DISCUSSIONS ON HYPNOSIS AND SCHIZOPHRENIA

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Abstract: A classic paper in intellect and argument, this article contains a transcript of a conversation between Jay Haley, John Weakland, and Milton Erickson as they discuss the role of communication in hypnosis and schizophrenia. In 1955, schizophrenia was considered primarily a psychological disorder. Whereas today schizophrenia is mostly considered a biological disorder, this very early, unpublished paper still gives much food for thought and a further glimpse into Haley and Erickson’s thinking and intellect at a fervent time in schizophrenia research.

Below is an abridged transcript of one of the conversations that Jay Haley (H) and John Weakland (W) had with Milton H. Erickson, MD (E), in 1955 on the similarities and differences between schizophrenia and hypnosis. The conversation took place in Erickson’s home. This is a lively debate about the interpersonal vs. the intrapersonal views of the relationship between hypnosis and schizophrenia. These conversations give the reader a glimpse into early discussions that preceded the many publications on this subject.

—Madeleine Richeport-Haley

E: All right. Now what is on your minds, gentlemen?
H: We want to know, to begin with, whether you think there are any similarities between schizophrenia, or the manifestations of schizophrenia, and the manifestations of hypnotic trance.
E: Similarities and not identities.
H: Either.
E: Well, let’s preface that with a kind of an analogy. The fever in dehydration is very similar to fever in typhus or pneumonia, but they are totally different kinds of fever. . . . The significance to the body is totally different. There are numerous similarities in the behavior of the schizophrenic. But their significance to the hypnotic subject and the significance to the schizophrenic subject are, in my estimation, totally different.
W: Could you tell us a little bit about what way you see them as different?
E: The hallucination for a hypnotic subject constitutes a subjective experience in which he is utilizing subjective experience comfortably, agreeably, for something that he regards as a legitimate purpose. And he is aware that he exercises some kind of control over it. The same hallucination for the schizophrenic is a subjective experience, but of a different category in that he feels it no part of himself, as something out of his control, something that really occurs regardless of any purpose or desires of his.

W: How would this go with hypnotic hallucinations that I have read of, that are apparently those to which the subject reacts with fright. In other words, you see examples certainly in stage hypnosis. You tell the subject a lion is in the room, and he appears to be very frightened.

E: That’s right, and so he reacts very much as the schizophrenic patient does, who also sees a subjective tiger. But the hypnotic subject has an awareness of some kind that this is the situation now. He does not have the sense of immediate continuation—that experience as a permanent thing. Just as you have the awareness now that you are a man, and you are aware of the fact that you are going to know that 20 to 30 years from now. That’s part of your knowledge that you are a man—it’s an essential part of it. Because, as a girl who is asked to sense herself as a man, senses herself now, and only now as a man, the hypnotic subject senses the tiger now, and only now as a tiger, without that element of continuation indefinitely.

W: It makes a great difference then that it is a limited part of his experience even though it is very real at the moment.

E: Very real at the moment, but there is that element of the continuity—continuation rather than continuity. The child can sense himself as the child, but he has a very definite feeling that “someday I’m going to be a man.” Childhood has a certain feeling of continuation and yet at the same time there’s a realization that it ends.

H: I wonder if the schizophrenic has such a feeling that it’s going to continue—that he’s going to continue to see this tiger?

E: But, is it really out of his control, or is it really in response to the situation in which he finds himself?

W: That raises the question of what we think about schizophrenia. Is that in response to a certain situation?

H: Yes, we assume—and are getting certainly more to assume—that symptoms of schizophrenia are a response to a situation they are in.

W: Or have been in.

H: Or the situation as they see it, which means the way it was before maybe.
E: Yes, and a hypnotic subject experiences his hallucination in terms of a specific subjective experience, of being put into a trance. And it relates to what he can do and what he can’t do in a trance state.

W: This frame would be something, in a sense, separate and limited then?

E: You can swim—know all the feelings—and yet no matter how aware you are of your feelings of swimming you have to get into the pool. And there you really experience your feelings of swimming, in the pool—a limited situation, that’s where you really swim. To experience a hallucination in a trance state, you experience it in a trance state in that circumscribed general condition. So it’s a part of a situation, just as your swimming is a part of the pool situation or the ocean situation. And it is your part of the ocean or your part of the pool where the swimming occurs. The hypnotic subject experiences these hallucinations in that sort of constricted degree.

W: What about someone who is put into a trance without so much of the usual framing, say without the mention of trance or hypnosis but by an indirect technique of induction in what appears to be, say, a social setting. Does this limitation still apply there equally, and if so what defines it then?

E: The person who goes into a trance does so by virtue of a progressive loss of contact with reality—certain realities. You, for example, as you listen to me are aware of the ashtray over there, the curtain in front of the door, the cooler. And yet at the same time your attention is directed primarily to me, you are aware of the things’ position. It has a part of your attention. And the person who goes into a trance state loses that contact with reality. You will be aware of it just as soon as he even changes his position, and you can make allowance for that. . . . When the subject goes into a trance, he loses contact with reality, loses contact with a great deal of the environment. The subject is able to redirect the attention behavior, and appraise the fact that this has happened, that this person has shifted his arms and crossed his legs, but that’s a separate bit of awareness. With you, as you listen, you’re going to be aware of it anyway, whether you’re paying attention or not. There’ll be that subliminal registration. The hypnotic subject does not have to do that; they slip out of the environment except for certain reserved parts.

