When Erickson meets Freud: The Therapist Trance and Countertransference as Resources for the Hypnotherapist

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■ *Training in hypnosis, following training and practice as a psychodynamically oriented psychotherapist, introduced new and exciting elements which required integrating to establish a coherent approach. The paper will elaborate the interaction between using the benefits of the Therapist Trance, „Ericksonian" storytelling, and elucidation of countertransferential themes in the working through of different issues during the psychotherapeutic process. A special emphasis will be placed upon the challenge of integrating the different approaches and techniques upon the struggle of the psychotherapist to maintain his integrity and coherence vis-a-vis the patient.*

An extensive training as a psychotherapist with a psychodynamic orientation sensitized me to appreciate the therapeutic relationship as the essential unit of concentration from which emerges the resources and experience to help the patient with the concerns which brought him to seek help. The resulting focus highlights the transferential as well as counter-transferential aspects. Subsequently, as I became familiar with Milton Erickson's approach, I was impressed by the flexibility and freedom involved in expanding the domain of therapeutic tools to metaphors, stories and use of "non" sense to assist the patient in reaching the resources necessary for change within his unconscious. I began to expand my therapeutic approach to attempt to integrate the latter. I will try here to share the results of the past few years of working out this "meeting" into a coherent and genuine approach. Specifically, I will elaborate upon the use of the therapist trance as it elicits and brings up into awareness associations and mentation which expand my grasp of my relation to, and experiencing of the patient. Among others, counter transferential aspects become highlighted. I will attempt to show how they become material to be actively utilized in the therapeutic process.

During the past 15 years, many hypnotherapists have begun to attend to trance aspects of their own experience during hypnotic work with patients. The phenomenon described as externally oriented interpersonal trance (Erickson & Rossi, 1977), or as

the therapist trance (Diamond 1986) has been purported to affect the therapist in the direction of (1) increasing empathy, (2) allowing freer access to unconscious material, (3) reducing anxiety and increasing a sense of relaxation, thereby increasing receptivity (Scagnelli, 1980; Diamond 1986), (4) reducing the tendency to intellectualization (Deikman, 1969), (5) providing greater access to internal trance processes which enable the communication with the patient to be more organically flowing from the interaction (Diamond, 1986), and (6) heightening sensitivity to minimal cues (Loriedo, 1995). In my experience, entering the therapist trance furthermore highlights and brings to focus aspects of counter transference during treatment.

A full inspection of the therapist's experience during therapy requires relating to the counter-transference dimension. Issues of disclosure and sharing of counter transference with the patient have been raised as several clinicians (Epstein & Feiner, 1979; Gorkin, 1987; Wollstein, 1988) have departed from Freud's (1910, 1915) narrow definition of counter transference as a more or less unconscious reaction (or "transference") on the part of the therapist to the patient's transference. The term will be used here according to the updated version, which pertains to the feelings, thoughts and sensations which emerge in the therapist in relation to the patient.

Disclosure of the counter transferential material has been shown to (1) confirm the patient's sense of reality, (2) to clarify his impact upon the therapist, as well as upon people in general, (3) to establish the therapist's genuineness and humanness (Gorkin, 1987), (4) to enhance intimacy and affective expression (Ehrenberg, 1984; Fisher, 1990), and (5) to foster mutuality of relevant self-revelation (Basescu, 1990) and identification (Menaker, 1990). On the other hand, caution is essential. The patient's reaction to disclosure needs to be carefully elicited (Gill, 1988), and the therapist needs to be open to the reactions (Josephs, 1990). Counter transferential reactions can especially enter into play in hypnotherapy in two basic forms:

1. Aggression may be expressed through unduly forceful and long attempts at induction which raise resistance, which in turn cause a projection of a sense of failure onto the patient, causing punitiveness and rejection. At times, a patient may be pushed too early or unnecessarily into traumatic material without due regard for his defenses (Gruenewald, 1971). One aspect of the misuse of power has been linked to a "sibling counter transference" (Fromm 1968).
2. Dependency may be expressed by identification, through taking over a parental role and reinforcing dependency rather than helping the patient deal with it. On the other hand, the therapist defending against his needs may keep the patient at too great a distance, denying him the warmth and support he needs (Gruenewald, 1971).

