only on themselves, not on others.

References

Breuer, J. & Freud, S. (1955) Studies of hysteria I: On physical mechanisms of hysterical phenomena: Preliminary communication. In J. Strachey (Ed.), Standard Edition, 2, pp, 1-181. London: Hogarth Press. (Original work published 1893-95)

Erickson, M.H. (1939). An experimental investigation of the possible anti-social ue of hypnosis. Psychiatry, 2, 391-414.

Fromm, E. (1965). Hypnoanalysis: Theory and two case excerpts. Psychotherapy: Theory, Research, and Practice, 2, 127-133.

Fromm, E. (1979). The nature of hypnosis and other altered states of consciousness: An ego-psychological theory. In

Fromm, E., Oberlander, M.I., & Gruenewald, D. (1970). Perceptual and cognitive processes in different states of consciousness: The waking state and hypnosis. Journal of Projective Techniques and Personality Assessment, 34, 375-387.

Gill, M.M., & Brenman, M. (1959) Hypnosis and related states: Psychoanalytic studies in regression. New York: International Universities Press.

Kris, E. 1952 (1934). Psychoanalytic explorations in art. New York: International Universities Press.

Levin, L.A., & Harrison, R.H. (1976). Hypnosis and regression in the service of the ego. International Journal of Clinical and Experimental Hypnosis, 24, 400-418.

Rosenberg, M.J. (1959). A disconfirmation of the description of hypnosis as a dissociated state. International Journal of Clinical and Experimental Hypnosis, 7, 187-204.

Watkins, J.G. (1949). Antisocial compulsions induced under hypnotic trance. Journal of Abnormal and Social Psychology, 42, 256-259.

Finding One's Voice: The Art and Process of Becoming a Therapist

Peter B. Bloom

■ *Psychotherapists from every discipline bring common longings to their craft: the need to feel competent, effective, and centered when working with patients and clients. Clinicians who choose to become therapists must repeatedly reappraise their development by examining their successes and failures to ascertain the nature of their evolving knowledge and skill.*

During the process of becoming a therapist, there appears a personal style, interpretation, and coloring in the clinician's work that is unique to him or her. Finding this voicing of our work and letting it lead our efforts to combine knowledge and intuition in the clinical setting is a worthy struggle. I will examine ways to facilitate finding one's voice. In developing our access to this creative and natural sense of ourselves, we must be alert to our own observations while keeping our curiosity alive. As we gain confidence in using ourselves in this new context of knowledge and experience, we may find we have returned to where we started and are comfortably practicing the Art of Therapy.

I wish to describe what it is like to spend a lifetime career striving to become the psychotherapist one longs to be. I will not discuss technique, theory or clinical results that seem so flawless that learning ceases. I believe that as therapists we cannot solely depend on our techniques and theories in achieving clinical successes, but only, in the final analysis, on ourselves. Our confidence must ultimately rest on finding our voice and enjoying its expression in the service of our patient care and our own continued growth.

The voice I speak of comes from that quiet place within each of us. It's a place that derives its strength from vigorous training, fully credentialed and peer reviewed. This voice is not "flying by the seat of one's pants" and it's not expressed in the therapy based only on

intuitions. However, it does, in addition to vigorous training, depend on one's unconscious intuitions that often present in flashes of insight and action within the context of carefully constructed therapy. This voice is the expression, then, of both our conscious and unconscious knowledge experienced in the context of being ourselves over many years. Carl Jung said the nature of psychotherapy is after all the treatment of the soul. If so, the art and process of becoming a therapist is a sacred journey and is shared and refined with our teachers, our families and our patients.

How do we find our voice? What constitutes our journey?My thesis in this paper is that one begins the journey in becoming a better therapist by examining one's failures and successes. In the former, repeated mistakes that commonly originate in the therapist can be recognized and later avoided. In the latter, techniques leading to success in one patient must be set aside in other patients. Techniques in one context are not useful in a different context. Sun Tzu in his essays on The Art of War writes, „When I have won a victory, I do not repeat my tactics, but respond to circumstances in an infinite variety of ways" (Griffith, 1963). Put differently, I try to avoid unnecessary attachments to success. Then when we have set aside the mistakes of our repetitive failures and released our attachment to our successes, we are able to use ourselves freely and creatively in an infinite variety of new ways. Should we arrive at this point in our career, we find our voice and become the therapist we yearn to be.

