Beyond training: The use of our personal self in clinical practice

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In Ericksonian practice and training, utilizing the personal resources of the patient is a cornerstone of all effective therapy. Believing that the seeds for further growth rest within each patient, Ericksonian therapists seeks to nurture this growth by a aligning the therapy with these unique resources available in every one seeking our care and help. Often overlooked, however, in the evaluation of how therapy works, is the equally important and creative use of the therapist's self in clinical practice. The personal self of the therapist is always a part of therapy and must be equally responsive to change and growth if similar change and growth is to occur in the patient. This paper will present guidelines for using the personal self of the therapist in practice with an illustrative clinical example for discussion.

Introduction

It is an inescapable reality that the personality of the therapist is fully present and known to each and every patient we see. Our irritations, our strengths, our weaknesses, and our deepest sense of who we are, are continually conveyed to those with whom we work.

Our training, didactic as it is in the beginning, is the academic cornerstone of our work in future years. If some of us are lucky, we engage in personal therapy that makes some of our unconscious strivings conscious; and gives us the experience of being a patient ourselves. In the years that follow, our personal therapy continues as patients work on us, and challenge us to deepen our self understanding in the service of better patient care. As Georg Groddeck wrote (1949), "The unconscious of our patients so changes our own unconscious, that we become more useful to our patients (paraphrased)". It is inevitable that this process is rich and essential if therapy occurs.

So since our patients know us anyway, and since the therapeutic relationship is intimate, personal, and intense, how can we actively use our personal self in helping patients prosper, grow, and enhance their own lives? This is the challenge I would like to examine today.

Discussion

There are four basic principles I would suggest are the hallmarks of successfully using ourselves in therapy: Honesty, courage, trust, and boundary maintenance.

A. Honesty

Honesty is not a quality we are born with. We come into this world with a pragmatic sense of obtaining what we need. My two year old granddaughter, Alexis, lay on top of my one year old granddaughter, Maddie, and wouldn't let her move. Alexis wanted to open Maddie's first year birthday presents. Alexis successfully unwrapped each of her younger cousin's presents one by one until the mothers intervened. Developing integrity, forthrightness is a painful process.

If we find an opportunity to share a truth that we have learned with our patients, we must struggle to make it real, while tempted to convey it turned out all right, when perhaps it didn't; to report how wonderful an event was in our lives when in fact we were terrified before it occurred - forgotten as all pain eventually is.

"Are you", the patient asks, "happy in your job, happy in your marriage, confident you can help me?" Others ask, "What would you do if you shaded the truth at work and needed to cover it up, shaded the truth to your children about your own early childhood, or slanted a scientific article based on incomplete data?" Few of us actually do these things, of course, but I am sure many of us have struggled with these issues or others like them. Patients knowing better will not judge us on these answers, but on the ability we have in facing the truth and sharing it when appropriate. Fortunately for most of us, patients let us alone in our private worlds yet respond to the many unspoken feelings we all share unconsciously and emit regularly.

B. Courage

Patients coming to therapy must have courage, the courage to face themselves, the courage to accept behaviors they observe in themselves about which they have no idea of the origins, the courage to face the fact that there is an unconscious part of their beings that will resist all but the most intense efforts to explore and understand.

We, if we have been patients, will have some experience in mobilizing ourselves in similar searches. We understand the need to have a courageous therapist guide us into these strange worlds and feelings. We can spend time with our frightened patients, unafraid, or less afraid because we have been there before. But that is no guarantee all is calm. Suddenly and without warning, we may be plunged into an event in the patient's life that we are totally unprepared for and have to mobilize our own courage once again to face the mysteries of the human condition. Courage is not easy. It, too, like honestly, must be developed over a life time.

C. Trust

In sharing one's personal self with a patient, trust emerges as the most important prerequisite. Do I trust the patient with this information? I suggest to my own patients, that information about my personal life is "top secret." Therefore, they must have the "clearance."

Being my patient often gives them that clearance. But they also must also have the "need to know". Will sharing of my personal self enhance their lives or it is a bit of gratuitous "self talk" that merely makes me feel better during the session? Can I trust the patient; and, equally important, can the patient trust me to share what is appropriate and useful to them? And that gets to the heart of it doesn't it? For what are the boundary issues involved?