The major point being raised in this paper is that as the therapist allows himself to enter trance, he is more able to connect with his counter transference and becomes aware of such themes as just described, the process of coming to terms and sharing provides an intimacy which may have a profound impact and serve as a kind of repair of the usual

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pattern of interaction of the patient (a "corrective emotional experience" as proposed by Alexander & French, 1946). Often, the therapist's counter transference reflects a kind of a "pacing" and matching of previous relations, while the disclosure provides the first "lead" or break from the old pattern.

A severely constricted and depressed young woman who had been sexually abused for years as an adolescent by her step-father, was very reluctant to depart from the normal talking mode. Having been trained in hypnosis, I thought from the outset to try to work-through the repeated traumas by doing age regression work. As I enthusiastically began to try to implement my therapeutic plan, I found the patient extremely resistant, and gradually becoming more constricted and withdrawn. I came to realize that I was recreating the abuse, by trying "to force her to take in" my hypnotic intervention. As I became aware of the re-enactment within the therapy, I chose to disclose and share with the patient my discovery which brought about a relaxing of her defensiveness. She had never confronted her step-father, and he had never said a word. For the first time, she was able to ward off "the attack" in the context of a male who was acknowledging how he was relating to her. The experience was extremely significant and had an impact on her, in the direction of beginning to heal the wound and open her to a different mode of experience with a man. Eisen (1989) has noted a similar pattern of excessive therapeutic zeal with amnesiac patients.

I access the therapist trance in four ways:

1. Natural/automatic self trance induction: The cues of sitting, facing, and focusing upon my client's (patient, student or supervisee) face and eyes bring about a narrowing as well as a sharpening of concentration upon the "myself with the client" dyad. The trance brings up perceptions of the patient, personal memories as well as memories of previous therapeutic relationships, stories, feelings, observations which are brought up for the patient's inspection, in a tentative while open manner. In supervision, the main reservoir consists of associations to situations wherein I am the therapist.

2. During "formal" trance work: Most of my trance work entails the use of a free worded, flow of association kind of induction. While I may have consciously planned to touch upon specific, salient points according to the treatment aims, I usually find myself drifting to further areas which just "seem to come to mind." I usually verbalize freely the words and images which come to mind. Whenever I look back and reflect upon my verbiage, interesting emphases emerge and become clear, as to my grasp of what Scagnelli (1980) emphasized was the present feeling state of the patient. I must add that I find my productions to reflect past, present as well as future dimensions.

A student in a hypnosis course asked to work on a severe flying phobia (she had to take a 500 km flight home that afternoon). As I began to work with her in trance, I found myself talking about buffers, cushioning, safety and insulation. Then I heard myself uttering "luftgeschäft," talking about psychologists and the necessity of using hot air (see Diamond's fascinating analysis of archaic involvement in Erickson's work, with the Wizard of Oz metaphor; Diamond, 1988). At that point, I made the click with her

inner world, and she sighed, smiled, acknowledging the connection and entered deeper into trance. She called later that night thanking me for the pleasant flight!

3. Working with the Gong: When I play the Gong for a patient (see Livnay, 1995 for a description), I draw upon a combination of my feeling state, my understanding of the patient's needs, and my treatment aims. These are translated into the tones I elicit, the intensity and rhythm which I use. While I start out my playing with certain aims, my playing brings me into a similar trance so that I find myself drawn into a specific pattern which both reflects the patient's reaction to my playing (pacing), as well as elements which at times reveal to be counter transferential on my part. As the playing is non-verbal, it is especially susceptible to be a medium for unconscious themes which are prevalent in the interaction at the time of the playing. The structure and pattern of my playing, as well as the patient's reactions, experience and associations to it then become the matter for subsequent discussion and analytical inspection.