Case examples

First I will present several examples of my failures. Then, I will present several examples of my successes. I will then conclude with a case example that seems neither failure nor success but touches the heart of patient and therapist change.

Case 1

I saw this woman just once. In her early thirties, she described a crisis that seemed a transitional developmental stress. Following a pleasant interview, I asked her to come back if she needed more help. A month later, the county coroner called me to say that my patient had jumped out the window of a tall buildi..g and was found dead on the street. He asked if she had been suicidal and I said, „Just a moment, I'll check my notes". I take pride that I teach my colleagues how to take and pass the American Board of Psychiatry certifying examinations and I regularly teach resident psychiatrists how to take thorough histories. The one question one must ask every time is „Are you suicidal?" I could not find in my notes any evidence for having asked her about suicide. I did tell the coroner it was my impression that it was safe to let this patient go from the office. Nontheless, I was disturbed that both the patient and I had denied the need to discuss it. But how did such a mutual

denial occur? How did she and I avoid the question?

I learned very painfully that day what I had known in fact known all along: we communicate unconsciously. In this case, we both shared the denial of the horror of ending life and youth. It was truly unconscious colluding on both our parts. However I am also reminded that our unconscious communication is also a great resource. We all appreciate that hypnosis facilitates multi-level communication. I am sorry a patient's life was lost in the process of my continued learning, however, I am also aware that as a physician we all lose patients and the process is always painful.

Case 2

My second failure was more complicated. My new patient announced in her first hour with me that her life mission in life was „to bring all men to their knees". A senior colleague asked me to see his patient that had caused him great difficulty. As he asked me to see her, he was sweating, heart pounding quickly, and stuttering more than usual. He said, „Since you are mature and capable of handling negative transference, you will be just the person to see this patient. "I needed some respect from a colleague at that moment in light of other bumps and bruises I was experiencing in my practice. And so it was with calmness and a sense of personal satisfaction that I said I would be happy to see her for him.

We spent two years working together - at times peacefully and at other times with great difficulty on both our parts. At the final appointment, I had asked fifteen members of our staff to gather outside my office. With a signed commitment paper in my coat pocket, I was prepared to commit this patient involuntarily to the hospital days, she found another therapist then another and another and another. At last count she was up to eight additional therapists.

What did I learn? I had not listened to my patient's opening statement. She told me what she was going to bring to the therapy experience and I had responded to my colleague's massaging of my own narcissism. While she may have been untreatable by me in the first place, I might have spared us both two years of unfruitful labor, a burden that took away from my own creativity in other areas. We must not burden our lives with too many difficult patients in the hope that we will succeed if we try hard enough. These burdens constrain and tire us in the end and I suggest limits our ability to grow as therapists.

Case 3

The last failure I will present here is also poignant and painful to relate. This older woman my age said „I'll make life miserable for you if you abandon me. "Those who know me understand I strive to be nice. I tend to avoid angry confrontations in my office work and I define therapeutic failure when the patient generates more countertransference anger than

the therapist can manage. Control can be lost in the therapeutic sessions, patient demands can escalate and boundary violations are a risk if the therapist tries to please the patient attempting to avoid angry confrontation.

Some therapists send postcards to patients on holidays. I have on occasion with very sick patients. But when I did with this patient, it had a different quality. It had the quality of performing as expected. Soon after therapy began, the patient's husband died from an unexpected cancer. How does one maintain an active therapy with a patient who is grieving? The transference and countertransference dynamics still persist. She asked and I agreed to lower my fee by one half. I learned at the end of our therapeutic experience that she could have paid the full amount from her insurance but had never told me. The manipulations continued. There were increasing telephone emergencies and finally, as she was involved in a litigious case, she asked me to present fraudulent information to the judge on her behalf. I didn't do it, and at that point, I finally realized that the process of this patient's illness was more than I could treat and I refused to continue treating her.

