# METAPHORIC AND SYMBOLIC IMAGERY IN THE HYPNOTIC TREATMENT OF AN URGE TO WANDER: A CASE REPORT

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Psychogenic fugue and psychogenic amnesia consist of sudden, temporary alterations in consciousness accompanying amnesia. The use of hypnosis has been generally restricted to removing the amnesia, although as early as 1898 Janet remarked that, in cases of fugues, hypnosis can also be used for uncovering and acting upon the subconsciously fixed idea that leads to the persistent recurrence of these fugues. A case history is presented of a client who often gave in to the urge to wander, at times due to a conscious decision to escape from a difficult situation, but frequently in a mental state which could be placed somewhere between psychogenic amnesia and psychogenic fugue. He summarized his situation with the words "I see no way out", a statement considered to be the *fixed idea* responsible for his dissociative states. Hypnosis was used as a medium for metaphoric and symbolic imagery work comprising a series of positive transformations of the original metaphorical statement. A few sessions of this type resulted in dramatic changes in the patient's everyday life.

According to the DSM-III (APA, 1980) the essential feature of psychogenic fugue is ". . . sudden, unexpected travel away from home or customary work locale with assumption of a new identity and an inability to recall one's previous identity. Perplexity and disorientation may occur. Following recovery there is no recollection of events that took place during the fugue". The area has recently received attention from Nemiah (1979, 1980).

Janet's (1907, 1909) observations on fugues still seem to be significant. He distinguishes four characteristic features which fugues have in common with other dissociative states such as "hysterical somnambulism":

(1) During the abnormal state (here the fugue) there is a certain fixed idea, an emotionally-laden system of images, thoughts, and convictions that develop to an exaggerated degree. (Mental imagery such as daydreams and fantasy and, in hysterical fits, for instance, hallucinations are all part of the fixed idea.)
(2) During the fugue state the other thoughts relating to the former life, the family, the social position and the personality appear to be suppressed. When some chance occurrence brings back to mind a thought about the family, the real name, or the former self, the person falls into another system of ideas and wakes up.
(3) Outside the fugue state and during the period considered normal, the recollections of the fugue have vanished-and that to an extraordinary extent. At the same time, the thoughts and feelings connected with the fixed idea that predominated during the fugue have disappeared more or less completely.
(4) During the state considered normal one finds the development of the psychological phenomena that were suppressed during the period of the crisis: recollection of the entire existence, perception of all present occurrences and exact notion of personality.

Janet also pointed out the following differences between a fugue state and hysterical somnambulism:

(1) During the fugue the fixed idea that develops has certainly not the same power as during hysterical somnambulism. It directs the conduct, but it does not bring



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on the hallucinations and delirium so characteristic of hysterical fits. The development of this idea is less intense.

(2) The fixed idea is not absolutely isolated as in somnambulism, the mind is not distinctly reduced to a single idea and this is the most characteristic fact. Patients who make fugues need a great many perceptions and recollections to enable them to travel without any mishaps.

## Psychogenic Fugue and Psychogenic Amnesia

Psychogenic fugue has much in common with psychogenic amnesia. Both consist of a sudden alteration in the normally integrative functions of consciousness, identity, and motor behaviour (DSM-III, p. 253). Whereas in most cases the fugue consists of little more than brief, apparently purposeful travel, in psychogenic amnesia there is confused and purposeless wandering. It is also characterized by more perplexity and disorientation.

