On the couch with Lady Macbeth

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Freud's view that Hamlet represented the archetypal neurotic was mistaken. It was Lady Macbeth who was the more suitable case for treatment, says Dr ROGER JAMES who argues hypnosis is often the most appropriate tool for dealing with trauma

Nobody knows precisely how hypnotism works, nor do we understand how any kind of suggestion works. Why are some people persuasive even though what they say is nonsense and others fail to convince in spite of a good case in rational terms?

In what follows I shall simply take it that hypnotism is a fact and that it is very easy to induce a trance in a willing subject. I shall regard it as a technique, one of many, that can be employed in psychotherapy, and I shall limit my discussion of psychotherapy to behaviour that the patient himself wants to change rather than to what other people may want to cure him of. I shall assume it to be a fact that the behaviour that he wants to be rid of is consciously determined: he or she wants to give up smoking because it is bad for health, an expensive dirty habit etc; but while the will is there, there is something else that keeps the habit going.

For instance, an agoraphobic patient wants a normal life like anyone else. But going out can produce uncontrollable fear. And, usually, the cause of such fear is unconscious.

Obviously nobody likes to wake up every morning in a wet bed. Nobody means to wet their bed. It is something unconscious that interferes with the neural mechanism, usually established in the first two or three years of life, that either holds on during sleep or causes awakening so that the bladder can be emptied.

In all these things there is clearly a dissociation between conscious desire and an unconscious mechanism or fear that frustrates it. Hypnosis seems to be a technique whereby the therapist can speak to the unconscious while, as it were, bypassing the conscious. The interesting question is what should he do, having achieved this means of communication. Should he just tell the unconscious to stop it, should he attempt to simply suppress the undesired symptom, or should he attempt to understand what, if anything, lies behind the apparently irrational behaviour?

The dichotomy between symptomatic and radical treatment is not confined of course to psychotherapy. It is a dilemma of which every kind of doctor is aware. Do you give a patient an analgesic drug for a headache or do you try to find out the cause and treat that? The answer in ordinary medical practice is usually considered to depend on the circumstances. Is this an isolated headache or is it something suffered three times a week?

Rationally, what one attempts to do is to find out the cause and treat it if it seems likely that the cause is still operating. If the headache is due to a recent blow on the head then nothing can be done to undo the blow.

Is it rational to alleviate the pain and leave it at that? If the headache on the other hand is due to inflammation of the sinuses the question resolves itself into a matter of acute or chronic. If acute it is likely to die down of its own accord and again analgesia is rational. Chronic inflammation is by definition something that is ongoing, not usually self-curing. Here an attack on the inflammation itself and a search for what caused that – a broken nose and deformed airway perhaps – is in order. Can one carry the same principle into the realm of the mind?

I think the answer is sometimes yes and sometimes no. The psychic equivalent of a blow on the head, although it is a thing of the past, may have a continuing effect in the present through the mechanism of memory. One theory is that all our experience is recorded and available to the unconscious. A sight or sound or smell may recall the 'blow' in the past

Hypnosis' role in psychotherapy

and so activate the fear or whatever just as strongly as in the past. An early sexual experience, if it was very unpleasant, physically painful, frightening or humiliating, can go on having its effect. The sight of a penis or the feel of a man's hand on the breast can reactivate the feelings of pain, terror or inadequacy and make normal sexual gratification impossible. On the other hand, experience with hypnotherapy in smokers would suggest that in this case the cause, the thing – usually the longing to be grown-up – that made the body in adolescence overcome the naturally noxious smell and cough-provoking effect of inhaling tobacco smoke is entirely a thing of the past. The patient is and feels grown up now. Direct suppression of the symptom can in such circumstances be successful.

Rational

Freud describes how from 1889 onwards he made extensive use of hypnosis. He quotes an old medical saying that an ideal therapy should be 'rapid, reliable and not disagreeable to the patient'. Hypnotism, he says, certainly fulfilled two of these requirements; but it was not reliable. It could be employed in certain cases and not in others – surely true also of psychoanalysis – and then he says a curious thing: *'In the background there was the warning of experienced men against robbing the patient of his independence by frequent repetition of hypnosis'*.

Again precisely what is most seriously alleged against psychoanalysis? Whereas hypnotherapy is ideally a matter of a few sessions, psychoanalysis is routinely a matter of three or four sessions a week over many years. However, his more rational criticism is that it did not last. He describes successful treatments after which the symptoms recurred and required a repeat treatment in six months.