I suggest all of us spend time learning to bring patients into therapy, but we must also spend time learning how to get patients out of therapy, or particularly out of our own offices. I'm happy to note that this patient was successfully referred to a younger colleague of mine and he saw her for several visits. She then found over time the ability in herself to be autonomous, responsible for herself and is no longer in therapy with anyone.

By the way, no sexual violations occurred nor would I have allowed it. It is useful to point out that these dynamics of appeasement can result in crossing patient-therapist boundaries. By beginning with a hug on the death of her husband, some might be led to other forms signs of intimacy. This is a lethal dynamic to both the patient psychologically and to the therapist professionally. Consultations must be liberally sought.

However, this patient taught I must be ever vigilant to maintaining my professional control, my balance, my center if I wish to remain effective as a therapist. If I ultimately wish to get closer to my own creativity and my own voice, then I have also learned that, despite my best efforts, there are patients I simply cannot treat. In other dynamic terms, I cannot afford to remain in a masochistic posture by continuing to work with patients like these while desiring to enhance my creativity. I am a good therapist, and like all others though, I have my limits. Now I would like to present a few successes. Even these cases, have an inherent attraction to laud a technique or result that as in cases which fail can keep one from finding one's voice.

Case 4

A 30 year old woman reported that from age 14 to 18 she had been kidnapped, and sexual-

ly abused, by her general physician. She stated that she had been forced to live with the physician while her family believed the physician was providing needed psychological care. She began therapy by reviewing the trauma and we soon discovered that underneath the post traumatic stress was a full blown borderline personality disorder. Her rage and memories of abuse resulted in multiple suicidal attempts during her therapy with me. When I placed her on MAO inhibitors, she would deliberately take sympathomimetic amines to purposefully and dangerously raise her blood pressure in front of her husband. He would have to take her to the hospital repeatedly. At one point, he called me to say that his wife had taken an overdose two hours ago and he was watching her getting sleepier and sleepier and really did not want to intervene because he was so tired. He said „Enough is enough. "I was forced to intervene which is why he called in the first place.

At the end of four years, she called on me on the telephone threatening suicide once again. I said to her „I cannot treat you if you commit suicide" and she said „Well, that's obvious, I'll be dead". I said, „No, you don't understand that I cannot treat you if you commit suicide" and she said, „Oh, now I can't threaten suicide in the office and you won't work with me dynamically" and I said, „No, that's not what I said. I said I cannot treat you if you commit suicide". There was a long quiet on the telephone when she understood it was the process of claiming the option to commit suicide to which I was referring. There was quiet on the other end of the phone and it became apparent she understood. I continued, „In addition, you must remain constructive, every word out of your mouth from now on must be constructive". We finished our therapy with only six more visits. It's been another five years since we ended therapy and I still get an occasional Christmas or birthday card.

I learned from this patient that given the therapeutic alliance built carefully over time by both the patient and the therapist, a context is created wherein the therapist's expectation for her change could be entertained. The statement, „I cannot work with you if you commit suicide" shifted her from the concrete to the abstract. Once the process of the statements are entertained, patients become free to let go of the pain and the memory of the abuse, of the traumatic experience and live the rest of their lives taking full responsibility for themselves without blaming the people in the past that created their problems. Without this resolution, sufficient growth or stability does not occur. She did this and continues to do this.

Central to my theme today is the recognition that this is not a technique to apply to every suicidal patient - stating „I will not work with you if you commit suicide". The intervention like all interventions is contextually dependent and although the patients may be ill in similar ways, no technique can be applied across the board. These interventions were valid

for these specific patients, but flexible therapy that is client-centered remains in the foreground.

Case 5

This next patient remains of great interest to me. I began to get a hint of some of the intuitions and creativity that might be a part of my own style should I continue to search for it more consistently. A physician's secretary reported lower epigastric pain coming from her esophagus and had been receiving from her employer injections of narcotics. In seeking consultation, she was admitted to the Hospital of the University of Pennsylvania for evaluation of a feared esophageal cancer and for narcotic detoxification.