H: That seems to be one of the things the schizophrenic doesn’t do. He seems so damn aware of everything that is going on all the time—

E: He often is exceedingly aware, even in the stuporous state. But none of it fits into deciding the issue. When Johnny would be holding court, he’d sit on throne, and listen to the court jester. And yet, despite the evidence of all that hallucinatory behavior and activity, Johnny would some way register the ward nurse, register ward events. When in the delusional state, there was no ward, there was no possibility.

W: Isn’t it possible also to see that sort of thing in a subject? Put him in a trance, have him hallucinate something, and yet at the same time proceed to passively register what proceeds in the room.

E: Yes, you can do that—as a controlled and directed activity. But it occurs in the schizophrenic when he’s got no control or free choice of any sort. It just happens to him.

H: Let’s put it this way, if you were brought into a room with a guy sitting in a chair—maybe in a stupor, maybe not—how would you tell whether this guy is schizophrenic or in a trance? We see patients around the hospital, and
it would be very difficult to tell. They look like a trance subject sometimes. Or those nice photographs in Kraepelin’s book.

E: That is the catatonic stupor in which catalepsy is shown.

H: Now, what’s different in appearance about a patient like that from a trance subject in a similar posture?

W: It’s not necessarily a question of appearance. First, is there something different in appearance, or is there something else?

E: Well, a catatonic, stuporous patient lets the hypnotist position his arms—and anybody else. “It’s something that’s within him.” The hypnotic subject responds to the hypnotist, and only those with whom he has rapport.

W: That could be generalized, though, couldn’t it, by instructions, “When anyone lifts your arm, it will just stay where he lifts it.”

E: “When anyone lifts your arm it will just stay put.” Now if I asked you to do that, how would you define the word “anyone”?

W: But, I’m not in trance, now.

E: No, but in a paper I published some time ago on the ability of subjects to be unaware of stimuli, I told Tommy, who was my subject, to be in a deep somnambulistic trance, and not to let anybody in any way discover that he was in a trance state. And Tommy was succeeding. And when any unexpected person came into the office, Tommy responded to him. Even though Tommy had met my friend Hugh, and Hugh lived in Chicago—and this occurred in Eloise, Michigan. Hugh, without my knowledge, dropped in from Chicago to visit me. And that was a contingency which did not and could not concern him. So he didn’t know that Hugh was there.

E: He had defined “anyone,” as “everyone,” as all persons.

W: That he might expect.

E: That could be expected in Eloise, Michigan. Hugh, coming from Chicago, didn’t come under that definition.

W: I am not sure that there is not some difference, though, according to who picks up the arm of a patient in a catatonic stupor.

E: All right, and the catatonic patient with cerea flexibilitas-like catalepsy, you lift his arm, and it’s really defined as waxy flexibility. Catalepsy appears to be similar. But it’s a waxiness in the catatonic, it’s a responsiveness in the hypnotic subject; thus with a downward touch—pressure—then the arm moves just that far. And if the arm is squeezed, but squeezed with a slight upward pull, then response is made to that, there’s an interpretation. In waxy flexibility in the catatonic stupor you are responsible for the movement. The hypnotic subject responds to an understanding.

E: Does that happen with a hypnotic subject who has dissociated an arm? Like that kid in San Francisco who didn’t know his arm was in the air? If you lift that arm, does he still interpret what you want him to do with that arm?

E: If you get good dissociation, and he sees his arm in mid-air, when it’s actually resting in his lap, he has no catalepsy in the arm in his lap. There is no arm there.

W: No but you can do it the other way. When he sees the arm in his lap and it’s really in the air, then does he respond to minimal cues to the arm when it’s up here and he thinks it’s here (in the lap)?
E: He can do two things: He may not respond to any touch on his arm in mid-air when he thinks it’s in his lap. Or, he may respond to the touch by noticing that the arm in his lap has been touched.

W: [laugh] That’s a nice piece of interpreting.

E: You look down to see what you are doing with that arm, and can get very much confused at you trying to push down his arm down still further when it is resting on his lap and can’t go further.

W: He must get even more confused if you succeed in pushing his arm down a few inches.

E: Then that results in the sense of pressure. Because his arm being in his lap, obviously you are pushing it down. Obviously this total experience tells me “there is pressure there,” so he has the pressure there—a sense of pressure on his leg, a sense of pressure on the polar surface of his hand and arm.

W: Well, if you think of this matter of the subject, what comes to my mind is an illustration that I read in Bleuler. About a catalepsy which sounded very much like something that might be done with a subject. Just a little indirectly. Bleuler gives this example because he often found a patient in whom other people had been moving the arm without demonstrating catalepsy, but he accomplished it by a slightly indirect procedure. He would come in and take the patient’s pulse, raising his arm and holding it out to do so. After taking his pulse, he would merely take his hand away, leaving the arm in mid-air, where it would remain.

E: That’s right. Often in hypnotic subjects you do not spontaneously develop catalepsy. The same procedure can be employed. And that’s their first discovery of catalepsy.

W: Well, it seems remarkably similar.

E: Very similar. Now, my feeling about the catatonic who does not show that catalepsy until you elicit it by such a procedure, they are rather sluggish in thus functioning and you’re merely providing time. You take their pulse, and then the arm becomes cataleptic.