Both dissociative states are seen as reactions to a wide variety of actual situations causing severe psychosocial stress for the person (cf. DSM-III; Abeles & Schilder, 1935; Kanzer, 1939; Kirshner, 1973). Examples of such situations would be: marital quarrels, military conflicts and, especially with psychogenic amnesia, threat of physical injury or death. In all these cases, the tensions seem to have become unbearable and the dissociative state is apparently seen as the only way out. Fisher (1945) speaks of a subjective situation where no solution is feasible and in which anxiety increases. Copeland and Kitching (1937) speak of a disinclination to face facts. Bychowski (1962) formulates something quite similar in terms of ego psychology, and Abeles and Schilder (1935) regard psychogenic amnesia as a weak attempt of a weak personality to escape conflicts of actual life. Kirshner rejects negative labelling and looks instead to the sphere of the ego as an adapting device. He calls the dissociative state of transitional role (cf. Spiegel, 1971) in which the "assumed role carries a benign connotation, de-emphasizing the discord between the individual and a situation in which his behaviour might have led to serious social consequences".

The observations of Abeles and Schilder (1935) and Stengel (1941, 1943) that a period of depression and (adds Stengel) of restlessness precedes the state, fit in well with the view of the dissociative state as a reaction to an intolerable life situation. Perhaps because these depressions are often accompanied by suicidal thoughts, these authors refer to a partial suicide (Abeles & Schilder) and a transformation of a suicidal impulse to the impulse to wander (Stengel). They also point out that most patients with dissociative states have a history of serious familial turmoil or early separation and deprivation. Although Kirshner's (1973) research confirms this, he adds that this was also true of the psychiatric controls he studied.

## The Role of the Fixed Idea in Psychogenic Fugue and Psychogenic Amnesia

Janet, it will be remembered, ascribed a controlling function to fixed ideas and systems of thoughts, images and memories dissociated from the patient's control, in perpetuating fugues and other dissociative states. A distinction can be made between the fixed ideas in psychogenic fugue and psychogenic amnesia. In the former a previously formed idea takes hold and is activated in the fugue state, where it starts to regulate the actions of the person. Raymond and Janet (1898, cited in Janet, 1907) gives the example of a French boy, Rou., 13 years old, who often went to a small public house visited by old sailors. They would urge him to drink and, when he was somewhat flustered, they would fill his imagination with beautiful tales in which deserts, palm trees, lions, camels and negroes were pictured in a most wonderful and alluring way. The young boy was very much struck by those pictures, particularly as he was half tipsy. The wish to make such a trip himself grew stronger and stronger. However, when his drunkenness was over, the stories seemed to be quite forgotten and the idea of the journey took on an unconscious character. However, if he became tipsy again, they came back to his mind. He had his first fugue when his parents once punished him

particularly harshly. He ran away and was found in a wood by workers the next day. He could not explain how he got there. He had his second fugue a year later, again after being severely punished by his parents. This time he had been underway for 3 months when he was found in a state of exhaustion. Upon questioning, he awakened from his fugue state. He had lost all memory of the preceding months and he was astonished to see where he was.

Briefly, in psychogenic fugue, the actual fugue is a realization of some previously developed fantasy, that is, a fixed idea. According to McDougall, typical fugues are prepared for

> *. . . by daydreams motivated by repressed tendencies. There occurs (generally, perhaps always, at the moment of some emotional shock) a dissociation of the system of mental dispositions concerned in and built up through the fantasies; and forthwith the repressed tendency, working through the dissociated system, finds expression in action. (McDougall, 1926 p. 159)*

In contrast to psychogenic fugue, psychogenic amnesia does not seem to consist of the realization of a previously developed fixed idea, but of the immediate dissociative response to severe psychosocial stress, often involving a threat of physical injury or death (DSM-III). In psychogenic amnesia the dominant idea (although it is not further developed) is the necessity to escape from a situation where one consciously sees no way out; it is perhaps an extreme form of depersonalization (Dollinger, 1983; Noyes, Hoenk, Kuperman, & Slymen, 1977).