Still in my medical training, I saw her shortly after admission and was soon called back by the nurses who stated she was ambivalently sitting on her packed suitcase in her nightgown asking to go home. I received the telephone call from the nurses four hospital floors above the ward and decided that because of the patient's obvious uncertainty, I should get my own mind as empty as I could. To do this, I counted backwards from ten every ten steps I descended and then walked on the open ward. I was calm, my mind was blank and I was ready to react to the patient as best I could. I found her sitting on her suit case with her long fingernails pushing into the palms of her hands. I walked over to her, took her hands and opened them. I could easily see the red marks in her palms. Without hesitating further, I said, „Oh, these are the stigmata, you know, the holes made by the nails in Christ's own hands." At the moment, when you say something like that strictly from your own unconscious, you have to check in Christ's own hands. I come down, I will pass the esophagoscope and do what we have agreed to do." She immediately got up, took her suitcase with her husband, and went back to bed. As I left the floor, the nurses whom I knew very well, said to me, „What did you say, how did you convince her to stay here?" All I dared say was, „Oh, we just had a brief discussion, everything is going to be just fine." I walked off the floor feeling euphoric, but also isolated in my ability to share what I was discovering about psychotherapy and finding my own voice.

The next day at esophagoscopy (I was in gastroenterology training at that time), she was lying on the bed awaiting the procedure to begin. I turned to her and said, „Ruth, I would like you to breathe in and out". As I turned to prepare the Valium (diazepam) for intravenous sedation, my senior attending who was watching me do this procedure turned to me and said „Your patient is not breathing. "Surprised to see she had taken my apparent request to breathe in and out only once, literally, I said, „Ruth, you can continue to breathe normally in and out. "Thus I had my first experience with a patient in trance. Frightening as it was, but encouraged by my attending, I said, „Ruth, I will pass this tube com-

fortably. You will not have to swallow the tube, you will not gag. "I passed the tube easily and on seeing the lesion, I said, „Ruth, this is just esophagitis, let's take a biopsy, but you're going to be fine". On completion of the study, we removed the esophagoscope. As I prepared to send her down to her floor, I asked her to read in the Bible, The Book of Job. Anybody who has suffered like she has, I thought, should „come to grips with how a `professional' did it".

Two days later, the biopsy proved negative for cancer. She was easily withdrawn from the narcotic, and soon went home. Ten days later, she returned for a follow up visit which I audiotaped as was the routine at that time for teaching purposes. She said, „Dr. Bloom, whenever I get pain at home, I sit quietly in the chair, I think of the Bible and of your kind words, Reverend, I mean Dr. Bloom. The pain goes away and then I get up out of the chair and go about my business. "

I learned two things. First, by freeing myself with the hypnosis prior to the interaction, freeing myself to be patient-centered with no other agenda in mind, and free to say whatever came in my mind, I was able to open myself in a beginning fashion to my own creative voice. My response to her sitting on the packed suitcase in her hospital gown was nonetheless based on my knowledge of medicine and psychiatry. These responses just did not appear de novo, but they appeared in the context of all my learning, all my training, and the previous interaction with the patient. Secondly, I learned that despite my success in keeping her in the hospital, completing her medical workup and removing her from all narcotics, reading the Bible and hypnosis are not techniques I can expect to apply to most pain and narcotic-dependent patients. Most importantly, to be open-minded, not technique dependent was an approach to patient care that I must learn to value and develop further.

Discussion

How does one develop a personal style of balance and openness? How does one trust what comes out of his or her mouth? How does one trust that what comes out will be therapeutic? Certainly there are steps one can take. The first step, I believe is knowledge acquisition. I have had 11 years of formal training after medical school including residencies in medicine and psychiatry. With additional military service, I was 34 years of age before I opened my private practice of psychiatry.

Recently, I have added some clinical research experience to my clinical experience which has become very important to me. This research lends a certain rigor to my clinical experiences and while it has come late in my career, I suggest each of us can profit from involvement in such controlled investigations.

