Contemporary Hypnosis (1998)
Vol. 15, No. 4, pp. 223–226

HYPNOSIS AS AN ADJUVANT TREATMENT IN CHRONIC PARANOID SCHIZOPHRENIA

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Abstract

Hypnosis may be a useful tool for clinicians in addressing anxiety and self-efficacy in selected chronic paranoid schizophrenics. The authors illustrate the application of indirect, permissive hypnosis in two case examples. Hypnosis is offered as a safe, non-pharmacological and relatively time-effective modality for an often under-served psychiatric population.

Key words: Hypnosis, adjunctive use, therapy, psychosis, schizophrenia

Introduction

Historically, mental health practitioners were warned that hypnosis was dangerous, and therefore should be avoided, in treating psychotic disorders (Rosen, 1960). However, in recent years this negative view has waned as clinicians now generally regard hypnosis as useful, and the application of hypnosis with psychotic patients continues to increase (Baker et al., 1990).

Spiegel (1983) noted that although there appears to be a subgroup of psychotics who are hypnotizable, as a group they seem to be less hypnotizable than non-psychotic patients. Nevertheless, various reports promote the utility of hypnosis with this population. Scagnelli (1976) concluded that hypnosis is especially useful in treating the anxiety and feelings of guilt and inadequacy of schizophrenic patients, and Murray-Jobsis (1985) cited heightened empathy for the patient's condition as a benefit of the rapport developed during hypnosis. Hodge (1988) examined several issues, such as whether special induction or treatment techniques are necessary with schizophrenic patients. He concluded that hypnosis can be a very effective adjuvant treatment and that limitations in the use of hypnosis or special precautions are not warranted.

Certainly, many schizophrenic patients may be suspicious or untrusting and readily decline the offer of hypnosis. However, with selected patients in our out-patient clinic, especially those with paranoid schizophrenia, we have found that a permissive, indirect method can be an especially valuable adjunct to multidisciplinary treatment. As many paranoid schizophrenic patients may be more functional or intact when compensated as compared to other schizophrenia subtypes, they can then be successfully engaged in the therapeutic process. Two targets, managing anxiety and bolstering feelings of self-efficacy, are frequently addressed in our hypnosis sessions. Subsequent improvement in these areas is often of immense assistance in overall management. As such, hypnosis with these patients can be valuable as a brief, cost-effective, and non-invasive method.

Case one

Mr T. was a 49-year-old African-American male with a 25-year history of paranoid schizophrenia. Although he continued to experience derogatory auditory hallucinations and persecutory delusions, he had been controlled on neuroleptics for many years and had not been hospitalized for 10 years. The patient was offered hypnosis to help his feeling of claustrophobia, fear of loss of control, and shortness of breath. The symptoms occurred especially in the context of his role as care-giver for his wife, a woman with borderline personality disorder who frequently lacerated herself with a knife and who had been admitted to a community hospital.

A dual-therapist approach was employed that involved a conversational induction and deepening that emphasized eye fixation, eye closure, and relaxation, and his imagining slowing down his mind and body. He was then told an ego-strengthening story and given an anchor, or associational cue, to use whenever he needed to relax. At the next session the patient reported a marked improvement in anxiety management. During three sessions over the next three weeks he continued to respond with a moderate depth of trance. The same process was followed in these sessions along with a different ego-strengthening story and rehearsal of the anchor, which was one deep breath. Mr T. experienced continued improvement in the management of anxiety for six months, and he understands he may return for a booster session if he wishes.

Case two

Mr N. was a 55-year-old Hispanic male with a 35-year history of paranoid schizophrenia and frequent hospitalizations for suicide attempts. Ten years ago he was referred for family therapy, which was unsuccessful, as conflict among his wife and children continued. One of his wife's complaints was the patient's restless movement in public, which embarrassed her. Mr N. agreed to a trial of hypnosis, which he promptly termed 'when you talk to me and put me to sleep'. He responded well to a concrete induction that involved imagining a warm feeling covering each part of his body. He was given the suggestion for slowing down his mind and body, imagining heavy cowboy boots on his feet, and going in his mind to a special place, 'any place you like . . . where you see yourself, and feel good about yourself . . .' He was also given an anchor, making a circle with his thumb and forefinger, to trigger the relaxation response.

Patients on large doses of neuroleptics may fall asleep during hypnosis. As Mr N. was prone to fall asleep, sessions were necessarily brief, usually less than 10 minutes. At the end of each monthly session he was praised for responding well, as during the session he would typically go from restlessness and hearing voices to no movement and no voices. He was given an audiotape of a session and began to use the tape nightly when voices were most frequent. He continues to be seen monthly for a 20-minute hypnosis session. A new audiotape is made for him whenever he breaks or loses his tape.

Discussion and conclusions

Usually hypnosis is not undertaken during the first session, when instead patients' questions are answered and they are educated about the process. Hypnosis is framed as a tool for skill acquisition and the therapist is defined as a guide who can help the

patient utilize existing strengths or resources. As an interactive process, patients are told that they will be asked to communicate in trance with a finger signal, head nod, or verbal report. A goal of partial symptom relief is encouraged, by suggesting, for example, 'That nervousness has been there for many years and maybe it helps you pay attention to what's important . . . so let's aim for this – to just take the rough edge off your nervousness, nothing more at this point . . .' Patients with unrealistic expectations, such as 'a magic bullet', are excluded during the first session.

During the first session patients are told that we will be addressing 'the front part of your mind' with concrete suggestions about breathing and relaxation. A careful explaination is also given of our belief that unconscious processes play a role in their problem and, accordingly, during hypnosis they will hear metaphor, stories, and words that may not make sense. This explaination is given in order to help the patient and to influence 'the back part of the mind', or 'to get in underneath the radar', which military veterans certainly understand.

Patients are asked about naturally occurring trance states, for example, listening to music, when their attention is absorbed and when they may lose track of time. Likening hypnosis to a common and pleasant experience begins to address control issues. Patients are also told that they are 'always in the driver's seat' and that it is understandable if they feel cautious or choose to hold back or go slowly. The second session, when formal hypnosis begins, trance is induced, the patient is then brought out of trance, their feelings are discussed, and then hypnosis is resumed. This process enhances self-control and patients invariably respond with greater depth after hypnosis is resumed.

Torem (1990), one of many proponents of ego strengthening, believes that psychiatric patients will not give up their symptoms until they feel strong enough to do so. We attempt to achieve this indirectly, such as with an anecdote about some other patient who overcame adversity, or stories that we have composed, e.g. a tree in the forest that has survived and become stronger while enduring drought and other natural difficulties. Stories such as those by Wallas (1985) are also useful.

Another technique that may aid ego strengthening is a *non-sequitur* followed by a suggestion, such as 'you can do it' (Gafner, 1997). A *non-sequitur*, e.g. 'It's hard to know whether the light is on or off inside the refrigerator when the door is closed', often produces a mild confusional state from which patients wish to escape. As they search to make sense of the statement, patients are thought to be receptive to a suggestion (Gilligan, 1987). Although at first we were skeptical about using confusion techniques with psychotics, we have found them to be eminently useful.

Our experience with the use of hypnosis for the relief of anxiety and for ego strengthening with selected paranoid schizophrenic patients in our out-patient clinic has been encouraging. It has given us an opportunity to offer a safe, non-pharmacological and relatively time-effective treatment option to an often under-served psychiatric population.

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Received 20 October 1997; revised version accepted 9 March 1998