W: I think those illustrations could also be looked at in a little different way, from the standpoint of different sorts of suggestions, different sorts of operation that indicate or control behavior, and different sorts of acceptances followed by whoever’s arm is being lifted. If you look at it on the basis of the relations between the two people and what would be indicated back and forth. The matter of time may be involved, but it is a different sort of indication to somebody to raise the arm directly. It’s a possibility that in some cases it may produce a cataleptic effect. That’s one thing. And to raise it slowly is a suggestion, but what might be considered a milder but more sustained suggestion. There are different ways, it seems to me, that you could look at why this effect is produced. And the angle from which we have been looking at is mainly the control angle.

E: I knew the patient, Laura, who was slow in her development of a good catalepsy. I would have Joe, one of the residents, enter the room from the rear, so Laura couldn’t see. And Laura was very much dissociated. If you would move her hand out of her lap to her side, it would take her quite a bit of time to discover the movement. And Joe could take her hand, if she happened to lift it, and lift it with a stop watch—no catalepsy—in so many seconds. With a sufficient number of seconds, there’d be catalepsy.
If Laura were to sit down in a chair and cross her legs, and if she had enough time, extending her leg and shifting her position, she’d develop catalepsy all right. Now, taking a rug out from under her feet, if you yanked it quickly enough, Laura’d lift her feet and drop them. But if you brushed something from the rug in the process of her moving from the rug, Laura’s feet would stay up in the air. So there seemed to be a time element, or was it a process of forgetting? Adaptive time treatment.

H: There is a basic difference here. I mean, you seem to look at these phenomena as results of an internal process in the schizophrenic, which is only partly related to what is going on around them, and we tend to look on it as a way of responding to what’s going on.

W: As an unusual way, but a way.

E: He has to respond from within.

H: There is a difference, for example, in judging the time it takes or in thinking in terms of the ways it is happening.

W: Yes, as we have been talking, there is an interpretation of the meaning. When something is done slowly or more rapidly.

E: Well, the removal of that rubber mat in front of Laura’s chair, a quick brisk removal, yet when we’d extend the time—I have forgotten the number of seconds—she had catalepsy.

H: If she was pleasing you by lifting her feet, so that her feet would be out of the way when the mat is removed.

E: Let us say that it took five seconds with no catalepsy; if Laura took six seconds there was catalepsy.

H: Isn’t this a little related to something that is very complicated in hypnosis and in schizophrenia, this factor of doing something for somebody. I don’t know whether it involves time or not. But in doing something voluntarily to please somebody there seems to become a shift when from that moment on you behave involuntarily. So many trance manifestations, to me at any rate, seem to happen in this way. It just sounded a little like that kind of catalepsy develops at a certain point.

W: You mean during the course of going into the trance, there seems to be this sort of shift.

H: Yes, in the course of going into the trance.

W: Or in the further development of the phenomena, either one.

H: When you get a series of voluntary yesses, and then you request something they can’t do voluntarily and they do that too, there is a shift to an involuntary kind of something in them.

E: That’s right.

H: Now, if she voluntarily lifted her feet and at a certain point this became involuntary, you’d have really a trance manifestation, wouldn’t you?

E: Yes, you would have the replacement of one type of behavior by a totally different and alien type of behavior.

H: Alien?

W: Well, if there are intermediate behaviors in trance, and those intermediate behaviors are often, it seems to me, used as transitions—for example, if you can give somebody a handclasp, and put it in a situation such as this (holding hands over head) where it is difficult to take your hands apart anyway. It seems to me there is a whole series of things of that sort which are used
to bridge, the gap between voluntary compliance and involuntary compliance, or compliance with things that you can’t do voluntarily, so that there are shifts. But there are also relations between the things as they shift: “In a moment as you get drowsier, you may swallow.” Of course you’re going to swallow, but then that passes on to, “When I count three, you’ll swallow,” or “When I count three, your pulse will slow down.”

E: Yes, and it passes on to the fact that you stop swallowing reflexively.

W: I am not quite sure I got that.

E: That continuance of swallowing, that responsive swallowing, continues on to the loss of reflex swallowing.

W: Yes, but you have a whole series of transitions between either the voluntary or the automatic, and the involuntary controlled through suggestion.

E: The hypnotic subject responds to stimuli. You suggest that they hallucinate and see a lion. Then he proceeds to do that. But once he sees that lion, it leads to the next thing, and the next and the next. So there is the natural progression.

H: Natural for a trance subject but different from an awaking progression.

E: That’s right.

W: I think what Milton is pointing out there is that you suggest one, and that leads him to another.

E: He responds not only to your suggestion, but he visualizes that grade school scene. In visualizing the grade school scene, there is an implied suggestion that he continue right on until you interrupt him. So the schoolroom scene leads to the recess scene, which leads to a return to the schoolroom, which leads to dismissal of school.

W: Although there is that implication, also the subject, in a sense, does some picking at some level, and this seems to me to sort of come under the head of finding limits, which we spoke about for some length when we were here before. I wonder if the matter of picking somebody’s hand up to here, then it drops back to there or it stays up there, it would also come under finding the limits?

E: If you hold it up there long enough, it stays up there.

W: That is another interesting point.

H: If you insist that they leave it there, yes. I mean, isn’t it conceivable they are reacting, in a way, of doing what you want them to do, and being negative as they dare. If you insist, they won’t be negative?

E: No. They are letting you do something to them. They are letting something happen to them. They are letting something occur.

W: But aren’t they to some extent testing the limits of that occurrence?

H: If they only let it drop a bit, they are letting it occur in their way, aren’t they?

E: I don’t think so.

H: Well, this is the basic difference here.

E: They haven’t had time enough for the automatic adjustment of the muscles.

H: Well, once again, in a deep trance it takes them a little while for a suggestion to take effect.