In addition to training, we simultaneously gather more clinical experience and know-

ledge which we can trust to guide us in future cases. We begin to rediscover how to refine and trust our evolving intuitive sense. We often realize it has always been there, always has guided us, and it can be consciously accessed. Finding one's inner voice, therefore one's own unique way of doing therapy, rests on being comfortable with one's style, and personal interpretation of clinical material.

It's been my privilege to have a number of artists in my practice. Whether their medium is painting, music, graphic design, or advertising, they all share these same struggles to become artists by fusing their technique with their intuition.

Robert Henri , an American artist and author of The Art Spirit, told his students over the years. "Don't worry about your originality, you could not get rid of it, even if you wanted to. It will stick to you and show you up for better, for worse, in spite of all you or anyone can do (Henri, 1923). "Also, „Join no creed, respect the truth that is". I become very concerned when we call ourselves Freudians, Ericksonians, traditionalists, or whatever. When we identify with others in this way, I believe we hide from ourselves, hide from that essential notion that to become our best selves, we must find our own ways in becoming a therapist. I asked Milton Erickson what one word he would give me as a young professional to spend the rest of my life thinking about and his word was observation. He said if you observe, you'll have all the data you need. Years later I asked Ernest Hilgard what his one word was and he said curiosity. He said one's mission should be „keeping curiosity alive. "I suggest you ask yourselves what is your one word.

Finding one's voice also involves trusting hunches, relying on your creative interventions and not turning them off. Had I looked at that woman and thought, „Geez, it looks like stigmata, but obviously at a major university hospital in a medical ward, my job is to get her back to bed. "That would have been the death of that experience and perhaps I could not have successfully treated her. One has to know when to let go while also keeping an eye on the process.

Seek consultants when you must free yourself from patients that constrain and limit you. You must ask your consultants to help keep you free to grow. You can discover yourself by videotaping and audio taping your patients. Let your patients shape you (Groddeck, 1949) and tell you what you're doing wrong, what you're doing right, and eventually then you can return to the place where we all started, the place we have always known our personal sense of being a therapist resides.

Case 6

This case illustrates neither success nor failure, but a grand experience of sharing a change in both therapist and patient. I was treating a young graduate student in psychology, while I was in training as a young resident in psychiatry. We were working on her need for control which was becoming a prominent theme. There was a playful nature to the therapy -we were both young and interested in doing whatever worked. One day she announced, „Ah, next week is my birthday", to which I responded, „Oh, that's fine. Why don't you next week bring me a present for your birthday." She smiled and agreed. Next week she returned and said, „Today, I have brought a present, I brought you a present for my birthday. I've brought you two marbles for my birthday. Choose one, pick one. "

We all know the wonderful story illustrating the double bind theory of schizophrenic communication about the mother who brings her son a blue sweater and a red sweater. She sends him upstairs to see them, and he chooses the red sweater. His mother asks, „What's wrong with the blue sweater?" Similar thoughts went through my mind as did many others. Which one to pick? I then experienced a profound silence, a silence that just enveloped me and slowed down all my thinking. When I was completely quiet, I found my arm reaching out, taking the two marbles, and putting them both in my mouth, I said, „You have brought me a present for your birthday, two marbles, you've asked me to pick one. Now I have two marbles in my mouth, what are you going to do?"

We started to laugh, a true belly laugh from deep in my gut. As we started to laugh, she had the reality sense to say, „Please, take the marbles out, you're going to choke". That was good advice! I took the marbles out, put them aside, and then we let the laughter flow for a long time. We spent the balance of that hour and the whole next session week discussing this experience from the vantage of every theory of psychotherapy we knew. Obviously, we started with psychoanalytic and went quickly to behavior therapy, even Zen (Reps, undated). Cognitive therapy was in its infancy. I think there are now over 400 identified psychotherapies and at that time is seemed we covered 200. It was a wonderful experience. I still have the marbles somewhere at home. From that point on, neither of us had the difficulty with the issue of control. It was gone between us. Our work became smoother. Twenty five years later, now a senior psychologist in the community, she came to our hospital for a conference. I pulled her aside and I told her that I had written of our experience and gave her a reprint. I said, „Do you remember that day?" She says „I do not forget a single word either of us said. That day has stuck with me all those years", as it had with me.