D. Maintaining Boundaries

Transference and countertransference are powerful forces. How do we feel about the patient and where do these feelings come from? From them? From our past? From our fantasy about them? From an honest, courageous, and trustworthy assessment of the value of what we are going to share? Or do they come from part of our unconscious that we are unaware of and may result in our acting out in various ways. Difficult questions. Boundaries are always being worked on and are continually set - re-established in the hurly-burly of two people working hard together in therapy.

Hilda Bruch (1974) defines psychotherapy as "a situation where two people interact and try to come to an understanding of one another, with the specific goal of accomplishing something beneficial for the complaining person". Getting to know someone is never a neat, smooth process with no bumps in the road. And, it often takes years.

Boundaries by definition are quite broad - for instance we all are enriched by the wonderful stories Erickson told about himself and his family. He was a master story teller - and while we know little of his private inner life, we know so much about his thoughts, feelings, and reactions from those of us who met with him, and from his patients that he told us about so thoroughly. There is great flexibility here, but always in the service of the patient/client - not the therapist.

Case example

As an example of the complex interweavings of these attributes in clinical practice, I will describe my experience working with a patient over many years. I treated a married man who stated he was a world-class jazz pianist. During our first visit, I challenged him to play for me so I could decide for myself. He was indeed the best jazz player I had ever heard. He complained of severe traumatic tendinitis that made playing both painful and difficult. Despite several surgeries to his hands, which only partially relieved his complaints, his symptoms persisted and he sought my help. I taught him self-hypnotic techniques for relaxation and pain control. To help prevent his tendency to re-injure himself by extended vigorous playing, I asked him to limit his playing to only ten minutes each session and to use an egg timer to mark the time.

I met his wife and learned that she was concerned by his single minded drive to play in light of his repetitive injuries. However, she came to realize, as I had, that she was living with a musical genius. If he couldn't play, he could still teach and write. So, he began to write two text books: one on jazz harmony and one on jazz improvisation, which were highly acclaimed. To his great pleasure, he became able to play 5 minutes

at a time in relative comfort. By careful attention to limiting his playing time to avoid further injury, and aided by his skillful hand surgeon, he eventually was able to record his music.

It is important to describe how I felt about this man and his art. I was aware of my deepening interest in his books on both jazz harmony and jazz improvisation. In my own youth, as I began to play the piano, I decided I enjoyed popular more than classical music. I wanted to learn more about chord progressions, alternate voicing of the notes of the chords, and methods for improvising. His two books were the very texts that I had tried unsuccessfully to find for over 25 years. Now he was sitting in front of me working on ways to write and teach his method.

As we discussed how he might grow in his art despite his physical limitations, I grew more aware of how important he was to my own interests. This recognition certainly allowed me to endorse and encourage his own development authentically, and I felt personally invested in our work together. As his great skill became recognized internationally both as a teacher and again as a performer, our sessions reduced in number, and were eventually stopped.

Our relationship, however, continued in friendship as we both celebrated his successes on the telephone, sometimes in person at a celebration party for a newly released recording of his music, and once during a visit with him in the hospital following an unrelated, fairly routine surgery. We shared a mutual respect and affection. I nonetheless realized that I had not yet addressed the final element in using the self in clinical practice: the art of letting go.

One evening on impulse while watching a television story about a gifted musician who also had learned to play despite great pain and suffering, I telephoned my patient to alert him to this story and encouraged him to turn on his television. After the conclusion of the show, I called to ask him how he felt about my comparing him with this other pianist.

He surprised me by stating that, other than the superficial elements, there really was no comparison with his experience and that of the other player. He became concerned that I might no longer understand his own special journey and the work we had done together. It was the first time that I became aware that I was not perceiving him faithfully.

So, what happened? What did I learn? Two things: one professional; the other personal. The professional one is easier to describe. I feel it is important for patients and therapists to come to an end of therapy if at all possible. The therapist must let go, and the patient must be ready to seek this own fortunes - equipped with good coping skills, insights and trust in inner resources. When the therapist has trouble letting go, the process becomes complicated. Many times our patients know better, and seek a way to gain more autonomy and freedom. How do we do this? Sometimes the answer is easy - a kind of impasse is created and the relationship is suspended. Yet, in spite of my own

involvement in his musical success, and my genuine interest in his career, I had presumed this process of letting go was occurring.

