Uses of Hypnosis with Multiple Personality

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In 1837, a report which may well be the first record of a successful treatment of multiple personality disorder (MPD) described a cure by hypnotherapy.1 Over the course of time the use of hypnosis in the therapy of MPD has waxed and waned.

In recent years most clinicians who have taken a serious interest in the investigation and treatment of MPD have found that hypnosis can make valuable contributions toward efforts to help these patients achieve symptomatic relief, integration, and character change. Allison,2-4 Braun,5-10 Brende,11 Caul,12,13 and Klufi14 are among those who have written about such interventions, and described their effects. Braun6,7 has offered a tentative and preliminary description of the neurophysiological changes which accompany this process; Klufi has described the stability of treatment results.15

Despite this, the use of hypnosis with these patients has been, and remains, controversial. Over the years, many prominent individuals have stated or implied that hypnosis can create multiple personality. Several other figures echo these cautions, and some investigators have used hypnosis to produce phenomena which have been described as multiple personality.1,3,5,14,16-18

In response to those opposing the use of hypnosis, Allison states: "I consider hypnosis a method by which one can open the Pandora's box in which the personalities already reside. I do not believe that such hypnotic procedures create the personalities anymore than the radiologist creates lung cancer when he takes the first x-rays of the chest."12 He goes on to urge the use of hypnosis in both the diagnosis and treatment of multiple personality. Braun supports this view in his article, "Hypnosis for Multiple Personality"9 and offers arguments to refute the concept that hypnosis creates multiple personality.5 Working independently, Klufi, in an award-winning article, strongly challenges the ideas that hypnosis creates multiple personality and is contraindicated in its treatment.14 Elsewhere, he reports statistics on a large series of cases (many of whom had treatment including hypnosis), and advances testable criteria for fusion (integration).15

Klufi14 and Braun5,9,10 found that reports of the experimental creation of multiple personalities with hypnosis were rather overstated. Experimenters have created phenomena seen in association with and analogous to multiple personality, but did not create a case of clinical multiple personality. Harriman produced automatic writing and some role playing, but not full personalities.10-21 Kampman and Hirvenojja22 and Kampman23 asked highly hypnotizable subjects to "... go back to an age preceding your birth, you are someone else, somewhere else." The resulting behaviors were taken to be alternate personalities. However, to be a personality, an ego state must have a range of emotion, consistent behavior, and a separate life history. Klufi14 and Braun5 show that none of the authors criticizing the use of hypnosis with multiple personality produced phenomena which met these criteria. It is widely known that ego state phenomena short of MPD can be evoked with or without hypnosis. A form of therapy has been developed to capitalize on this.24

Allison,3,4 Caul,13 Braun,5,8,10 and Klufi14 all concluded that there is no established contraindication to the judicious
use of hypnosis in the diagnosis and treatment of multiple personality. All emphasize the need to proceed with care. Their work describes the use of hypnosis for symptom relief, ego building, anxiety reduction, and the building of rapport. It can be used as well for diagnosis (by facilitating the switching process). In the treatment it can aid in history-gathering, creating co-consciousness, and achieving integration. After integration it has a role in dealing with stress and enhancing coping skills.

GENERAL ISSUES CONCERNING HYPNOSIS

Allison,4 Caul,13 Braun,5,7-9 Bliss,25 and Kluft14 have reported that multiple personalities are good hypnotic subjects. One can take advantage of this to expedite both diagnosis and treatment. Access to the several personalities can be facilitated. After inducing trance, one can teach the patient to respond to cue words (called "key words" by Caul12) so that future inductions can be achieved more rapidly.

In determining whether or not to use hypnosis, it is recommended that it not be undertaken unless the clinician has specific therapeutic objectives in mind and can anticipate the possible outcomes of the intervention. If the results are as expected, one is likely to be on the right track. If not, one must clarify one's understanding before proceeding. Poorly planned hypnosis can cloud issues.

When hypnosis is employed, the therapist must formally "remove" the trance before the session ends, and reserve enough time to process the sessions and help reorient the patient to the current time and place. In emerging from trance, a sense of disorientation is common. This is accentuated in MPD, because the trance experience is akin to their switching process. Patients may complain of a "hangover" effect if a trance has not been removed properly.

USES OF HYPNOSIS FOR DIAGNOSIS OF MULTIPLE PERSONALITY

Our discussion begins with a renewed word of caution. As noted above, one cannot "create" multiple personality, but the injudicious use of hypnosis (via pressure, shaping responses, and insensitivity to demand characteristics) may create a fragment3,9 or elicit an ego state which can be misinterpreted as a personality.14

I withhold the use of hypnosis until I have exhausted other means. One consideration is to avoid difficulties and criticism (inducing artifacts). A more substantial reason is that since these patients have often been abused, I do not want to do something abruptly or early on that might be perceived as another assault. Spending extra time in observation and building rapport is generally worthwhile.