E: Uh-huh. You always have that time lag in trance subjects—either a marked time lag or a brief time lag.

W: Some things can, perhaps, be done alternately by giving them more time, or by changing the form or intensity of the suggestion, so that perhaps it
would be possible to find a lot of cases where it is not only a matter of time, but where their time can be seen as part of this whole hypnotic suggestion situation. To some extent at least, it can be replaced by other avenues of operation.

H: There is really a very classic difference here we are discussing. And if you assume, for example, that schizophrenia is organic, then what the schizophrenic is doing is rather random, is by definition meaningless, if he is detached from reality. Therefore, he isn’t communicating with his real environment. Therefore, everything he develops is rather meaningless.

W: As far as what is going on around is concerned.

H: Yes. If you assume that everything that he does is meaningful in response to the situation he is in, but he is responding in his own peculiar way. Then any response he makes is going to be a reaction to what you are doing to him, not something internal.

E: What do you mean by meaningful?

H: I mean if you said anything to a schizophrenic and got it on a tape, and sat and studied it long enough you would find in his response something appropriate to what you said, in terms of his life. You might say to a schizophrenic “I’d like you to come over to my office,” from the ward, and he might say—

W: “It’s a long way to Siberia.”

H: Yes, or “The North Pole is cold today.” But that’s certainly a response to your request that he go somewhere with you.

E: Uh-huh. But does the schizophrenic behavior signify more than to try to find some meaning? It is meaningful in that they are searching for a meaning.

H: I think very definitely they are searching for a meaning. If they don’t have it, I mean, anybody is. You have to have a meaning for what’s going on. But I don’t see that they are quite so isolated as you seem to think. I’d say, for example, that if it takes some time for them to respond to you, that they are to some degree paralyzed about what you are going to do if they do something wrong. It takes them time to figure out what is best to do, so that it wouldn’t be too disastrous if something went wrong.

E: It can be quite slow.

H: Well, if you do something with me and I respond immediately, and you do something else with me and it takes me a few minutes to respond, it is very possible that the time lag on the second instance is my concern about how are you going to react to what I do, react to my response—not that it just internally somehow takes longer in certain circumstances for me to respond. But when certain things are done to me it takes longer to respond, because of fear, or based on fear, or panic of some kind.

W: Or an attempt to figure out a safe response.

E: I’ve offered you a cigarette.

H: All right.

E: Suppose you were a schizophrenic, and you accept. Now the question is, “What are you going to do?”

H: I think if I were a schizophrenic, I’d get very interested in one of them to avoid thinking about why did you offer me Winstons. I’d get interested in the lettering, coloring, or I’d get into a discussion of Winston.

W: He is a nice fellow, isn’t he?
H: Yes, that sort of thing.
E: Yes, and yet the schizophrenic responds to this.
H: To eat it?
E: To eat it.
H: It could be, yes.
E: And then your question is, “Am I hungry?”
H: My question to the schizophrenic wouldn’t be that. It would be “Do you think I’m your mother?” or something of that sort, that you accept something from me as food.
E: Why drag in mother?
W: Well, there is another one of the central points of difference in the way we approach things, that we are always looking for more or less early etiology in early relationships between people.
H: Not only early etiology, but if he started to eat something that wasn’t really appropriate to eat, I would take that as a message to me that he was making a statement about our relationship.
E: Well, one might assume that it is expressive of the emptiness of his belly.
H: I just wouldn’t. That is again thinking of him in terms of his internal processes instead of his response to you. I might think it is the emptiness of his belly if I took that as a way of his saying to me, “Why don’t you get me something to eat?”
E: But he’s got a long history of using his hands when he is hungry and putting them to his mouth.
H: And a long history of things in hands when he’s hungry that he doesn’t put in his mouth.
W: Then the significance if he puts something distinctly inedible in his mouth, I would take as some sort of connection as to what I get to eat, but I don’t get what really nourishes me, I don’t get what I really need, something along that line.
H: This is the basic difference. If you take that as a message from the person who gives to you, if you take his response as a message, it is quite different from taking his response as a clinical kind of thing, or a typical example, or this is how screwy he is, or this is how his logic works. That is, if you shift the discussion of what is going on inside him, which is unknowable anyhow, to what is he saying to you by his behavior.
E: All right, watch the stuporous schizophrenic sitting in a chair alongside of the bed. You know him very well. He never wets his pants, never soils his pants. He has been sitting there stuporously immobile for several hours. Then he begins to move his head and look around. He takes hold of the sheet, draws it up to his mouth as if he were drinking it. Next he puts the sheet back down, puts his feet on the arm of the chair. He goes through a wealth of seemingly random activity. Then he finally gets up and goes to the bathroom. Why did he pick up the sheet as if it were a glass of water? Why did he try to lift the arm of the chair? There is some stimulus he becomes aware of vaguely. It had no meaning. He tried out this; that didn’t end the stimulus. He tried out this and that didn’t end the stimulus. This didn’t end the stimulus. Lifting his hand didn’t end the stimulus. Eventually he manages to get to the bathroom.
H: You see that’s a totally different point of view. That’s a point of view as if he was alone in the world.