I thought he needed autonomy and wholeness and the confrontation provided the necessary and required distance. Therefore after I wrote him of my future availability and interest, I decided not to initiate another call to him, and to respect his need for separation in the name of boundary maintenance and letting go. Was I in for a surprise?

I learned that the personal relationship remained important too. A year after I presented this lecture in Venice, my patient and his wife called me to say hello. Later that month, he and his wife sent me a Christmas card. I wrote back in thanks and took the liberty to ask more clearly what had happened.

He and his wife said he had been simply disappointed when I compared him to someone else with only superficial similarities. He felt that by not recognizing the complex differences between the other pianist and himself, I no longer appreciated the true nature of his art and his lifelong learning. While the dynamics of transference and countertransference abound, I have learned there is always more substantive human aspects to all relationships whether in our personal lives or with our patients: I had simply lost sight of who he was, what I meant to him, and what he meant to me.

An old story comes to mind, It is one of my favorites since my own young adulthood. It is the story of *The Little Prince* by Antoine de Saint-Exupery (1943). Remember the fox told the little boy about friendship, "It is only with the heart that one can see rightly; what is essential is invisible to the eye." I had simply forgotten to see him with my heart. I have learned this from my patient. Something I feel destined to learn again and again.

Using our personal self in clinical practice is never a smooth road. But better to experience a few bumps along the way, than never to travel this path with heart.

Some final thoughts

In every therapy, there occurs surprises, things begging to be learned once again. We must, as Carl Whitaker (1983) strived in his own life, to hope for anxiety, struggles, and the shocks of new learning springing forth from our unconscious that serve to make us better therapists. By sharing ourselves with our patients, and making these relationships more intense, we position ourselves to learn until our last breath. Sir William Osler (1900), the Regis Professor of Medicine at the turn of this century, said, "More clearly than any other, the physician should illustrate the truth of Plato's saying, that education is a lifelong process". In our own field it is equally so. Let us not lose our courage to grow, our trust in ourselves, and our honesty to look at who we are. By maintaining boundaries with care and understanding, we will integrate our many parts into a wholeness and wisdom that mark the successful career.

Today we celebrate Milton Erickson and his life as we seek not to become like him, but to use him as an example that encourages ourselves to find our own voice as therapists and then to share this voice, our selves, with all who seek our care.

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The revolving doors of pain: Hypnotic synaesthesia as a multi-sensory modulation of pain experience

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■ *Synaesthesia is a condition in which the individual experiences a sensation in one sensory modality triggered involuntarily and automatically by a sensation in a different sensory modality (e.g., coloured hearing, tasting shapes). A synaesthete might describe the colour, shape and flavour of someone's voice, or music sound or, seeing the colour red, a synaesthete might detect the 'scent' of red as well. In addition to the well known developmental and drug-induced synaesthesias, the author describes a hypnotically induced synaesthesia. Hypnosis, with its eidetic and holistic properties, can be the appropriate catalyser to evoke synaesthetic experiences even in non-synaesthetes.*

Hypnosis and synaesthesia share common features (e.g., transient changes in self-awareness and consciousness, experiential absorption, focused attention, enhancement of integrative processes, cross-modal sensory processing). Moreover they share, at least in part, common neurophysiological correlates and mechanisms (i.e., limbic system activation and inhibition of prefrontal cortical areas).

Hypnosis and synaesthesia can be considered as functional remnants of the primeval mind or living cognitive fossils (Cytowic, 1997). So we might think of both, hypnosis and synaesthesia, as "working memories" of the past that can still deeply influence our present and our future because of their strong, adaptive, evolutionary power.

Hypnotic synaesthesia can also provide new perspectives for hypnotherapy, such as, for instance, for pain control. In fact, somesthesic and emotional experiences may trigger and/or up-modulate pain sensations in most pain syndromes in holographic mode (e.g., migraine, neuropathic pain, complex pain regional syndromes), even in the absence of pain stimuli. If a pain (nociceptive) percept can establish crosstalk links with other sensory network to up-modulate it, it can also down-modulate it. Hypnotic suggestion can enhance the crosstalk link between a discrete sensory percept (auditory, visual) and the pain network, in order to reduce the pain concurrent.

Synaesthetic perception is the rule, and we are unaware of it only because scientific knowledge shifts the centre of gravity of experience, so that we unlearn how to see, hear, and, generally speaking, feel.

Maurice Merleau-Ponty, 1962