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Once the decision is made to use hypnosis, I proceed by doing an induction, and at times, teach self-hypnosis. Merely inducing hypnosis and observing often suffices to yield the material needed to make the diagnosis. The serendipitous discovery of MPD during hypnosis for other problems has been reported by this author7,9,10 and others.15,14,17,18,25,26 A major part of the session is conducted with the patient in a hypnotic trance. If the necessary information is not forthcoming, use is made of material that the patient has disclosed, including inconsistencies, to probe further. "Talking through" has also proven useful.9,14 In this technique, one talks through the current host personality using statements aimed at underlying personalities, who are presumed to be listening. When doing this, one pays careful attention to facial expressions, posture changes, movements, and response patterns to observe subtle shifts. One notes the topics under discussion when these occur. When the host appears confused by the words spoken by the therapist and there are data to indicate the existence of another ego-state, one might say, "I'm not talking to you," or ask if there is anyone else inside. Finally, an attempt can be made to call out another personality by inquiry about a troublesome event: for example, "Will whoever picked up the man and let Mary find herself in bed with him, please be here and talk with me?"

Hypnosis can be used to confirm a suspected diagnosis. One may move faster when doing a consultation than when working with an ongoing case. When working with limited time, a consultant may miss the diagnosis due to insufficient rapport and trust. On the other hand, he may get some information more easily because it was withheld from the primary therapist for fear its revelation would prompt rejection. There also may be an empathic connection between an experienced consultant and an alter personality which allows it to come out when it was previously reluctant or unable to.

When other personalities have been out, the host may notice that he or she cannot recall what happened during parts of the session. When confronted with the existence of "others," the denial shown by some personalities can be astonishing. A confrontation using tapes (especially videotapes) of previous sessions can be invaluable, but denial can override this evidence also.
Timing is critical. If the patient is confronted with the diagnosis too early, before a good therapeutic alliance has been established, he or she may avoid future therapy. Multiple personality patients test the doctor and the therapeutic relationship almost continuously and rather excessively. If a therapist waits too long, the patient may believe that the therapist is unable to help him or her because early “obvious” cues had been missed.

With the therapist’s and the patient’s mutual acceptance of the diagnosis, specific treatment for MPD can begin. Prior to this point, many non-specific benefits of therapy may be realized, but the core pathology remains largely untouched.

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THE USE OF HYPNOSIS FOR PSYCHOTHERAPY WITH MULTIPLE PERSONALITY

In 1974, Allison published the first modern treatment plan for MPD which involved the use of hypnosis.27 Cauble elaborated upon it in 1978.12,13 Braun offered an expanded protocol.9 Two recent articles by Kluft listed relevant interventions and gave a detailed examination of successes and failures involving hypnotherapy and other methods.14,15

Overall, the first step consists of establishing rapport and some modicum of trust. Then hypnosis can aid in furthering the therapeutic relationship. No matter how much these patients are reassured that they cannot be “controlled” via hypnosis, their fear of loss of control will persist until they have experienced formal trance. Thereafter heterohypnosis may facilitate rapport via its association with autohypnosis, which has rescued them many times before from overwhelming circumstances.

Hypnosis can be used to call out personalities so that they can be treated or express their feelings about the issues at hand. When a personality is called out, it may or may not be in trance. Sometimes a second level of hypnosis (multi-level hypnosis) must be used to help this personality recall a memory which has been repressed. An hypnotic age regression technique can be useful at this time. If this is done, one must remember to orient the personality to the current place and time to end both levels of trance.

Various personalities will need to be contacted in order to obtain contracts such as to work in therapy, not create new personalities, not be violent, or not to commit suicide/homicide. The specific suicide/homicide contract I use is a modification of one proposed by Drye et al.28 The wording is, “I will not hurt myself or kill myself, nor anyone else, external or internal, accidently or on purpose, at any time.”

I first ask the patient to just say the words, not to agree to anything. I observe and ask how the patient feels about it. The first modification is usually around self-protection, “Can I fight back if I’m attacked?” This will be agreed to if it is specified that the protection is from a physical attack from an outside source. The second is the duration of the contract. This can be modified for a set period of time down to 24 hours or until the therapist physically sees the patient again, whichever occurs last. If I do not get a clear contract which I feel is secure, I will commit the patient to the hospital. This contract cannot be allowed to expire without renegotiation. If this happens, it will be seen as a lack of concern and/or permission or instruction to “act out.”

Histories may be gathered by collating information from several personalities about certain time zones or incidents. Their stories will often fit together like pieces of a jigsaw puzzle. With sufficient yet incomplete information, the missing pieces can be deduced and then found.

The personalities individually are capable of repression, but often they do not repress information the way non-MPD patients do. Instead, information might be shifted to another personality. The affective and the informational aspects of the memory may be held separately. Another way of dealing with the stimulus overload is to store sequential segments of an event in different personalities so one personality or the system of personalities is not overwhelmed.