E: And that he is unaware of the fact that his bladder is full, but he knows there is something, just something to which he ought to respond to, which he should respond in a meaningful way. I can think of George sitting there. You could always wonder, what is George going to do? Is he going to get a drink of water, is he going to go to the lavatory, is he going to lie down on the bed, or is he going to ask a nurse for a cigarette. You knew he was going to do something that was reasonable. And it was apparently a random search as he made these partial movements. George never wet himself. He never soiled himself. He’d wander over to the stuporous patient and that didn’t seem to be the answer. He’d wander over to the cot and get his wallet. Wander over to a chair. The nurse would be walking around. The doctor would be walking around. Eventually, however, George would wind up in front of the doctor or the nurse. Sometimes George would get his cigarette and then be confronted by another problem. He’d study his cigarette, and some more of this seemingly random activity, searching for other needs like this.

H: Well, again, you look upon it as an internal search within the guy. We would look upon it as a fear of requesting a light, a fear of making any request.

W: Which he might be very confused about internally. It might not be clear to him, but which would in some sense exist.

H: He might not be aware that he didn’t dare ask for something. In fact he probably couldn’t be aware. And to keep that out of awareness, he would have to avoid knowing what he needed.

E: Put him in the soundproof room, view him through the one-way mirror. The cigarette is there on the table.

H: Who put it there? Is he going to take something that somebody put there for him, or that belongs to somebody else.

W: Or is he going to take something that is put there to test him?

E: He might sit there for hours, never make a move. The next time you put him in that room, he might immediately begin to search, in a random fashion, look for the cigarette. And even after finding the cigarette, there’s still that problem of lighting it.

H: I think we have a chasm here.

W: Well, I think we do, but we don’t necessarily—we can come to mutual agreement about what the difference is.

H: Yes.

E: But his behavior in relation to the cigarette is the same as his behavior in relation to urination, the same as his behavior in relationship to other things. Why drag in persons?

H: Why leave them out?

E: If you’re dragging them in, and leaving out the self.

H: If you get into a discussion with him, if he got better and you talk to him about a sequence about cigarettes and urination, I think you’d find that people were very much involved. I don’t think it is dragging them in.

W: Another answer to that same question is the answer, if you’re dealing with him in a therapeutic situation, and you and he are involved in the situation, and that’s what you have to work with.
E: But you start out with this first stimulus—bladder tension.
H: Yes.
E: That belongs entirely to him.
H: It doesn’t. He has had a lifetime of problems about where he’s going to urinate.
W: That belongs entirely to him when he was being toilet trained.
E: He urinated before he was toilet trained, as a response to bladder tension.
W: And he was then taught that he just shouldn’t do that.
H: He shouldn’t respond by just urinating. He should go to a particular place and urinate.
E: But you want to start the understanding after another person gets into the scene.
H: That’s right, and there is another person that comes into the scene the day that kid’s born.
E: Is there?
H: Isn’t there? If there wasn’t he’d be dead.
E: Regardless of whether another person is in the scene or not, the infant’s going to have a personal experience.
H: Yes, I’m not denying that. We have personal experiences.
W: We agree very much to that, only we are interested—
E: They are apart from all other people.
H: They may be at first, but I think that very soon they’re not.
W: I think it’s remarkable how much other people can be involved in something which is that personal and physiological. That is one of the whole reasons why we are interested in hypnosis along with schizophrenia.
E: I don’t understand, you want to cut them off at the first part, and yet you say he wants to go back to the earliest—
H: I don’t want to go back to the earliest. I mean, this is a debate in the project. I don’t think it is an infantile problem. I think it is still going on with the adult schizophrenic and his parent and was going on when he was an infant, so it doesn’t make much difference. And we can observe it when he was an infant very conveniently. But now, for example, I am a little thirsty right now, which is an internal process in me. But whether I go to the trouble of going and getting a drink is very much involved in this conversation and your wife in the kitchen, and the trouble of going through the door, and the inconvenience it might have in the whole situation.
W: And to some extent the development of the thirst may also involve the situation.
H: I may develop the thirst as a way of avoiding something in here. It’s possible, and I may not quench the thirst as a way of keeping looking at it. The way the internal stimuli is handled is what we’re concerned with. That isn’t to deny it.
E: All right. You might feel sleepy, and how will you handle that? It would depend upon all the thinking you do about the chair, Weakland, Erickson, the tape recorder. And if, without your knowledge, the carbon dioxide content of this room could be increased, and the oxygen count decreased, slowly, imperceptibly. All of the thinking that you would do would have nothing to do with the eventual outcome. As the oxygen content went down and the carbon dioxide content went up, the physiological responses would
be more and more. All you could do would be to have a delaying babble. It wouldn’t be in relationship to us.

W: But the degree to which he fought the battle might be.

E: That’s right.

W: Even on something that is as physiological as that.

E: But his behavior, his sleep behavior, which is a function of all the physiological processes within his body.

W: Yes, but it could be a function of both.

H: Sure, I’ll agree with that. And I think those are most unusual circumstances.

E: Being thirsty has the same physiological circumstances.

H: Well, except that it has a little—

E: It’s more easily controlled.

H: Yes, but this is really a basic difference. I know you are more concerned about the self in an individual than you are about the other people involved with the individual. We once talked about it, the last time we were here, about the child has ideas or experiments with things to please the parents and he experiments with things to please himself. I would agree. But what I have the feeling here is you’re leaving out the parents, or leaving out the other people. You’re trying to emphasize the self more, we are trying to emphasize the other people more, instead of us getting to an agreement that there are both things involved. We feel that with the schizophrenic it’s not just the self involved, but what’s going on with the other people around them all the time. As much as if not more than other normal people.

E: Yet where would you expect schizophrenia to develop?

H: Well, we can pose you a question. Suppose you set out to produce schizophrenia in an individual. Suppose you were given an infant, and around the age of 18 he was to have a psychotic break. Now what would you do with this child to produce this phenomenon as an experiment?