4. Client-as-hypnotist: A special variation of the therapist trance is the situation where the therapist invites the patient to take on the role of the hypnotist, and to hypnotize him. The technique has been described by Plapp (1976) in an innovative treatment of a highly disturbed adolescent, and by Diamond (1980, 1983). I use two variations. With patients who are uncomfortable with closing their eyes and express feelings of vulnerability and discomfort, I suggest that they keep their eyes open, and that I close my eyes while I continue with the induction and hypnotic work. This has proved to ease their concerns and hesitations, provided that I have been sensitive to their feelings and questions about the change in balance between us, fears about „taking over" and so forth. In other cases, I let the patient actually do an induction, while I enter trance along the lines described by Diamond.

Allowing myself to access as well as express my experience has several consequences:

1. A model is being provided for openness to both inner processes and interaction, for letting go and flowing, and foremost expressing trust in my unconscious. Trust begets trust. When such interactions are repeated throughout the course of the process, they have a cumulative effect upon the client.

2. The atmosphere becomes looser, lighter, more flowing as well as intimate. A playfulness is introduced which can be likened to Shapiro's (1988) hypno-play therapy.

3. There is an enhancing and strengthening of the rapport and the working alliance, on both the conscious and manifest level, as well as on the unconscious, pre-verbal level (see Diamond 's excellent analysis of the 4 dimensions of therapist-patient relationship in hypnotherapy; Diamond,1987). The sharing of the therapist's inner life and processes with the patient, especially insofar as these are connected to the patient's dynamics, has a very strong impact upon the "magical" expectations and primitive striving of the latter in the therapeutic relationship.

4. A special corroborative atmosphere of open inspection becomes established, wherein both participants are better able to access relevant aspects of their experience, and to share them for mutual benefit.

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5. I come in contact with material which both increases my empathy and grasp of the client. I often use the materials as a kind of symbolic anchor long thereafter, returning to the image, thought or sensation henceforth during the working through of the material. It provides me with a focal point, as well as with a channel and direction for organizing the associative material.

During the course of therapy with a severely debilitated young borderline woman, I kept imagining symbolic crossroads between a Rock Concert and a tribunal with a judge sitting high above. I used my "visions" to connect to an inner world of conflict and strife which had been split off, but expressed through hysterical conversion symptoms. The disclosure led to an active dramatization of the different parts, and a complex dialogue on different levels (real dimension vs the fusional). As a result, there was a subtle strengthening of the working alliance, and significant progress.

The departure from standard therapeutic procedure raises questions of appropriateness:

1. Personality organization. While disclosure of counter transference has often been described first and foremost with the most disturbed cases (Racker, 1953; Searles, 1979; Scagnelli, 1980; Vas, 1992), Diamond (1983) has cautioned against using this technique with patients with a poor level of organization. I find such poorly organized patients thirsty for role reversals, thriving whenever there is real, intimate sharing. Though extreme caution and elaborate preparation and structuring is necessary, I have found that first of all, patients with severe personality disorders are those who most elicit in me entering into trance states. These states very often bring me into contact with a more "mothering style," according to Banyai's descriptions (1992). Secondly, these very patients are most in need of feeling that the therapist is departing a standard position and coming at least half-way to meet them. Lastly, these patients especially need to feel that they reach us emotionally, that we really empathize and feel their way of experiencing the world. Sharing with them makes us real and genuine, and enhances the basic trust of which they are so lacking.