This sudden, unexpected expression of your therapeutic self in a context of training and accessing one's own intuitive side is pure joy. One finally knows the nature and expression of one's true voice and one feels whole as a therapist and one can glimpse anew the art of therapy.

Conclusion

Over time and with attention to one's failures and successes, a therapist can find his voice: that special combination of knowledge and intuitive insight that fuses in creative acts of therapy. Finding our voice and becoming a therapist is an act of becoming our full selves. Only then can we truly express ourselves (Felder, 1991).

Becoming a therapist involves finding expression for your full self in your work. When we are constricted, constrained by our patient failures, or when we hang on to techniques that once worked with another patients, we diminish ourselves and what we therefore can offer our patients.

The road to our full selves entails keeping our paths free of obstacles stemming from our failures and the seductive allurement of our successes and allows our artistic voice that has always been inside to come out and play. At this point, success and failure melt away and we find we are effective in our work in new and creative ways. We constantly approach our work in „an infinite variety of ways" that reflect our deepest sense of who we are. In essence then, we can say we have found our voice in becoming the therapist we have always yearned to be.

References

Bloom, P. B. (1990). The creative process in hypnotherapy. In M. L. Fass and D. Brown (Eds.), Creative mastery in hypnosis and hypnoanalysis: A festschrift for Erika Fromm. Hillsdale, N. J. : Lawrence Erlbaum Associates.

Felder, R. E. (1991). Existential psychotherapy: A symphony of selves. Lantham, New York: University Press of America.

Griffith, S. B. (Translated, 1963). Sun Tzu: The art of war. London:The Oxford University Press.

Groddeck. G. W. (1949). The book of the it. London: Vision Press Limited, Pp. 262. (Authorized translation of „Das Buch vom Es" by V. M. E. Collins, M. A. Vienna: the Psychoanalytischer Verlag, 1923)

Henri, R. (1923). The art spirit. New York: Harper & Row, pp284.

Reps, P. (Compiled by author) Zen flesh, zen bones. A collection of Zen and pre-Zen writings. Rutland, Vermont: Anchor Books, Charles E. Tuttle Company. Undated.

Minimal Cues in Diagnosis and in the Hypnotherapeutic Process

Camillo Loriedo

■ *Minimal cues are those behavioral indicators, seemingly trivial and irrelevant, of a specific state of mind or internal processes, usually not considered a signal by the untrained people because only a careful observation reveals the connections between these indicators and meaningful behavioral responses. Attention to minimal cues and to the slight differences in the subjects behavior are probably the best indicators of the therapist's experience and effectiveness. Intuition, anticipation and clinical skills are the results of a good training to observe minimal indications of the subject combined with patient exercise. Hypnotic rapport is also considered as a mutual sensitivity of both hypnotist and subject to each other's minimal cues. Suggestions for recognizing different types of minimal cues' are given together with some general guideline on their hypnotherapeutic use.*

In all forms of psychotherapeutic approaches there is a general tendency to isolate special life events, facts that are considered to have the greatest importance in the story of each single individual. These events are usually given a notable value in order to explain that peculiar human being's behavior and/or the reason why problems and symptoms arose in the course of that individual's life.

On the contrary I have always been impressed by the fact that despite this diffused tendency to identify meaningful and unique events that could have, by themselves, the power to change the habitual way of living, one of the most important contribution of Erickson's work and of hypnosis in general has been the attention paid to little, seemingly unimportant details and cues that, because of their profound impact and implications can produce enormous and often unexpected changes in a person's life.

Hypnosis, has always stimulated popular fantasy because of its spectacular effects, and these dramatic qualities that sometimes the trance state is able to produce created serious misunderstanding of the hypnotic reality. The unconscious power amplifies greatly the