The "Ripple Effect" Following Adjunct Hypnosis in Analytic Psychotherapy

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Treatment of several patients in analysis seemed obstructed by a single persisting symptom; in each case a consultant psychiatrist removed the symptom through hypnosis and the patients were returned to their referring psychotherapist. The authors note that not only were there no unfortunate sequelae but that a "ripple effect" occurred that resulted in genuine emotional growth by the patients.

PSYCHOANALYSIS HAS always looked askance at symptom removal as the primary approach to psychotherapy. Although we usually think of hypnosis as the prime technique for relieving a specific symptom, other devices may be employed, such as surgical correction of a cosmetic defect that has become the object of an obsessional rumination(2) or the use of specific medication to relieve target symptoms(3), to say nothing of direct advice and guidance.

In every instance the principle is the same: symptom formation is viewed as the blowing of a fuse in an overloaded electrical circuit; removal of a symptom (according to this analogy) is like removing an essential fuse and thereby precipitating a more serious conflagration elsewhere.

The actual facts are more complex. For one thing, the clinical dangers of direct symptom removal have been somewhat exaggerated(4). For another, symptom removal may have long-term generalized therapeutic advantages in selected cases. The latter phenomenon, which we propose to call the "ripple effect," [1] will be explored in the case histories in this report.

In the group of cases studied, psychoanalytic psychotherapy had reached an impasse and in each case treatment seemed obstructed by a persisting single symptom. In a consultative setting the obstructing symptom was removed by hypnosis. Hypnotic intervention was brief (one to six sessions), and in each instance the patient was returned to the referring psychiatrist for continuing psychotherapy.

Case Reports

Case 1. U.L., a 34-year-old married man, presented himself for treatment because of chronic depression, marital disharmony, and general dissatisfaction with life. He worked for an industrial medical group headed by his father and a younger brother, age 30. Although the patient possessed considerable talent and ability, he was relegated to a minor role in the group because he was unable to pass his specialty examination. During the examination he would experience episodes of paralyzing fear that adversely affected his performance. The personal unhappiness and family upheaval occasioned by his fifth consecutive failure was the factor leading to his request for psychiatric help.

During the initial interview the patient disclosed that he suffered from a perversion characterized by sexual gratification in response to fantasies of being beaten. These masochistic fantasies regularly took the following form: He imagined that he was being scolded by a woman attired in rainwear—that

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[1] A term proposed by H. J. Leichter, Ph.D., Teachers College, Columbia University.

is, in a rubberized raincoat and rubber boots. The fantasy culminated sexually in orgasm when he imagined himself lying naked across her lap on top of her raincoat while she administered a spanking and a continued scolding.

He stimulated his sexual excitement by reading "flag mags" (as he called them)—pulp magazines containing illustrated stories involving women flagellating men. From time to time he was able to persuade his wife to act out this fantasy. She would don the prescribed rainwear and scold and spank him playfully as a preliminary to sexual intercourse.

For the most part the marital relationship, of 12 years' duration, had been an extremely unhappy one. Between sexual encounters she tongue-lashed him mercilessly for his failure socially and professionally. Masturbation was his main sexual outlet. Although they once had a fairly large circle of friends, he had gradually withdrawn from most of them over a period of years and preferred to spend his weekends by himself reading and listening to his phonograph.

In the course of psychoanalytically oriented psychotherapy it appeared that the rainwear of his sexual fantasies was related to the rubberized accoutrements his mother wore when she bathed his younger brother when the latter was an infant. He recalled the loneliness he had suffered when his mother was so deeply involved in the care of the new baby. He would watch her tender ministrations enviously and recalled how she patted the baby's backside with powder. The patient had been able to capture her attention only in relation to "bad" behavior, at which time she paddled his backside.

In the course of these psychological explorations the patient became more depressed. He was often late for work due to oversleeping and became increasingly withdrawn and uncommunicative. Finally he was placed on an antidepressant.

The depression lifted but an extraordinary change took place in his masturbatory fantasy. Instead of the fantasy of being scolded and beaten he now fantasied himself as a "good" child who was receiving an enema from a loving nurse because he was sick. Thus, in spite of fundamental changes in the content of his fantasy, the basically passive narcissistic anal preoccupation remained unchanged.