## Fugues and Hypnosis

It is common knowledge that persons with dissociative disorders such as psychogenic fugue and psychogenic amnesia can be easily hypnotized. People were aware of this at the turn of the century as well (Janet, 1889, 1907, 1909; Raymond & Janet, 1898). According to Janet, this is because hypnotic trance in these patients reproduces the dissociated state of consciousness they are in during the fugue. In his view, hypnosis can be used not only to remove the amnesia, but also to uncover and act upon the unconsciously fixed idea that leads to the persistent recurrence of these fugues. It might even be used to get rid of the fixed idea, although he deemed the occurrence of a relapse entirely probable. The tendency to dissociate, he said, and the "faiblesse de synthèse mentale" would remain in existence.

Most later authors do not use hypnosis in psychogenic fugue and psychogenic amnesia for much more than removing the amnesia (cf. Schneck, 1954) and much more is not usually needed. Improvement occurs quickly, with little or no medication and the disorders seldom recur (DSM-III). According to Abeles and Schilder (1935) it must take place as quickly as possible, in the interests of the patient and his or her family. Crasilneck and Hall (1975), however, emphasize that removal of the amnesia must not be too abrupt, so that should the amnesia be serving an important psychodynamic function, its sudden removal will not precipitate severe anxiety or even more undesirable symptoms. Garver, Fuselier, and Booth (1981) and Mac Hovic (1981) present cases that are excellent descriptions of cautious removals of the amnesia. Fisher (1945) also uses hypnosis to uncover the fantasies, the fixed ideas, preceding the development of amnesia. Spiegel and Spiegel (1978) assist the patient under hypnosis in re-experiencing the dissociated episode, find abreaction often useful, and extract what meaning can be found in the experience.

## A Metaphoric Hypnotic Approach

The present case history is of a 38-year-old man who often gave in to the urge to wander, at times due to a conscious decision to escape from a difficult situation, but frequently in a mental state which could be placed somewhere between psychogenic amnesia and psychogenic fugue. The patient summarized his entire situation with the words "I see no way out".

In this case hypnosis is not used for the cure of amnesia with respect to foregoing episodes. Instead, hypnosis is used as a medium for metaphoric and symbolic imagery

work for solving the patient's current problems and for working through problems originating in the past. The patient's fixed idea, "I see no way out", is taken as the starting point. The idea is regarded as a metaphorical kernel statement (Fernandez, 1977). It is metaphorical because it is figurative. It is a kernel statement because it expresses something essential. Such a metaphor can be brought to life in hypnosis, for instance, by creating a metaphorical domain from which the patient literally sees no way out, and then presenting him with an opportunity of finding one. In this way several emotional-perceptual transformations of the metaphorical kernel statement can take place, transformations within the domain of the patient's imagery work. They also exert influence in the principal domain, perceptions and emotions regarding his actual life situation (van der Hart, 1984a, 1984b). Changes occurring within the principal domain will affect the further development of the metaphoric imagery work. In other words, what we have here is a process of looping and feedback of information (Fernandez, 1977; Miller, Galenter, & Pribram, 1980).

## The Patient

Klaas van Wijk, 38 years old, was referred by his physician to a home for vagrants. He had been there a few months and had isolated himself more and more. He felt at a dead end in his life and that the only thing left to do was to put an end to it. Just a look at Klaas was enough to see what bad shape he was in. He looked tense and depressed and his face was covered with deep lines-life had left its mark on him. He told the following story. He was the second son of a large family in which there was a great deal of tension. His father often beat his mother and the children, and the brothers and sisters quarreled a lot, too. His father was a blacksmith, self-employed, and Klaas worked for him. When he was 20, Klaas "had to" get married and within a few years he had several children. His father made it known that he wished Klaas to take over the business one day. But when his father died suddenly, his mother presented the business to his eldest brother, a "good-for-nothing". Klaas could not accept this injustice. He held a grudge against her and he and his brother continually beat each other up. The relationship with his wife also grew very strained because he vented all his rage on her. Things went from bad to worse, partly because Klaas had started drinking too much, and would then go into a rage. His family ostracized him and even his wife had had enough of it all.

