger and be able to go home soon but he needs attention

*Does he need to talk to me more like this?*

I think he will need support

*remember that connor will also try to get u to believe that he is alright and ok and can walk because he wants to go home and start his life again with sports and barb but u need to make him aware that these things take time*

*I will do that. I will encourage him just like you said... Please help him listen to this advice.*

I will tell him and also teach him that good things take time

*Correct. And as he does hypnosis you will find it much easier to talk to him and he will be able to hear you much better and he will listen to you much better.*
Anbar

Thnx for ur help
You are most welcome. Thanks for your help.
Anything to have the old connor back
The trusting and secure one.
Yea and the happy one
Am I supposed to show him this typing if he wants to see it?
No
he has a hard time dealing with the truth I will calm him and explain when the
  time is right

Following AWP the patient reported that he could not recall what he had typed, and
had no wish to see the transcript. He elected to take the elevator down a floor, and needed
to sit down half way down the corridor to his hospital room. He was taken by wheelchair to
his room. On the next day, the patient was able to walk with encouragement. A day later, the
patient’s mother returned suddenly, and the patient was able to express to her some of his
anger about her decisions. That same day he was able to walk well, and was discharged from
the hospital. It was reinforced that the patient would benefit from counseling.

Case 2 - Chief complaints: Headaches, emesis, and musculoskeletal pain

The patient was a 17-year-old boy who developed recurrent headaches two years
before his hospitalization. He characterized the headaches as “intense” and associated with
dizziness, which prevented him from participating in social activities and attending school
on a regular basis. The headaches occurred a few times a week, lasted for “hours”, and
sometimes were relieved by over-the-counter analgesics. Seven months before his
hospitalization, he developed daily episodes of nausea and vomiting. As a result, he curtailed
his eating and lost 40 pounds. At about the same time as the nausea developed, the patient
also reported onset of neck pain, which spread to his collarbone, ribcage, shoulders, ankles,
and knees. A month before his hospitalization he began fainting, and as a result was
hospitalized for evaluation. His physical examination, brain MRI, comprehensive metabolic
panel, thyroid screen, HIV status, and urinalysis were unremarkable.

The patient characterized himself as “nervous about everything.” He said he was
worried about his mother’s health, but denied worrying about himself. He explained that
during the past 4 years, he had had difficulties falling asleep. Three years before his
hospitalization he was diagnosed with depression, but a number of psychotropic medications
were not of benefit. He had seen a counselor for a few sessions, but felt these were unhelpful
and therefore discontinued them. The patient stated that he had smoked cigarettes secretly
for the past 3 years in order to calm himself.

The patient lived with his mother and stepfather, who were both disabled. His
natural father had passed away a year ago. The patient reported he had a girlfriend until the
previous year, when she left him because of his health issues. The patient stated that when
he was in school he had received A’s and B’s. However, he said that even when his symptoms
resolved, he did not want to return to school because of difficulties with his peers who had
expressed racial intolerance directed at him. Instead, he planned to obtain a General Education
Diploma, and thought about attending community college perhaps to study acting.

The psychiatry service’s diagnosis was generalized anxiety disorder, depression,
possible somatiform disorder, and possible bipolar disorder. It was recommended that the
patient be offered counseling. The patient was interested in learning how to use hypnosis to
help himself. Following use of hypnosis for relaxation, the patient stated that his shoulder pain had resolved, and that his headache and nausea had improved. Later in the day he was able to eat without associated emesis by utilizing his triggering gesture as he ate. The patient stated he was interested in finding out why he was sad, and therefore, was instructed in AWP, which was excerpted as follows.

Hello, are you John’s subconscious?
Yes
How are you?
Good
How is John?
Sad
Do you know why he is sad?
Because his lifestyle
He is sad because of his lifestyle?
Who he is as a person
Does he dislike something about himself?
Yes
What does he dislike?
His preference
Tell me...
My sexuality
He thinks he might be gay?
Yes
Has he admitted this to himself?
No
Do you think he’s gay?
Yes
What does it mean to you, for him to be gay?
Pain
Why?
My family
What about your family?
Does not accept
So if they found out, it would cause a lot of pain?
Yes
So they don’t need to find out.
No
So, John’s sadness is related to his gay feelings that he did not admit to himself?
Yes there is a lot that he’s just not willing to let go

[In an omitted excerpt of the AWP the patient was reassured that his sexual preference does not reflect on his worth as a person. Additionally, he was given ego-strengthening suggestions about his personality and future potential.]
What, if anything we talked about, can I talk to John about?
I’m not sure if he is ready
So I think I will let him bring it up with me, if he wants to...Otherwise we can talk about it next time if he/you want to type again... But he should understand that someone knows and still likes him.
I think he knows and it makes him feel a lot better because he has all ways been scared people will give up on him before they know him
Is there anything else you want to tell me?
No
Will John know what you told me?
Yes
So he will know that I know.
Yes
Good. This will allow us to continue to have an open relationship.
Yes it will

Immediately, following the AWP session the patient said he recalled some of what had been typed, but did not want to see a transcript. Two days later, he asked to discuss why he was sad. Without hypnosis, it was suggested that he recall what he had typed, at which point he openly discussed the difficulty with his sexual orientation. He reported that at one time his mother thought he might be gay, and threatened to throw him out of the house if she found out that he was. Therefore, it was reinforced that the patient did not need to disclose his sexual orientation to his family. The patient verbalized that he was unsure whether to act according to his sexual feelings, and was reassured that he could wait until he was more certain of what he wanted to do. At discharge from the hospital, the patient’s headache, neck pain and nausea had improved, and he was referred for follow-up with a psychiatrist, as well as a counselor.