Unfortunately, these interesting psychodynamic insights left his primary life "hang ups" similarly unchanged. He continued to fail the examination and to suffer all the demeaning consequences.

One day the patient raised the question of whether hypnosis would help to prevent examination anxiety. With the therapist's encouragement the appropriate referral was made and the experiment was carried out. The patient was readily hypnotizable, and after a few sessions he was able to take the next examination in a state of total calm. He thought clearly, answered the questions swiftly and accurately, and left the examination convinced that he had passed. However, in discussion with fellow examinees immediately afterward he discovered to his dismay that he had omitted one entire question of sufficient importance to ensure his failure. The patient had absolutely no recollection of the question; he had apparently suffered a hysterical scotoma in relation to it.

The incident effectively dramatized for the patient the degree to which he was imbued with a need to fail and his unwillingness to surrender his familiar role as victim.

After further working through of these issues he took the examination again and passed. The patient has continued in psychotherapy although at a considerably reduced frequency in visits. Many fundamental changes have taken place:

1. He left the family group and started one of his own, which he operates effectively and with considerable personal satisfaction.

2. He has resumed an expanded range of social activities. He and his wife are happier than they have ever been. She shows him affection and respect. Their children (a ten-year-old boy and a six-year-old girl) are developing well, obviously benefiting from the improved family milieu.

3. Sexually the patient remains unchanged. Masturbation with beating fantasies remains his principal sexual outlet. He and his wife have sexual relations infrequently, but they no longer involve acting out his perverse fantasies.

4. The patient continues to use auto-hypnosis to calm himself during periods of stress. He retains a strong attachment to the consultant, making himself available for demonstration before the latter's classes in hypnosis once a year.

The patient is not "cured" in any ideal sense of the word, but his adaptation in nonsexual spheres is unmistakably better. This generalized improvement constitutes the "ripple effect." By contrast, his sexual activity remains unchanged or perhaps even more regressed in that the actual quantity of heterosexual activity has been considerably reduced. However, the patient and his wife regard the marital adaptation as considerably improved over what had existed prior to treatment.

Case 2. K.T., a single 27-year-old businessman, presented himself for treatment because of premature ejaculation in relations with his fiancee. He stated they were compatible in every other way and wanted very much to get married. In spite of his fiancee's reassurance that this was a matter that could be worked out after marriage, he was deeply depressed by his sexual failures and was rapidly developing an attitude of phobic avoidance in relation to intercourse. He felt it was unfair to proceed with the wedding plans in the face of his "sexual handicap." The problem cast a pall over the entire relationship and threatened to bring the engagement to an end.

The patient was an intelligent, energetic young man who was making rapid progress in his business career. Although somewhat overly perfectionistic in his expectations of himself and others, he was basically a warm person with a broad range of intellectual interests and a normally active social life.

After a good therapeutic relationship had been established the suggestion was made to him that he explore the use of hypnosis to remove the sexual symptom. He acceded and was referred to the consultant. He was readily hypnotizable, and after a few sessions he was able to carry out the sexual act normally and to the satisfaction of both partners.

For the first time the psychotherapy was able to move on to other themes. The patient was an only child. Both parents owned businesses of their own. The mother's firm was outstandingly successful and brought her considerable acclaim. By contrast, the father was involved in a modest enterprise. He was a passive, likable person who was overshadowed by the towering success of his wife.

The paradoxical family situation created a developmental dilemma for the patient. To model himself on the mother and her outstanding success seemed to demand that he surrender his masculine identity. Similarly, identification with the father also seemed to demand such surrender. Furthermore, the mother was a social climber and had reservations about the status of the family into which the son was marrying. To some degree the patient shared his mother's point of view.

All these matters generated considerable ambivalence in the patient concerning both himself and his fiancee. It is not surprising that his fiancee reacted to his wavering attitude with hostility and rejection. Their sexual life, which had improved following hypnosis, returned to the previously unsatisfactory pattern. However, he was able to recognize the etiology of this failure in psychological terms and to resolve this symptom as his overall ambivalence was resolved. The patient married his fiancee, and they apparently have a good relationship.