After an attempted suicide he was admitted to a psychiatric hospital. While he was there his wife filed for a divorce. After the divorce he led a lonely and roving existence. He could not find any place where he felt at home. After a little while he would become restless and would have to start roaming about again. It was not only his inner urgings, but outside circumstances as well, that kept forcing him to run away. Klaas was supposed to pay alimony for his children, which he felt was unjust because it was his wife who had left him, so he decided that he would not pay it under any condition. However, as soon as he moved somewhere else, he always reported his address to the local authorities, so they were always seeking his money. Each time his possessions were seized, he fled once more.

Earlier, Klaas had often consciously run away, but the last few years it had happened more and more often that he "went off" literally and figuratively. He would roam for days and nights in a state of constricted consciousness, without eating or drinking, and later he would remember nothing of this. Several times he was admitted to a hospital in a state of confusion and on the verge of starvation. Neurological examination had showed no impairments. The last time his dissociated state has lasted 5 days and it was after this that he had been sent to the home for vagrants.

Klaas reported with some pride that he had stopped drinking. When he talked about liquor there was something immovable, something very adamant about him. This I saw as a positive point which might be put to good use in therapy. Klaas knew that he could not possibly manage on his own, and he also know of nothing that could possibly help him. He thought the home was terrible. He was becoming more and more tense and repeated that his urge to end his life or to start roving again was getting stronger and stronger.

## The Therapy

At the second session, Klaas again stressed his feeling about the home, a "gutter", "completely vile". He saw no way out, he said repeatedly. He had no money so he could not rent a room somewhere else. He needed a job to be able to pay rent, but whenever he applied for one, he had to give his address and then they always managed to find an excuse not to hire him.

At my attempts to discuss how to break this vicious circle, Klaas recoiled. He said he felt tension building up inside him. He was afraid that, if the tension was discharged, something terrible would happen. I concluded that a rational problem-solving approach with the immediate goal of improving his situation would very likely be of no help, and even though he talked about suicide, I did not think he would benefit by a stay in a psychiatric hospital. Given his ability to dissociate, hypnosis seemed to be appropriate. In such therapy, his symptomatic tendency to dissociate can be used as an asset (Beahrs, 1982). I regarded his statement "I see no way out" as the metaphoric kernel statement that would form the starting point for hypnotic imagery work. Klaas willingly accepted my suggestion to approach his problem using hypnosis.

At the next session he readily went into trance with hand levitation. The hand touched his forehead and, despite my suggestion, did not go down again. He seemed to be in a deep and peaceful trance. A well-managed deepening technique could now serve to create a metaphoric context in which he would literally see no way out. I suggested to him that he was standing before a stairway with 12 steps, that he could take his time about going down them, and that he would then be in a very dark hallway with one door. (This suggestion implied that, even if he could not see a way out, there was one after all.) Klaas reported that he did not see anything at all downstairs and not the door either. I suggested to him that he find the door by feeling his way. He found the door and opened it at my request. When I asked him if he wanted to go through the doorway and step into the space behind it, he was not so sure about it. It was dark in there, too, but he did see a speck of light, far away. The room looked like a long corridor, a sort of tunnel.

At my encouragement, Klaas went across the threshold and then into the corridor step by step. He noticed that he was sinking deeper and deeper into the sandy floor. Quicksand? He grew a little panicky, but could just manage to get himself out of it and went back to the hallway. If he took a good look around there, I told him, he could find some things that he could go on to cross the quicksand. He found two old doors. He pushed them across the sand and when he came to water he used them as a raft. He was happy when he reached the other side and found out that he could walk on. All kinds of lovely red flowers were blooming. Klaas enjoyed their colors and scents; he was cheerful and started to dance.

Suddenly the flowers started to wilt and die. Everything around him turned to a sombre brown. A smell of decay grew stronger. Klaas became sombre and hurried on. After a while he came to a church and next to it was a hospital. In front of the church were German soldiers holding guns. Next to them was a group of civilians. Most of these were sent away, but four were made to stay behind and were shot.' The soldiers left and the dead were left lying. It was quiet and peaceful.