Another time, he says, *'during the treatment of an especially obstinate attack in a patient whom I had several times relieved of nervous symptoms, she suddenly threw her arms round my neck'* while hypnotised. This seems finally to have put him off hypnosis; but he explains his giving up in an irrational way as a revulsion against the method of direct suggestion, after he had already explained that he used hypnosis *'First with prohibitory suggestions and later combined with Breuer's System of the fullest enquiry into the patient's life.'*

He contradicts this later by saying that the difference between hypnotic and psychoanalytic suggestions is that *'The hypnotic therapy endeavours to cover up and as it were to whitewash something going on in the mind, the analytic to lay bare and remove something.'*[1]

Ernest Jones in his biography of Freud gives a slightly different explanation of why Freud abandoned hypnosis. He says that Freud had been unable to hypnotise many of his patients, at least as deeply as he then thought necessary. But Jones too agrees that it was the incident of the 'arms round the neck' that was the final straw. Freud, Jones says, had at that time begun to realise more and more that the success of the treatment depended on the personal relationship between therapist and patient.

The 'arms-round-the-neck' incident confirmed in his mind that there was an erotic element here. Psycho-analysis became more and more a matter of analysing this erotic relationship, the 'transference', as it came to be called, and Freud, according to Jones, freed himself from the *'mask of hypnotism'* which 'conceals the important phenomena of resistance and transference.' This also makes little sense as this intense 'transference' phenomenon had, according both to Freud and Jones, occurred during a hypnotic treatment.[2]

The realisation that much of what we do is motivated unconsciously had been increasingly acknowledged in European thought over the two centuries preceding Freud. But it was Freud who introduced the concept of 'the unconscious' as part – and the larger part – of the mind. There was nothing new in the realisation that a lot of the working of the body, breathing, heart-rate, digestion, and so on is carried on unconsciously.

'Freud's greatness', says L.L.Whyte, 'lies not in any of his particular ideas but in the fact that he compelled the race to face the problem of finding an adequate concept of the unconscious mind. He showed, once and for all, that the unconscious is so powerful that this task cannot be neglected'.[3]

Mythology

However, J. M. Roberts in his history of the world, says of Freud that his importance beyond science lay in providing a new mythology which was to prove 'highly corrosive'. 'The message men took from Freud', Roberts continues, 'suggested that the unconscious was the true source of most significant behaviour, that moral values and attitudes were projections of the influences which had moulded this unconscious, that therefore the idea of responsibility was at best a myth and probably a dangerous one, and that, perhaps, rationality itself was an illusion . . . This was what many people believed he had proved – and still believe'.

Roberts goes on to say that 'such a bundle of ideas called in question the very foundation of

1. Sigmund Freud: Introductory Lectures on Psycho-analysis, Allen & Unwin 1922, pp375-6

2. Ernest Jones: The Life and Work of Sigmund Freud, (abridged edition), Penguin Books 1964

3. J.M.Roberts: The Hutchinson History of the World, Hutchinson 1976

liberal civilisation itself, the idea of the rational, responsible, consciously motivated individual, and this was its general importance'.[4]

Nevertheless, one can only say thank God for Freud when one reads what pre-Freudian psychiatrists – and his contemporaries who had not yet heard of him – did to their patients. Virginia Woolf provides a marvellous case study. To us, looking back and with our insight that owes so much to Freud, it is obvious that sexual interference by her half-brothers, who were there ostensibly to protect her, was a major factor in her neurosis. None of the psychiatrists who attended her realised this and three out of the four probably never knew that it had happened. Indeed their conduct was characterised by what seems to us now to be an extraordinary lack of curiosity as to the cause of such mental perturbation – leading on several occasions to suicidal attempts or intent – in a young woman so well endowed and gifted.[5,6]

The idea of 'the unconscious' was novel, immediately attractive and yet perhaps terribly mistaken. It has certainly very much popularised the notion, that may well be mistaken, that there is in fact what Freud called in the passage quoted above 'a something in the mind', a something 'at the root' of everybody's psychological difficulties, a something that has to be uncovered, understood, excised, exorcised, abreacted or in whatever way 'removed', before cure can be achieved. A similar concept, in this case definitely mistaken, deludes many physically ill people who cling to the example of that very satisfactory illness, appendicitis. Here all you have to do is to 'get to the root' of the trouble – the inflamed appendix – cut it out and the patient is as good as new. Unfortunately, appendicitis is almost unique. There are practically no other illnesses like it, with the possible exception of gall-bladder disease and some tumours.