E: [pause] Let’s postulate certain things. The parents are tremendously interested in music and can be pleased by music, and the child is tone deaf.

H: Wait a minute, you are bringing in something physiological to start with, or do you mean a tone deafness caused by the fact that the parents are. I just can’t conceive of the parents of a potential schizophrenic rejoicing or being pleased with anything he did. They can’t be pleased you know.

W: Really pleased.

H: Yeah, they’d say “That’s fine,” and now—and there’d be another task—you should be the head of a hospital, or such and such.

E: Hmm.

W: So that lien is taken away in the moment of success.

H: Yes. If he succeeds in some goal they set for him, instead of being pleased, it’s only the beginning of something else, or it’s something that he shouldn’t have done really. They’ll understand it somehow.

E: Well, of course, with this chap they undercut it by mentioning the fact that after he got through medical school he would take his internship at the proper hospital, and then he’d take his residency at the proper hospital, and then he’d take a specialty that pleased his father. None of those things had yet been decided, but it was a foregone conclusion.

H: That sounds typical, yes.
E: So that there was no way for the chap to please himself. And it was getting higher and far more solid, not so vague. It is in front of him; it starts to spread and encircle him. He was still getting his good grades and then all of a sudden, he could feel panic reaction—learned that wall was about all the way around him, and he was really headed for a nice schizophrenic break. I stepped in and yanked him out of medical school. And that wall has evaporated. It’s getting now so it’s possible for him to view medicine as a marvelous profession for anybody else, and he pleased his parents.

H: Well, that’s a little different.

E: But he didn’t get any personal individual satisfaction. I think the schizophrenic’s process develops from failure to do things that agree with the self first.

H: And what we are interested in is why this occurs. Why it becomes so important to the schizophrenic to please his parents. And we think it is because they’re unpleasable.

E: You think it is what?

H: Because they can’t be pleased.

E I think the schizophrenic process develops when the individual is not allowed to please himself first and foremost.

The following short excerpt provides a glimpse of the enthusiasm with which Haley (H) and Weakland (W) returned to the Gregory Bateson Research Project on Communication to discuss Erickson’s work with Bateson (B) and Don Jackson (J), known as the West Coast authority on the therapy of schizophrenia. The Bateson Palo Alto team was together for 10 years (1952–1962) and logged hundreds of hours of conferences and discussions, with an emphasis on schizophrenia. Many of the discussions were transcribed at that time. This excerpt is one of the first times that the double-bind nature of the hypnotic induction was emphasized. Erickson, Haley, and Weakland (1959) published a detailed presentation of this induction, “Transcript of a Trance Induction with Commentary.”

—Madeleine Richeport-Haley

H: One of the things that Erickson found so useful in working with is this thing that is so specific and yet so general.

J: What did Erickson say about double binds and transference, etc.?

H: He adopted the words bind and he was perfectly willing to say this is what he did with a patient. . . . It was very hard to get over to Erickson what we meant by bind, partly because he didn’t listen very much and partly because he doesn’t care how somebody got that way, really. So the talk about families, mothers, and fathers didn’t particularly mean anything.

W: He has a combination of great knowledge plus thinking about it in a certain way, at least certain parts of it, and the rest just comes along with it.

H: One of the things, for example, is where he was talking about a manic, and he said he talked to them about how they were very resistant in this chair, nice chair, etc. He would go on about the chair and the resistance from them to the chair. Then he would have them move the chair so that they weren’t in that chair, in that place anymore; they were now over here. And he would

2 Ellipses denote inaudible sections omitted from this transcript.
have them pick up the chair and carry it over, turn around, and sit down on it. And I asked him what would he do if they wouldn’t move the chair. And he said, “I would say to them that you didn’t stand up and you didn’t turn around, and you didn’t pick up the chair, you didn’t move the chair over there, and you didn’t sit down in the chair over there”—and somehow he had the person in a bind where by not doing it they were doing what he suggested they do. And he works on that edge of it all the time.

J: Can you develop at all this thing about a person being in a trance. The answer to not being able to do these things?

H: What I said was, a lot of the things you ask them to do in a trance are—you can say, “I want you to lift your hand without doing it yourself,” or, “I want your heart to slow down” . . . or all those things which are normally involuntary processes in the body, you suggest that they do it in a sense, and they do it. But there are things you can’t do . . . and I asked him, “If you ask somebody to do something which they couldn’t voluntarily do, would they go into a trance?” And he says, “If you ask them to do something impossible they can only try.”

J: That’s sounds essentially to me the double-bind situation. This is a catatonic—

H: What we were emphasizing all this time is the schizophrenic in a trance—is there something related? And when we present them, what we want to know is, since there are similar manifestations in trance and in schizophrenia, is there a similar etiology in induction? We would present that to him, he’d get away from it, we’d present it to him, he’d get away from it. I don’t know whether he didn’t know quite what we wanted, or what it was—