For some time, Klaas seemed to be in a very deep trance. I gave him suggestions for relaxation and refreshment. I told him that what he had been through in the session would have a positive effect-unconsciously, of course, but when the time was right, consciously as well.

When Klaas came out of the trance, I asked him (as an indirect test for amnesia) if he knew how long he had been here. He said that he had just come in.

At the next session, 2 weeks later, Klaas reported dramatic changes. He was no longer depressed and was a little optimistic about the future. He had been to the welfare department and to the dentist, whom he had not attended in 16 years. He had also been busy painting and drawing. Klaas felt "a twinge" about his family. He had not seen them for years; he had thought he would never want to see them again, but now felt inclined to get in touch with family members. The people around him were surprised by the changes that had taken place in him. He was, too, and remarked that it must not go too fast. I went along with him and decided not to bring up hypnosis at this session. Instead

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[1.] Klaas was a small boy during World War II. But I never asked him if he had actually seen something like this happen.

I brought the conversation around to sports. Not only would Klaas benefit by improving his condition, but undertaking some sport could also be an implicit model for actively looking for a job. It would also give him an opportunity to get acquainted with some new people.

Klaas then said that he would be glad to quit smoking. He had managed to quit drinking, but no matter how hard he had tried, he kept on smoking, two packets of cigarettes a day. I wanted to help him with this and remarked, "Maybe next time, or maybe something else will happen then", thus leaving open the possibility to go into other experiences if necessary.

Three weeks later Klaas looked much more relaxed. He was also quite cheerful, but the home was more or less driving him up the wall. He had been doing calisthenics and enjoying it. He went in for three jobs, but was turned down because he was in the home. He wondered how long it would take before he could get out of it. Klaas now said on his own initiative that he wanted hypnosis for his addiction to nicotine. I agreed to this, and Klaas went into a trance in the same way as before. This time I did not talk about going down stairs, but suggested to him that he was somewhere in nature, some place he thought was beautiful and where he felt comfortable. Klaas said he was somewhere in a forest of chestnut trees, looking for chestnuts. There were some other people there too. After he had been at it for some time, with obvious enjoyment, I asked him to go to a very special place in the forest, a place where he could dig a deep hole. He started looking and ended up in a very quiet part of the forest; there was no-one else there. I asked Klaas to dig that deep hole and, when he was finished, to bury his last packet of cigarettes there for once and for all. After he had done so, I asked him to breathe in and enjoy the fresh, healthy air of the forest. Klaas said that he felt relieved. He felt very light; he seemed to be gliding between the trees. He met a few people on his way, but everything around him was very peaceful and it did him good.

The treetops kept attracting Klaas' attention. I asked him to pay some attention to their roots, too, but he was not very receptive. Finally I asked him to go to a special place where he could have a good rest and would be able to take in everything that happened earlier quite naturally. He chose a place in the forest where a rotting tree trunk lay with a beautiful large toadstool growing on it "rotten underneath but beautiful on top". He was intrigued by this image.

After I made a few post-hypnotic suggestions for positive affect, relaxation and satisfaction, Klaas came out of hypnosis. Three weeks later he said he had not smoked since the last session. He thought it was really odd that, for the first few days after the last session, he was not in the least aware that smoking had ever had anything to do with him. He still had his lighter in his pocket. If other people asked him for a light, he gave them one, not realizing that he had ever smoked himself. After that smoking became more and more distasteful to him, so much so that he rarely went to the smoky coffee shop any more, and he had hung up a "No smoking" sign on the door of his room. His room? Yes, that's right; he had left the home and was living in a room of his own in town. Now he could lead his own life and enjoyed his freedom, the peace and quiet. He had resolved to start looking for work again.