In this instance movement in the psychotherapeutic process could not take place until the sexual symptom was removed. At that point it became possible to identify and resolve ambivalent attitudes; this led to psychotherapeutic progress and to the apparently successful marriage. It is noteworthy that the patient's tendency to premature ejaculation remains and that it returns in the face of psychological stress. However, it is readily responsive to insight. More important is the overall clinical improvement as expressed in his marital relationship, his work, and his social adjustment. We believe that further sexual improvements will occur as satisfactions derived from nonsexual life situations continue to occur.

The recollection of previously experienced mastery both in sexual and nonsexual spheres provide a springboard for continuing effort in therapy and in the mainstream of his life. It is precisely this pattern of generalizing and reciprocating improvement from one sphere to another that we call the "ripple effect."

Case 3. N.L., a single 41-year-old businessman, presented himself for treatment with a lifelong history of premature ejaculation, ejaculation prior to penetration, and periods of total impotence. This pattern of sexual failure was associated with a chronic depression, feelings of low self-esteem, and self-disparaging behavior in relation to others. In his work he was listless and passive. He permitted his partners to exploit him, and he tended to overlook the fact that certain supposedly trustworthy employees were stealing from him.

He was involved in a protracted courtship with a 38-year-old woman who had a responsible post as an executive assistant in a large corporation. She was in treatment with a psychotherapist. She lived in an apartment with an aging mother who did the household chores while she provided financial support for the two of them.

She responded to the patient's sexual inadequacies with varying attitudes of anger, disappointment, depression, and aloofness. These negative attitudes notwithstanding, the patient felt that there was enough positive in

the relationship to justify marriage in spite of his infirmity. She finally agreed to marriage, apparently with the encouragement of her therapist.

After the marriage when they moved into an apartment of their own the sexual difficulties became more pronounced. In addition, her announced unwillingness to do more than 50 percent of the household chores became a source of dissension. Because the patient was convinced that all his difficulties stemmed from a probably incurable sexual infirmity, he became more depressed than ever. At this point he accepted the suggestion to explore the use of hypnosis to relieve the sexual difficulties. The consultant found that he was readily hypnotizable, and after a few sessions the patient was able to carry out sexual intercourse normally for the first time in his life—that is, he could achieve a good erection, vaginal penetration, and prolonged and vigorous coital friction.

As might be expected the patient responded with a sense of elation. He could recall no happier time in his life. He thought and behaved with greater self-esteem. Almost at once he saw the inequities in the arrangements with his business partners and reorganized his firm accordingly. He put an end to the thieving in a firm but kindly manner. Those who could not grasp the fact that a fundamental change had occurred and continued to steal were dismissed; one particular recalcitrant was turned over to the police for prosecution. His activities in relation to competitors also took a turn to his advantage. In addition, where he had previously taken business trips by himself he now planned enthusiastically to have his wife accompany him.

His wife's reaction to these changes was startling. She began complaining that he was too rough. She did everything she could to avoid intercourse and when he finally would not be put off she admitted she had a cancer phobia. She became fearful that he would injure her breasts or her cervix and by doing so would cause her to have cancer.

As her fears and pattern of avoidance intensified, his sexual ardor cooled considerably. Gradually his previous pattern of brief sexual contact with premature ejaculation reappeared. It seemed as if the wife, in response to her own neurotic needs, had succeeded by her suggestions in overcoming the consultant's suggestions. However, it is an error to suppose that the pre-hypnosis status quo returned completely:

1. Gains in the nonsexual spheres were for the most part retained.

2. The patient's wife recognized her own active role in their sexual experiences and no longer responded with hostility to his premature ejaculation. She apparently recognized that it was a mode of response that fit in best with her own neurotic sexual inhibition. In fact, she made a definite move in the direction of more graciously accepting her feminine role in the marriage, including giving up her job and applying herself more good-naturedly to her role of homemaker.

3. The patient has expanded his understanding of his sexual inhibition in terms of early childhood negative conditioning. The details are not relevant to this paper; however, his psychotherapeutic progress would not have been possible if he had not first been relieved of his belief in his sexual incurability.

In the sexual sphere the marriage operates on a compromise level of adaptation, but he is optimistic that both he and his wife will make progress together in this regard. In all other aspects of the marriage, at work, and in the patient's social involvements the "ripple effect" is unmistakable.