Discussion

The patients reported little awareness about factors which may have predisposed to their development of symptoms prior to utilization of hypnosis. Both cases were consistent with a diagnosis of conversion disorder in that the patients’ symptoms represented a symbolic resolution of their psychological conflict (American Psychiatric Association, 1994). Connor reported that he was concerned about losing his girlfriend because of his excessive involvement with basketball. Thus, his inability to walk precluded him from playing basketball, while reflecting his psychological paralysis about what he should do. Similarly, John’s physical pain and emesis may have represented his anguish related to his sexual orientation, which he was unable to express verbally for fear of alienating his family. The patients’ conversion symptoms may have improved because they were given alternative solutions to their psychological issues. Connor may have been able to feel more secure as a result of his hypnosis experience, as well as his ability to tell his mother how she hurt him. John was able to disclose his sexual orientation in a supportive setting during AWP, which may have helped reassure him that it is possible for people to accept and like him for who he is.

There are several elements of AWP that may promote its efficacy. The initial question posed to the patients promotes dissociation when the patient is discussed as a third person. Further, the dichotomy between the “subconscious” and the third person is emphasized
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when the patients were asked about the welfare of each one. The established dissociation subsequently allows for other phenomena characteristic of the dissociative state to unfold (Hilgard, 1977). Once the “subconscious” in AWP explains that the patients are in turmoil, open-ended questions allow the “subconscious” to choose the direction of discussion, thereby empowering the patients. Through much of the interaction, a reflective technique is utilized in which the therapist repeats what has been typed, which allows the “subconscious” to restate and clarify its thoughts, thereby increasing understanding on the part of both the patients and therapist (Baron, 1985; Brown, Weston, & Stewart, 1989). Exploration of psychological factors leading to the development and persistence of patients’ symptoms may help achieve their resolution (Torem, 1992). Asking and trusting the “subconscious” to provide essential input into the therapeutic process may have given patients an important boost in self-esteem (e.g., ego-strengthening) that promoted the success of the therapy (Anbar & Savedoff, 2005/06). This process may be augmented through the use of other hypnotic methods such as age regression or time distortion (Hammond, 1990).

As occurred with both patients, the majority of children who use AWP choose not to read what they have typed (Anbar, 2001; Anbar, 2004; Anbar & Savedoff, 2005/06), which suggests that the process may lead to discussion of emotionally charged materials that patients are not ready to bring to full awareness immediately. This process may be facilitated by the anxiety-lowering effects of this hypnotic strategy, as well as the “protection” afforded by the “subconscious” ability to choose what to disclose during hypnosis and what to remember following hypnosis. Thus, it is possible that improvement following AWP may be related in part to ego-strengthening provided by the technique, rather than to the specific insights identified by the patients. For example, such insights may represent rationalizations in response to the prompting of the therapist, or inaccurate or incomplete observations by the patients (Anbar, 2004.)

Alternatively, the success of “subconscious guided therapy” may arise from a mutually agreed upon “social fiction” that allows patients to discuss uncomfortable or embarrassing topics without having to take much personal responsibility for the divulged information. In this way, patients can disclose potential psychological causes of their symptoms without losing face. Further, such disclosures may be facilitated by side-to-side typing as this is a less personal mode of interaction than face-to-face oral conversation. Thus, the efficacy of this process may not depend necessarily on dissociation or unconscious involvement.

The effectiveness of “subconscious guided therapy” may lie in its ability to rapidly: (1) disrupt the tendency of psychological disturbances to feed on themselves (e.g. a patient may worry about worrying; Udolf, 1992); (2) reduce internal conflict by strengthening the ego; (3) change the patient’s frame of reference; (4) improve the patient’s self-image; and (5) foster development of insight. Thus, “subconscious guided therapy” may yield more rapid improvement of a conversion or somatoform disorders than dynamic therapy (Kaufman, 1962), behavioral management (Gooch, Wolcott, & Speed, 1997), suggestion (Dubowitz & Hersov, 1976), and removal of secondary gain (Schulman, 1988).

“Subconscious guided therapy” can be taught in ways other than AWP. For example, the “subconscious” can communicate verbally or through automatic writing (Coulton, 1966; Hilgard, 1977). Also, similar therapeutic results may be obtained without using the term “subconscious”. For example, the “hidden observer” (Hilgard, 1978), “center core” imagery (Torem & Gainer, 1995), or the inner adviser techniques (Bresler, 1990; Torem, 1996) can be modified to promote an immediate change in behavior similar to that achieved by “subconscious guided therapy” (Anbar, 2000).
At times, AWP may not yield effective “subconscious guided therapy”. This may occur in the case of patients with poor typing or hypnotic abilities, resistance, or lack of knowledge on the part of the “subconscious”. Children may have a high success rate with AWP because they more readily use some forms of hypnosis than adults (London & Cooper, 1969). Furthermore, because of their high rate of familiarity with computer technology, children may be more comfortable with typing as a form of communication. Finally, use of a computer screen as the forum for AWP may help maintain the achieved hypnotic state because of the children’s established association of focused attention with prolonged watching of a screen for the purpose of television viewing or playing video games.

As with other psychotherapeutic and hypnosis techniques, “subconscious guided therapy” should be employed by health care professionals who have sufficient experience and supervision. Such professionals are likely to have successful results in part because of their calm approach to the patient, as well as to have knowledge and clinical skills applicable to challenging patient responses such as unanticipated emotional reactions.

Conclusions

The presented case reports demonstrate that instruction in self-hypnosis-induced relaxation techniques, as well as helping adolescents develop awareness about the cause of their debilitating symptoms, can be associated with rapid improvement.

Research needs to be undertaken in order to characterize the elements of self-hypnosis and “subconscious guided therapy” that underlie this apparent success, as well as to define the psychological basis for their efficacy.

References

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