We made an appointment for 3 weeks later. Then I read an obituary for Klaas' landlady in the newspaper and I started to wonder what would happen to Klaas and to his room. He did not come to the appointment and I didn't hear from him. My attempts to get in touch with him were unsuccessful. Although I wondered for a while if his old behavior of running away had come back again, I was confident that the therapy would go on having a positive effect on his life. Reactions of colleagues were varied. Some of them thought that the patient would put an end to his life, or might have already done so; others were more optimistic.

## Follow-up

More than 2 years later Klaas called me. He asked if I still remembered him, and he told me that I once helped him to quit smoking. He was still grateful to me for this. He was now married and living with his wife in another part of the country. His wife was also addicted to smoking and he wondered if I could help her too. I told him it was theoretically possible and we made an appointment. In the conversation with Klaas and

his wife I first asked him how things had been with him in the past 2 years. Shortly after our last talk Klaas found a job and so he had to cancel the next appointment. He had called to say so, but the message had not been given to me. After I had written to him, he had tried to reach me several times, but without success. It was not his landlady who had died; he had lived at her place for another year. The obituary I read had been someone else's.

A few months after the therapy important changes had occurred. Klaas found a better job, one that gave him more satisfaction and also paid better. He had got in touch with his family and the ties with his mother, whom he now sees regularly again, are once again good. He met a nice woman, Marion, whom he married shortly after that. They both moved to another city not far from the town where he was born. There they started a new life. They had a business of their own and both of them took pleasure in working there. They were very happy together. The wandering and the amnesia had not recurred.

A year and a half after the initial contact with me Klaas' physical condition suddenly became very poor and it was found that he had cancer of the stomach, of the spleen, and of other organs. He underwent an emergency operation and several organs were removed. His physical condition was still grave and he had not yet really come to accept this fact or the operation. Before the operation he was self-confident but he had been unsure of himself since then. When he had to think back to it, he put all his effort into focusing his attention on something else.

Circumspectly I asked Klaas about what he remembered of the therapy. He knew that hypnosis helped him to stop smoking. But he did not remember very much of the contents of our talks. He had talked repeatedly with his wife about stopping smoking; she had smoked some 20 cigarettes a day for 20 years. Both of them felt the time was really ripe for her to stop. We agreed that Marion and I would work on her stopping smoking, using hypnosis, and that Klaas would get an opportunity to work through his experiences with his cancer and operation in follow-up talks. Her husband had informed Marion very well about hypnosis, but she was still a little afraid of it. She wanted the same procedure that was used with Klaas, but this turned out to be not quite so easy. Introduction using hand levitation did not go as smoothly and her experiences in hypnosis were less intense. She reached a light trance, in my estimation. As far as I was concerned, I was very doubtful about the results but, remarkably enough, I later heard that Marion reacted after the session just as Klaas had (and had told her): it was as if smoking never had anything to do with her. And she was so happy about having stopped smoking that, in her enthusiasm, she managed to help her neighbour, a confirmed smoker for many years, to stop as well.

At the next session Klaas told me more extensively about his experiences with the operation and about his life during the past 2 years and he was able to express something of his feelings about it all. He made it clear to me that his condition was extremely grave. The next time he was told, before and after the induction of hypnosis, to ask his subconscious to help him in working through the fact that he had cancer, the operations "and any other experiences", and to place his confidence in it. In a deep trance, he made a journey through stony mountains, until he reached a place where many people were building a castle together, very crude and gray, but beautiful. He enjoyed all that activity and the view. He walked along a path and felt inclined to go further. But the path stopped somewhere and something inside him told him to go no further, not to traverse the impassable. He turned around, looked for a place where he could sit down in peace and "command a view of it all". He developed an awareness of space, peace and quiet. He seemed to be in a very deep trance. After a while I gave him some post-hypnotic suggestions for positive affect and I told him that he could come out of the trance refreshed and with a feeling of satisfaction. The images became obscure but the feeling of peace remained when Klaas came out of the trance.

A month later the report reached me that Klaas has died of his affliction. He really did live the last month of his life in peace and tranquility.