W: Or whether he didn’t want to answer—

H: But anything we could ask him specifically, he would give us an example which would illustrate it. And we asked him about a double bind, a yes and a no—and he said he did this. He said to me, “Have a cigarette” and then he pulled it back. As I reached for it, he pulled it away, and I was compelled to reach for it each time he put it out, even though he kept pulling it back. And he said he did an experiment. He set it up with a chain smoker who was sitting here and he [Erickson] was sitting here and the chain smoker didn’t have any cigarettes, and he had three friends over here—it was a regular seminar. He had the three friends set up for the situation. The chain smoker was sitting here. He took out a pack of cigarettes and offered them to the chain smoker, and at that point the guy on the end talked to him, and he turned away and answered the fellow’s questions. Then he remembered and offered the cigarettes again, and at that point the next guy talked to him and he put his cigarettes away. And then he remembered, pulled them out and at that point was interrupted again. And he did this five times and then put his cigarettes away. A few minutes later one of the guys, Paul, went up to the subject and said, “How did you feel about Erickson putting those cigarettes away?” and the guy said, “What cigarettes?” Paul said, “Erickson’s pack of cigarettes. And the guy said, “He didn’t offer me any cigarettes.” And Paul said the guy actually didn’t remember. Now, Erickson had told the friends that what he was going to demonstrate was that you could produce amnesia by intensifying annoyance, by doing it over and
over again. What his giving and pulling it away benevolently without realizing he was doing it—what it produced was amnesia and a lack of desire for a cigarette.

J: But did he say that it was benevolent and that he didn’t really understand it?

H: The subject felt that Erickson wasn’t deliberately pulling his cigarettes back, that he meant to give him the cigarettes, but something—somehow he didn’t.

J: But that wasn’t true.

H: No, but the subject didn’t know that.

J: Couldn’t he have responded as if it were. In other words, the amnesia is a suppression of the hate.

H: At some level he might have known it, yes. But it seems very much like what we think happens with the schizophrenic. There is amnesia and a lack of desire for it.

J: It happens to the same kind of stimulation, too.

H: It’s awkward. You don’t care, and yet the person doesn’t seem like the person to do—

W: You can’t pin it on them.

H: It’s a wonderful experiment. And we talked a little bit about yes and no and the—

H: You get he did a similar thing with the books in the library.

J: I’m trying to put this experiment up with the double bind. What would be the other way? You cannot refuse the cigarette at some point, but when you say you don’t want them, you’ve lost out.

H: Well, this friend, Paul, had to do some therapy on the guy. There would be a kind of a bind set up . . . I assume Erickson was the teacher in that seminar, the authority. We asked Erickson for more examples, and he said he has done about six of these. He said that a friend of his wanted him to read a book, so he went to the library and took the book out, took it home. He told the friend that he went to the library and the book wasn’t in. Every day he went to the library and he managed it so the friend knew he went to the trouble to go to the library to get this book and it wasn’t in. After a certain period of days, Erickson mentioned the book, and they said, “What book?” He produced amnesia again by intensifying this every day. But, again, the gesture was benevolent: “I am doing my best; I’m trying to give you this cigarette.”

W: I’m knocking myself out for you.

H: We have it on tape, fortunately. Anyhow, this went on for a period of days and each day Erickson was arranging it so that the friend knew he went to the trouble to go to the library to get this book and it wasn’t in. After a certain period of days, Erickson mentioned the book, and they said, “What book?” He produced amnesia again by intensifying this every day. But, again, the gesture was benevolent: “I am doing my best; I’m trying to give you this cigarette.”

W: I’m knocking myself out for you.

H: We thought that was the hottest thing in the trip. It’s benevolent, but somehow you don’t get it.

J: Sure, sure—I see it in the double-bind situation. . . . If you recognize it as unbenevolent you lose out. Suppose that this is mother, you see. Suppose I choose to recognize that he is pulling a trick on me, that he isn’t benevolently offering me the cigarettes, only forgetting to give them to me. That’s
a terrible thing to do. The only way to escape this is to withdraw. It changes the whole content of everything by becoming paranoid. But I think most people agree that the catatonic state comes before the paranoia.

W: I know the other one. He asked him what happens, on the idea that maybe schizophrenia is something like the description of a trance—what happens if you try to hypnotize somebody who was already in a deep trance. He gave us an example of an experiment. He was supposed then to give a demonstration, and without letting him know one of his friends hypnotized the subject into a very deep trance beforehand. Well, Erickson began to talk to the guy. As soon as he did he could pick up the fact that he was already in a deep trance, and he began to cast around his mind who could have put him in that trance and he decided that this guy, Paul, was probably the one. But in thinking it over and talking to the guy, he would get certain reactions when he mentioned Paul, so he decided that was it. Then he began to [think] of hypnosis and certain similarities between his message and Paul's message—

H: An experiment he and Paul had done together.

W: An experiment he and Paul had done together. If he were Paul, he would do things a certain way, and talked to him [the subject] that way. And he had then displaced Paul and he had the subject in a deep trance. And I thought, boy, does that sound like somehow what you have got to do to get in. Sounds very much like some of the things Rosen has done to get in.

J: There is something about the unrecognized [deception] that seems important. It's so important in the double bind. He does it more deliberately. Only it may be not too deliberate in that he is so damned good at it.

H: The guy had a remarkable ability for saying something in such a way that you believe absolutely he means what he says when he doesn’t necessarily. He can give all these signals that say, "That is it," whether he is having you see something that isn’t there or whether he is pulling a trick. Like if he offered that guy a cigarette, there would be doubt in that guy's mind. I don't think, that Erickson was really trying to give him a cigarette and somehow was prevented by the others from doing it.

B: Jay, is there any indication at all—the cigarette story, the guy had been in a trance—would the response to the sequence have been the same?

H: I would doubt it, but I don’t know.

B: Would the response have been the same? Would the state of being in a trance be a defense against the experience of this offering and withdrawal? If the guy had been in a trance, would he have been safe from the trauma?

H: I think he would have been. Erickson believes that a hypnotic subject doesn’t have to deal with real things.