Those who believe in the group of treatments for psychological disorders that may broadly be called behaviour therapy, that depend on the conditioning theories of the Russian psychologist, I. P. Pavlov, are quite certain that the theory of the hidden something, that 'core' of the neurosis, which must be uncovered but not smothered, is totally mistaken. You don't have to believe in conditioned reflexes – as I don't – you merely have to concede that individuals *do* learn to see the sense of their point of view. It is that, what is wrong, is always a wrong learning; and the problem for the therapist is to find a way of changing the position of a switch. You don't need to know why the patient learned the wrong behaviour in response to a certain situation; what you have to do is to switch him to the right one. If this is successful the 'something' is not smothered or whitewashed. It ceases to exist.

Wolpe says for example that Freud, having observed patients cured when they recalled and narrated the story of the precipitating experience, concluded that the symptoms were due to the imprisonment of emotionally disturbing memories. He quotes Freud as saying: *'We are of the opinion that the psychic trauma, or the memory of it, acts as a kind of foreign body constituting an effective agent in the present, even long after it has penetrated . . '*[7]

Facilely popular group therapy is undoubtedly related to the fact that reliving a painful experience in the group situation may make the entire experience worse . . .

There can be little doubt, Wolpe thinks, that this statement would not have been made, and 'the mind-structure theory that is psychoanalysis would not have been born, if Freud could have known that memories do not exist in the form of thoughts or images . . . but depend on the establishment, through the learning process, of specific neural interconnections that give a *potentiality* of evocation of particular thoughts and images when and only when certain stimulus conditions, external or internal are present.'

The behaviour therapists' most effective technique has been developed by analogy with a known physiological phenomenon, that of reciprocal inhibition, which is a fact of the nervous system of the body. Take for example the ankle joint. There is one group of muscles – situated in the calf – which bend the foot and toes down, the muscles that are activated when you stand on tiptoe. Another group of muscles in the front of the leg pulls the foot and toes upwards. If the group that bends the foot down is in operation the opposing group is automatically inhibited. The system is 'wired' like a traffic light system. When the green light shows to one road, green cannot be shown to the cross road.

4. Lancelot Law Whyte: The Unconscious before Freud, Tavistock Publications 1962

5. Quentin Bell, Virginia Woolf: A Biography, Triad/Palladin 1976

6. Stephen Trombley, All That Summer She Was Mad: Virginia Woolf, Female Victim of Male Medicine, Continuum, New York 1982

7. Joseph Wolpe: Psychotherapy by Reciprocal Inhibition, Stanford University Press, 1958

One can demonstrate and use this physical reciprocal inhibition to alleviate an episode of cramp. When there is pain in the calf due an intense spasm of the muscles there, it can be relieved by consciously and actively – i.e. not with the hand – pulling the foot upwards. Bringing the opposing muscle group into operation automatically inhibits the contraction of the calf muscles and relieves the cramp.

In the psychological sphere, there are moods which are mutually inhibiting. One such pair is anger and fear. You cannot experience both at once.

Christabel Bielenberg, in her brilliant and moving account of her own unique experience, [8] an Englishwoman married to a German in Germany throughout World War II, gives a vivid example of this. She describes how, while waiting to be interrogated by the Gestapo in a concentration camp where her husband was imprisoned, she became incensed at the humiliating treatment that she witnessed of a middle-aged prisoner by a clerk taking a statement. She was so angry as she went into the interrogation room that her fear was overcome. In introducing the television series on her book, she emphasised even more than she does in the book itself how this anger saved her from fear and ultimately probably saved her life and her husband's too. In similar circumstances people are apt to describe it as forgetting – 'I was so angry I forgot to be afraid'. But it is more than this. **Anger drives out fear**. It is impossible to experience both at the same time.

Christabel Bielenberg
... her anger overcame her fear

In practical psychotherapy, muscular relaxation and general bodily feeling of comfort are more often used to inhibit anxiety. The agoraphobic patient, for example, is exposed to the anxiety-provoking outside world in the relaxing company of a friendly and sympathetic nurse, perhaps first in the dark, when the anxiety is likely to be less intense, and so de-sensitised. Day-by-day, the provocation is increased as the lesser stimulus is tolerated. This time-consuming process can undoubtedly be shortened by the use of hypnosis. For what is experienced in the trance state is in some way intermediate between the imagination and real life. For the hypnotised patient to leave him or herself in the chair and go outside, takes rather longer than for the wide-awake patient to imagine doing this, but it is much quicker than doing it in real life. Similarly, probably the emotion experienced is greater than in imagination, but less than in reality.