## Discussion

1. In the treatment described here, Janet's recommendation to use hypnosis not only for uncovering but also for acting upon a subconsciously fixed idea was implemented, using guided metaphoric imagery work, consisting of a series of

transformations of the patient's metaphoric kernel statement "I see no way out". The therapist's suggestion that the patient was at the bottom of a stairway in a dark room with one door implied the existence of a way out that could not be seen, it is true, but could be found by groping. We need not necessarily assume that such a metaphoric kernel statement comprises the entire fixed idea or system of images, thoughts and convictions. But practice has shown that it often is an excellent starting point for therapeutically acting upon this system of ideas. This is not only true of patients with psychogenic fugue or psychogenic amnesia or with hysterical disorders. Numerous patients with other complaints and symptoms who describe their troublesome situation in such a way (e.g. "I'm down in the dumps", "I'm up against a wall") can benefit from a similar therapeutic approach (van der Hart, 1984a, 1984b). Patients without recognized dissociative disorders can also exhibit dissociations. These are always characterized by the fact that a complex of images, thoughts and convictions isolates itself from the field of consciousness and starts to lead a life of its own, thus interfering with habitual behaviour.

2. The process described here was considered to be an extended metaphor, or metaphoric imagery work. This does not mean that symbols and symbolic processes were absent. On the contrary Fernandez (1977) remarks that rituals also seem to be applicable to this imagery work: ". . . although we presume the study of metaphor to be primary to the study of symbolism, nevertheless symbols of various kinds are constantly appearing and being manipulated". These symbols are condensed symbols, that is, they have more than one meaning: they are multivocal and have a strong emotional quality (Sapir, 1934; Turner, 1967). Several images in the imagery work described, such as the dark room, the quicksand, the water, the flowers, can be regarded as metaphors of the patient's actual life situation, but there may be other levels of meaning at the same time, for instance, referring to relationships as they were in the parental home. The "twinge" the patient mentions after the first session of hypnosis, to get in touch with his family once again, is a sign of this. And perhaps the grave he dug during the second session for his lost pack of cigarettes symbolizes his own grave. We cannot be sure, because no attempts were made in the therapy to translate the primary process language of the patient into secondary process language.

3. Lastly, the imagery work in the first session of hypnosis can also be regarded as an ego-strengthening task. Examples would be finding a way out in a dark room and crossing quicksand and water on doors. Fromm (1968) remarks in this connection:

> *In trance we develop a stress situation for the patient and then let him experience that, and how, he can handle it with increasing skill. Thus, in hypnosis, experiential situations are created which lead to the mobilization of ego strength and the feeling of trusting oneself in real life, too.*

According to Fromm, this can be done either by means of imagery and symbolism, or through dreams. Generally speaking, patients with psychogenic fugue and psychogenic amnesia experiences seem to benefit by such ego-strengthening tasks. Good timing is essential in successfully completing them.

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## REFERENCES

Abeles, M., & Schilder, P. (1935). Psychogenic loss of personal identity. Archives of Neurology and Psychiatry, 34, 587-604.

American Psychiatric Association (1980). Diagnostic and Statistical Manual (DSM-III). Washington, DC.: Author.

Beahrs, J. O. (1982). Unity and multiplicity: Multilevel consciousness of self in hypnosis, psychiatric disorder and mental health. New York: Brunner/Mazel.

Bychowski, G. (1962). Escapades: A form of dissociation. Psychoanalytic Quarterly, 131, 155-173. Copeland, C. L., & Kitching, E. A. (1937). Hypnosis in mental hospital practice. Journal of Mental Science, 83, 316-329.

Crasilneck, H. B., & Hall, J. A. (1975). Clinical hypnosis: Principals and applications. New York: Grune & Stratton.

Dollinger, S. J. (1983). A Case Report of Dissociative Neurosis (Depersonalization Disorder) in an Adolescent Treated with Family Therapy and Behavioural Modifications. Journal of Consulting and Clinical Psychology, 51, 479-484.