2. Whose need? Whenever the therapist considers sharing or disclosing, sharing must always be weighed with respect to the benefit or needs of the patient. Many authors have cautioned about therapist's irreverent use of sharing or disclosure for narcissistic, aggressive or dependency needs (Gruenewald, 1971; Josephs, 1990). The caution must be weighed against over-intellectualization and loss of the benefits of spontaneity. The approach described here assumes a high level of maturity and self awareness on the part of the therapist, including the ever present tendency to check and assess the basis of the motivation for verbalizations and actions. Diamond (1983) has stressed the need for the therapist to have reached a high level of integration. It is critical to discriminate between an urge to share expressing a personal issue which is not connected to the client, and an urge being countertransferential in the sense of a manifestation of enactment which when subsequently analyzed along with the patient, will express openness and a meaningful inspection of the interactional patterns which the patient elicits.

3. "Right or left brain" interventions. Must the material be understood first before

being shared? A measure of trust and modeling for the client is achieved in trusting the unconscious by sharing spontaneous productions, as long as the therapist is willing to integrate and process the intervention in a responsible manner, maintaining his integrity throughout. I find myself "chewing" on associations for months, and returning to them repeatedly, as therapeutic anchors or milestones. In this manner, the patient receives a complex message that one can trust spontaneity, and gradually integrate it with understanding and meaning.

4. Acting-out/dramatic dimension. The approach emphasizes a willingness to introduce a dramatic mode into therapy which is under the therapist's control, rather than to be merely limited to the analytic, observer position. Spotnitz (1963, 1976) has referred to the use of the therapist's "acting out" both the unconscious conflict, as well as the suggested solution to the conflict within the therapy session. This is a further aspect of integrating a vital tenet of the Ericksonian approach: The therapist's perception and grasp of the patient's unconscious is used to guide him in his approach to the patient, without necessarily interpreting and analyzing the material. The themes are "worked through" as they are played out in the interaction between therapist and patient.

Concluding remarks

In conclusion, as I continue to integrate the two major orientations and influences, I remain ever vigilant as to the question of the coherence and integrity which might be compromised when different approaches are brought together. Often I am asked whether I am "confabulating" by bringing together the themes of countertransference and therapist trance. Surely, each one is enough in its own right? I have found them to intermingle well within me, and in time to blend into an orientation beyond merely a mixture of techniques (the curse of "eclectic"), which today lend to my uniqueness as a therapist. I have tried to share some of the issues involved in order to stimulate thought and self-inspection.

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Hypnotism and the Eternal Return: The Case of Ideomotor Signaling

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■ *Forty years ago the American psychologist and hypnotherapist Leslie M. LeCron introduced an exploratory psychotherapeutic technique that became known as ideomotor signaling. For some years it was widely used, then for reasons none too clear it fell in disfavor. It appears, however, to be making a comeback, bringing with it the same kinds of poorly recognized conceptual and practical problems it initially had. After reviewing what the concept of ideodynamic, and especially, ideomotor action entails, this paper presents arguments that raise questions regarding the applicability of the adjective "ideomotor" to LeCron's procedures. The expression "nonconscious signaling" would appear to be more appropriate than that of "ideomotor signaling." Further examination of the process in question also raises doubts regarding its capacity for establishing a communication line between the therapist and the patient's "unconscious." It is proposed that it more likely creates an artificial psychic structure more like a conscious mind coexisting with the patient's actual conscious mind. The label "L-C unconscious" is suggested for it so as to allow one to distinguish it from other psychic structures also referred to as an "unconscious." The technique is shown to be particularly open to the therapist influencing the patient's responses. In spite of its weaknesses nonconscious signaling does appear to have some clinical utility and can probably be used effectively if proper care is taken in applying it.*

1. Introductory remarks

If I am not mistaken, it was Ibsen who wrote about the "eternal return," whereby it would seem that what has happened once, good or bad, will essentially inevitably happen again and again. This certainly appears to have been true for hypnotism in more than one instance. Ideomotor signaling is one of these recurrences. In itself this would not necesarily be a bad thing were it not for the fact that the first time around ideomotor signaling quickly became associated with serious conceptual as well as practical