J: But how would he have been safe, you see? He would have been safe by making it part of an experiment.

B: The cigarette would not have been the real thing.

J: Well, by an explanation I think we have a good point, here. Do you see what I mean? In other words, the way the trance would protect him would be the way a dream protects.

B: Like protecting you against the knock on the door.

J: Yes, that's right.

B: You are insisted into—
J: Into a contextual framework. A different one, but it’s—it may do that at night, and if you wake up that way, then all hell breaks loose.

W: If he is in a trance, suppose he hallucinates that he gets the cigarette. That’s one of the things, one of the possibilities.

H: I asked him to compare schizophrenics and hypnotic subjects. He says with a real person if you offer them a cigarette, they expect a real cigarette. With the hypnotic subject if you say, “Have a cigarette” and you offer them an empty hand, the willingness to give the cigarette and to accept the cigarette is the same as if it were a real cigarette, then he thinks—

J: But somebody is kidding somebody in this last one, is what I mean.

H: When you get in a trance, Don, I don’t know what is kidding and what isn’t. That guy can really take a cigarette when there isn’t one there.

J: That’s right. Which is all right, I’m not worried about his hypnotic subjects. But if he tried to live his life that way . . .

W: If he did it all the time, it’s a very different matter.

H: But the important question of whether the hypnotic subject feels there is any kidding involved when he really believes—

J: Here is what I’m thinking. What Piersall first did was to withdraw. He didn’t go home; he disappeared for a couple of days, etc. The next thing he did was to make a joke out of everything, like in the dream, you see. It isn’t the knock on the door or the telephone that might get me up, it’s planning a New Year’s Eve party. And this making a joke is the paranoia—the beginning of it, anyhow, the less poisonous aspect. Everything is something else.

W: Where does the hebephrenic come in?

J: I don’t know, not in connection with making this kind of joke. I was trying to think of the connection between—thinking in terms of the double bind—between hypnosis and the double bind. In the first place, we have the subject reach for the cigarette and he doesn’t get it, and he has to become amnesic. This is the catatonic state. That is, you have to withdraw, repress the hurt. The next thing we are told is that being in a trance—What about the cigarette problem? And this is where it becomes paranoid. That is, you supply a hallucination or whatever. And this is what made Piersall withdraw first. Then he went to Florida as though he were going through with the set and everything was a big joke, etc., as though the frame of reference has been changed from something serious to something not real, as in the trance. I think that there may be some connection between catatonia and paranoia.

W: I may be all wrong, but I thought that that sometimes has its trying aspects, and it changed from that to the bitterness. That that was the paranoid edge.

B: No, I think that bitterness is above the trying edge.

J: The thing that goes along with the jokes of the hebephrenic is almost invariably the omnipotence aspect. “I am running everything” . . . they are laughing at. Whereas the paranoid it’s all, “You think you are fooling me, but you are really not, because I know it’s a joke, so I’ll go along with you as if I were really being serious.” This is not hebephrenic; it’s a make-believe. Paranoids can talk to you in a “we’re all boys together” way. It’s not too unhealthy if you go into a group of strangers and you sort of act like you are one of them. It’s a possible approach, whereas the hebephrenic is more
removed. You don’t know what they are actually thinking. Just the fact that they are so much more inaccessible.

J: Did you get any thoughts about how we could shut off the double-bind situation?

H: No. What I’ve been thinking more of is whether hypnosis isn’t all that really.

B: Yes, I think that so.

H: What Erickson said to me in talking about binds, he said, “I want you to say to me, ‘I don’t want to go into a trance.’” So I said, “I don’t want to go into a trance.” He said, “You mean you want to stay awake?” I said, “Yes.” He said, “You can do that too.” Now, how much more of that sort of thing is going to make—?

J: It’s too, too utterly.

B: He asked you to say—

H: He was demonstrating so he asked me to say that, yes. So that he could give me the reply to that. And the reply is, “Do you mean you want to stay awake?”

Reference


Diskussionen zu Hypnose und Schizophrenie

Jay Haley


Stephanie Reigel, MD

Discussions sur l’hypnose et la schizophrénie

Jay Haley

Résumé: Un classique dans le domaine de l’intellect et de l’argumentation, cet article contient la transcription d’une discussion engagée entre Jay Haley, John Weakland et Milton Erickson portant sur le rôle de la communication l’hypnose et dans le traitement de la schizophrénie. En 1955, la schizophrénie était considérée comme un trouble d’abord psychologique.
Bien qu’aujourd’hui elle soit considérée comme un trouble principalement biologique, ce document non publié datant du tout début de la carrière de M. Haley alimente encore beaucoup la réflexion, et nous donne une meilleure idée de la pensée et de l’intellect d’Haley et d’Erickson à une époque fertile de la recherche sur la schizophrénie.

Johanne Raynault
C. Tr. (STIBC)

Discusiones sobre la hipnosis y la esquizofrenia

Jay Haley
Resumen: Un artículo clásico sobre el intelecto y la argumentación, este artículo contiene la transcripción de una conversación entre Jay Haley, John Weakland, y Milton Erickson en donde discuten el rol de la comunicación en la hipnosis y la esquizofrenia. En 1955, la esquizofrenia se consideraba primordialmente un trastorno psicológico. Aún cuando hoy en día es vista fundamentalmente un trastorno biológico, este artículo inédito todavía provee material para reflexionar y un vistazo al pensamiento e intelecto de Haley y Erickson en una época ferviente en la investigación sobre esquizofrenia.

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