Fernandez, J. W. (1977). The performance of ritual metaphors. In J. D. Sapir & J. C. Crocker (Eds.), The social use of metaphors: Essays on the anthropology of the rhetoric. Philadelphia: University of Pennsylvania Press.

Fisher, C. (1945). Amnestic states in way neuroses. Psychoanalytic Quarterly, 14, 437-458. Fromm, E. (1968). Dissociative and integrative processes in hypnoanalysis. American Journal of Clinical Hypnosis, 10 (3), 174-177.

Garver, R. B., Fuselier, G. D., & Booth, T. B. (1981). The hypnotic treatment of amnesia in an air force basic trainee. American Journal of Clinical Hypnosis, 24 (1), 3-6.

Janet, P. (1889). L'automatisme psychologique. Paris: Felix Alcan.

Janet, P. (1907). Major symposions of hysteria. New York: MacMillan. (Reprint of second enlarged edition: New York: Hafner Publishing Company, 1965).

Janet, P. (1909). Les neuroses. Paris: Ernest Flammarion.

Kanzer, M. (1939). Amnesia: A statistical study. American Journal of Psychiatry, 96, 711-716. Kirshner, L. A. (1973). Dissociative reactions: A historical review and clinical study. Acta Psychiatrica Scandinavia, 49, 698-711.

Mac Hovic, F. J. (1981). Hypnosis to facilitate recall in psychogenic amnesia and fugue states: Treatment variables. American Journal of Clinical Hypnosis, 24 (1), 7-13.

McDougall, W. (1926). An outline of abnormal psychology. London: Methuen & Co. Miller, G., Galenter, E., & Pribram, K. (1960). Plans and the Structure of Behaviour. New York: Holt.

Nemiah, J. C. (1979). Dissociative amnesia: A clinical and theoretical reconsideration, In E Kihlstrom & F. J. Evans (Eds.), Functional disorders of memory. Hillsdale, N. J.: Lawrence Erlbaum. Nemiah, J. C. (1980). Psychogenic amnesia, psychogenic fugue, and multiple personality. In A. M. Freedman, H. I. Kaplan & B. J. Sadock (Eds.), Comprehensive textbook of psychiatry, Vol. 2. Baltimore: Williams & Wilkins.

Noyes, R., Hoenk, P. R., Kuperman, S., & Slymen, D. J. (1977). Depersonalization in accident victims and psychiatric patients. The Journal of Nervous and Mental Disease, 164, 401-407. Raymond, F., & Janet, P. (1898). Nevroses et Idees Fixes, Vol. 11. Paris: Felix Alcan. Sapir, F. (1934). Symbolism. Encyclopaedia of the social sciences, 14, 492-493. [Also in D. G. Mandelbaum (Ed.) (1949). Selected writing of Edward Sapir in language, culture c& personality. Berkeley: University of California Press.]

Schneck, J. M. (1954). Studies in scientific hypnosis. Baltimore: Williams & Wilkins. Spiegel, J. (1971). Social roles. New York: Science House.

Spiegel, H., & Spiegel D. (1978). Trance and treatment. New York: Basic Books.

Stengel, E. (1941). On the aetiology of the fugue states. Journal of Mental Science, 87, 572-599. Stengel, E. (1943). Further studies on pathological wandering (fugues with the impulse to wander). Journal of Mental Science, 89, 224-241.

Turner, V. W. (1967). The forest of symbols. Ithaca, New York: Cornell University Press. van der Hart, O. (1984a). Hypnotherapie voor agorafobie: Het opwekken van depersonalisatie en bet beheersen van paniek. Dth: kwartaalschrift van Directieve Therapie en Hypnose, 4 (1), 4-25.

Van der Hart, O. (1984b). Metaphoric hypnotic imagery in the treatment of functional amenorrhea. Manuscript submitted for publication.