Information can be retrieved by tracing the affect, using an affect bridge technique.26 In doing this, one builds a given affect until it is all-consuming, then suggests that it stretch out through “time and space” until it attaches to another event which had a similar affect. The patient can then “cross the bridge” and describe what is seen.

This author has modified the technique by allowing the affect to change. One thereby learns about the connection of affects, ideas, and memories. For example, one may start out with anger and trace it back in time to an event where fear was involved as well. At this point, fear could be traced in a similar fashion and might yield information about an incident of child abuse. Such discoveries help to unify the affect and the historical information.

If the information about an event was so overwhelming as to force sequential memory encoding across personalities, then the best way to retrieve it is to start with the facts of the event and discover who knows about it (not necessarily gathering the details). Next, locate the personality who has the last piece in the sequence. Obtain what information it has and from whom it took over. Follow this chain backwards using hypnosis to call forth the personalities and to calm them, allowing them to relate the needed information. While this discovery process is going on, each personality can be desensitized by multiple abreaction techniques, learn coping skills via rehearsal in fantasy, and gain mastery through hypnotic manipulation of the contingencies.

Age regression and age progression techniques are useful for gathering information about specific life events.2,6 A patient known to have two lines of personalities can be given a set of ideomotor signals: movement of index finger would

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be understood to mean yes, thumb—no, and little finger—stop. Stop is used to give the patient some control and avoid a forced choice situation.

This author uses the term “cue words” (or phrases) to describe the word(s) established as hypnotic induction cues or signals. Caul first described their usefulness in MPD especially for the protection of the patient and the therapist. Cues cannot be relied upon exclusively for this. However, they do reduce the time spent on induction, especially if one is going to do multi-level work (for example, using hypnosis of one personality to contact a second which will be treated hypnotically).

Cue words are valuable in negotiating matters such as who will be in control of the body and when. In this way certain goals can be accomplished and internal disputes can be settled before an incapacitating escalation of conflicts takes place. For example, a personality dedicated to hedonism and another trying to complete graduate school might be helped to an accommodation.

After needed information is gathered, the psychodynamic issues of each personality must be worked through so that integration will yield a functional whole, not one paralyzed by conflict. This phase of therapy is done with or without hypnosis, as circumstances suggest. For an excellent discussion of the fate of integrations based on insufficient working through, see the outcome data reported by Kluft, who also discusses other pitfalls.

The next step toward integration, or fusion, is the establishment of co-consciousness: the ability to communicate with, and be aware of, what other personalities are thinking and doing. This can be established initially using the therapist as the “switchboard,” with each personality telling the therapist and the therapist telling whomever. Later it may be done via an Internal Self Helper (ISH), internal group therapy with the ISH or therapist as group leader, or without any intermediary. At this point, integration may occur spontaneously, but often needs a push and the aid of a ritual, usually hypnotic.

Integration ceremonies have been described by Allison and Kluft. They use various fantasy techniques such as going into a library, reading about, and absorbing others; various forms of flowing together as streams into a river or the mixing of red and white paint to get pink, etc.

Successful and lasting integrations have physiological components. Some patients report that stimuli are greater, things and colors seem sharper, color blindness is lost, allergies are lost or found, eyeglass prescriptions need changes, insulin requirements change drastically, etc.

At first reading, there also appear to be neurophysiological changes that go along with the psychophysiological ones.

The final integration which meets Kluft’s criteria still represents only about the 70% mark of therapy. If the patient has not learned self-hypnosis before, teaching it is valuable at
this time. It can be used to learn new coping skills such as relaxation, assertiveness training, rehearsal in fantasy, etc. For protection from overstimulation, an adaptation of All- son's "egg shell" technique is very useful. One imagines a healing white light or energy entering the body (via the top of the head, umbilicus, etc.), filling it up, coming out through the pores and laying on the skin as a semipermeable membrane. This membrane is as moveable as the skin, but protects the patient from the "slings and arrows" of life like an armor.

Deep hypnotic trance can be used... as a coping skill and healing process.

It serves to damp down stimuli so they can be observed and registered without inundating the patient and causing blocking, denial, and additional dissociation. The patient needs to be assured and reminded that stimuli will be moderated so that they may be responded to appropriately, but nothing important will be missed.

Deep hypnotic trance can be used (like meditation) as a coping skill and healing process. This is equally true both before and after final integration. I first learned of this from M. Bowers, in October 1978. The patient is placed into, or goes into, a deep trance and continues to deepen it over an extended period of time. Usually, it is suggested that the mind will be blank until a prearranged signal is heard. This may be an alarm clock, a danger stimulus, or a cue from the therapist. Occasionally it is useful to suggest that the patient will work unconsciously on "X," or have a dream about "X."