In the trance, the patient can go further and further into the outside world, quickly and frequently, and be subjected to more and more intense stimulation and all the time be relaxed in the comfort of the trance. It seems likely that the treatment does not work unless some anxiety is experienced. Anxiety has to be experienced if the patient is to learn how to turn it off. In his book Battle for the Mind, [9] William Sargant describes how sedation was used during the war to deal with neuroses resulting from battle experience. The aim of the treatment was 'abreaction', the re-experiencing in all its intensity of fear experienced at the time. He says that during the World War I, hypnotism was more used for the purpose. In 1940, sedation with barbiturates was used and by the end of the war he was preferring Ether, as he found that a more explosive kind of abreaction could be achieved with it than with either barbiturates or with hypnosis.

It is clear that similar therapeutic techniques can be used under both chemical sedation and hypnosis. Ether or other drugs may well have been better in the highly unusual circumstances of war – unusual because the patients were usually men who had until some recent traumatic incident been functioning quite normally. The advantage of hypnosis, in the more usual civilian circumstances, would seem to be that hypnosis is more under the control of the therapist.

The patient is responding to him rather than to an impersonal influence. Abreaction can be brought about in either case but the hypnotist, in contrast with the user of sedatives, can terminate the trance quickly, leaving no after-effect. But, what is probably more important is that, under hypnosis, amnesia can be suggested. The patient can be asked to explore a traumatic situation and told that he will remember nothing of it on awakening, that he will not have to 'confess' to the therapist, who is not going to 'probe'.

The unconscious can be told to work on the material, to re-arrange the jig-saw, to re-learn the response, without, as it were, informing the conscious. This may well make it easier for a patient to go back to the real memory, knowing that he is spared the embarrassment of having to

8. Christabel Bielenberg: The Past is Myself, Corgi Books 1984

9. William Sargant, Battle for the Mind. Heinemann 1957

Lady Macbeth . . . neurotic symptoms?

share it with the therapist.

The danger of the facilely popular group therapy is undoubtedly related to the fact that reliving a painful experience in the group situation may make the entire experience worse by now associating it with the embarrassment that arises from public disclosure or confession.

In determining what sort of therapy is appropriate, we have also to bear in mind what might be called the Hamlet-Lady Macbeth dichotomy. Freud cited Hamlet as a kind of archetype of the neurotic; but undoubtedly many so-called neurotics are better typified by Lady Macbeth, and this example shows the danger of the medical model, of seeing neurotic symptoms as manifestations of an illness, which implies something that has happened to one, something for which one is in no way responsible.

Guilt feelings

Lady Macbeth's obsessional hand-washing and her inability to sleep were clearly the consequence of her own guilt, not just what Freudians are prone to dismiss as guilt-feelings, but real guilt about her dominant part in cold-blooded murder.

Her own doctor's comment was entirely apt: 'More needs she the divine than the physician'. [10] A successful 'cure', a successful relief of her guilt, might enable her to murder again without feeling guilty, in other words convert her from a woman of sensibility into a psychopath. What she needs is to realise her guilt and then probably to be encouraged to expiate it by self-sacrifice of some sort – to accumulate a positive balance of good deeds over evil. But in many cases it is a matter of 'guilt-feelings', where the patient needs reassurance that what he has done is no more than rebel against harsh attitudes instilled in childhood. Guilt about sexual activity is a typical example.

Whether you believe, *pace* Freud, in a structured mind which, in the case of neurosis, has a fault that needs to be reassembled, or whether you believe, as with behaviour therapy, in what is essentially a re-education, that the fault is unconscious and the patient cannot by an effort of will put it right.

Hypnosis is a tool which provides quick access to 'the unconscious' or the unconscious processes and connections of the mind and, in many cases undoubtedly enables a quicker cure to be achieved than might otherwise be effected. But we are dealing with individual, highly idiosyncratic matters. No two patients are the same. Each one has had very different experiences and learned very different things.

The hypnotherapist must always take time to talk to the patient in order to assess in the first place whether hypnosis is appropriate and, if it is, what kind of therapy he will attempt under its influence.

10. Shakespeare, Macbeth, Act V, Scene 1.