Discussion

We would like to extract a few generalizations from this study as a forerunner of further investigations.

1. The therapeutic approach we have described is limited to a specific group of patients who came to us possessing basic personality strengths. These patients are not psychotic. They have considerable ability and have had a certain amount of success in broad areas of social interaction. However, they function with a handicap of emotional origin and as a result suffer loss of self-esteem, which causes in turn underachievement in a number of seemingly unrelated life roles. Removal of the symptom in question sets the stage for their learning new skills. With repeated success there emerges a sense of mastery and increased self-esteem. This in turn leads to increased effectiveness in all life roles.

2. We have found that the spirit in which the referral is made is a matter of no small significance. Suggestion, which underlies trance induction, begins in the office of the referring psychotherapist. When a referral is made destructively, in a spirit of rejecting a seemingly uncooperative or hopeless patient, or competitively, with the consultant expecting that his efforts too will fail, a patient

otherwise capable of induction may refuse to enter a trance state in order to comply with subtle, often unconscious cues from the therapist. Conversely, respect for the patient and the consultant, tempered with appropriate scientific objectivity, sets the stage for an experiment with a higher chance of success(4).

3. In the face of a laudable concern for therapy aimed at psychodynamically based insight and genuine emotional growth, there is understandable suspicion about interventions that seem to gratify infantile magical expectations and to reinforce passive patterns of relating to others. However, we cannot avoid the fact that these influences operate in all cases, whether the therapist wills it or not. We know how often a panic state can be relieved by simply giving a patient an appointment. Early symptom relief, including the so-called transference cure, is an almost universal occurrence, even when therapy is conducted in accordance with the most rigidly prescribed psychoanalytic procedure. And yet we also know that the ultimate emergence of insight is by no means foreclosed by this transient use of hope or magic. On the contrary, the experience of symptom relief and resulting gratitude can become a lever by which the patient is compelled to confront painful insights he might otherwise choose to avoid. In the words of Freud, clinical experience "compels us to alloy the pure gold of analysis freely with the copper of direct suggestion and hypnotic influence too"(1).

Finally, we wish to enumerate several of the advantages of using a consultant psychiatrist for ancillary hypnosis: This procedure makes hypnosis available to the patient even when the primary therapist is not versed in its clinical use. By focusing his concern on the removal of a specific symptom, the consultant therapist does not disrupt the intactness of the primary transference relationship. If the intervention fails, it is less likely to reflect negatively on the competence of the primary therapist or on the validity of his technique.

The impact on the patient of this type of referral is to emphasize the fundamental concern to help him rather than to maintain any personal aura of omnipotence on the part of the primary therapist. This tends to neutralize the patient's magical expectations and encourage him to make constructive use of all forms of help. If the intervention succeeds, the primary therapist is given a powerful lever to improve the patient's capacity for reality testing and emotional growth. The experience of *mastery* in relation to the circumscribed specific symptom exerts a "ripple effect," initiated by the consultant in that improvement also occurs in other aspects of personality functioning.

Summary and Conclusions

A group of patients with whom psychoanalytic psychotherapy had reached an impasse was studied. In each case treatment seemed obstructed by a persisting single symptom. The obstructing symptom was removed by a consultant psychiatrist by means of hypnosis. This hypnotic intervention was brief (one to six sessions), and in each instance the patient was returned to the referring psychiatrist for continuing psychotherapy.

Although it is commonly assumed that such a procedure is fraught with danger, the three cases presented illustrate the fact that removal of a chronic deep-seated symptom can be accomplished without deleterious sequelae. One patient had a recurrent pattern of panic in the midst of a professional qualifying examination. The others were victims of severe sexual impairments. In each instance, the experience of mastering the crippling symptom resulted not only in increased self-esteem but in psychodynamic clarifications as well. These in turn resulted in widespread clinical improvement and genuine emotional growth, a phenomenon called the "ripple effect."

Problems of patient selection, techniques of referral, the role of suggestion and hypnosis in psychoanalytic psychotherapy, and the advantages of using a consultant psychiatrist for ancillary hypnosis are also discussed.

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