Structure versus Freedom: The therapist's dilemma

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In treating psychotherapy patients with hypnosis, the therapist is faced with a dilemma. Should he/she strive to retain the theoretical structure of his/her therapeutic discipline, or should he/she strive for freedom to capture the unique opportunities hypnosis provides the psychotherapist in working with different patients. I will discuss the role of flexibility, the need for the therapist to change, creativity, and the question whether hypnosis is an adjunct to therapy or a therapy unto itself. I will conclude by commenting on my own opportunities for balancing structure and freedom as these twenty years of being an officer of the International Society of Hypnosis come to a close.

Introduction

In his book, The Book of the It, Georg Groddeck (1923/1949) writes a series of letters to his niece describing how he learned to treat his patients psychologically at his Spa in Baden Baden. He was an internist primarily, and came to view each of the body's organs as having an unconscious part that he named "das Es" or the "It". Groddeck wanted a concept that would help explain psychosomatic illnesses. He wrote to Freud who in turn acknowledged he borrowed Groddeck's idea to name a similar process in the mind. Freud's *"das Es"* was translated to the "Id". The rest is history. Here is what Groddeck said:

> "Later on, when I came to look into my own medical activities more searchingly, I discovered that often before I had been forced by mysterious influences of this kind to adopt some other attitude than the paternal one towards my patients, although consciously and theoretically I held the firm conviction that the doctor must be friend and father, must control his patients.
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> And now *I was confronted with the strange fact that I was not treating the patient, but that the patient was treating me; or, to translate it into my own language, the It of this fellow being tried so to transform my It, did in fact so transform it, that it came to be useful for its purpose* (Emphasis mine - PBB).
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> Even to get this amount of insight was difficult, for you will understand that it abso-

lutely reversed my position in regard to a patient. It was no longer important to give him instructions, to prescribe for him what I considered right, but to change in such a way that he could use me. But it was a long step from understanding this principle, to fulfilling the conclusions to be drawn from it."

So how do we balance the structure of how we conceptualize the world of therapy with the freedom to change and work in new ways as Groddeck so eloquently described above? I will briefly discuss three areas, which affect the balance between structure and freedom in the therapist. I will then focus on what I have learned the nearly thirty years I have been in the private practice of psychiatry.

1. Flexibility

In my previous presentations over the years, I have emphasized the role of the therapist in the therapeutic alliance. Finding one's voice as a therapist: the sense of self that is temporarily put aside while we pursue our training; and which must be regained if successful practice is to ensue (Bloom, 1995a, b). The thoughts, daydreams, feelings and behaviors of the therapist convey enormous material for the patient's own therapeutic work. Can we keep these to ourselves? I think not. We are transparent to our patients, and any attempt to hide behind a blank screen or *tabula rasa* is futile and perhaps injurious to the therapeutic process.

Flexibility in the therapist is a cornerstone of all therapy. However there always remains a need for boundaries between the structure of the relationship and our freedom to adapt to the different needs of each patient.

To this end, I regard each patient as being equal to me. There are a few differences though. First, I am more equal because of my training and experience. But they are more equal because it is only they who can decide what goals of therapy they will embrace, and the level of motivation they are willing to apply to the work of change. We therapists often hide behind the techniques of hypnosis, cognitive behavioral therapy, insight oriented therapies, psychopharmacological interventions, etc, and forget that the close intimate face to face bonding that characterizes all good therapy is another cornerstone of successful change.

As Groddeck noted in his letters to his niece, such intimacy requires the openness of the therapist to be him or herself in unique ways needed by the patient at every successive moment in time. Today, changes in the therapist during psychotherapy are an additional prerequisite for making changes in the patient/client (Kahn & Fromm, 2000). However, once the therapist is more flexible and open to change, what about the role of creativity?

2. Creativity

I have been fortunate in my own experiences to join my patients in creative moments that spring *de novo* from the therapeutic work, moments that shape our further therapy in unique ways. These moments are not preplanned, seem totally spontaneous, solve a

clinical problem, are characterized by initial silence followed by an image of how things might be in the patients or myself, and then are followed by a behavior. Let me give an example I have published before (Bloom, 1990).

This case occurred early in my training. I was treating a young woman also early in her training as a clinical psychologist. The issues centered on control. In addition, fortunately, there was a flexible therapeutic alliance and playfulness throughout this therapy. One day, she sat back, crossing her arms, and said, "Next week is my birthday." I responded, "Give *me* a present for *your* birthday," She came in the next week and stated, "I brought you two marbles for my birthday. " She put the two marbles on my desk and with a mischievous look in her eyes, she said, "There is *your* present for *my* birthday. Choose one!"

There was a moment of intense silence while I was thinking and feeling. Which one to choose? Either one I chose would be wrong; her response would be "What's wrong with the other one?" and so on. Suddenly, with an inner experience I have described above, I reached out for both of the marbles and put them in my mouth. She looked at me, I looked at her, and we both started a deep belly laugh that rose up in each of us.

Fortunately for me, she was more objectivity alert at that moment than I and said, "Please take them our of your mouth - you are going to choke." I followed that good advice and we continued to laugh and experience deeply what had happened there between us.

Finding two marbles in my mouth was a wonderful, humorous experience for both my patient and myself. Taking control within the context of a flexible therapeutic alliance is often difficult, Fortunately, playfulness, humor, and metaphor were intermingled with a conscious need to work through issues of control. The image, dynamics, and therapy converged on the precise moment of change.

I have kept the two marbles. The issue of control between us was softened from that point on. She and I, both in training, spent the rest of that session, as well as much of the next, trying to understand the process that had just happened from every theoretical viewpoint we could remember. This intellectual discussion, although enjoyable, did not however change the process of what had happened. From that session on, she remained more flexible in her relationship to me and to others. She is now an exceptional professional in her own field.

In my opinion, moments of creativity depend on bonding with the patient, flexibility, and willingness for the therapist to change. I believe that a moment of creativity must occur in every patient's therapy or real change does not occur. While I also believe it occurs more easily when hypnosis is employed, I do not know whether it matters if hypnosis is used as an adjunct to other therapies or as a free standing therapy in its own right.

3. Hypnosis or hypnotherapy

In Professor Walter Bongartz' Presidential Address, the question was raised as to

whether hypnotherapy can be considered a therapy in its own right. I would like to take up this issue in the context of my brief remarks today on structure versus freedom: The therapist's dilemma. How do we understand the nature and effects of hypnosis on the brain and behavior? I will present several examples that explore hypnotic interventions from a psychological and physiological perspective.

First, during this 15th International Congress of Hypnosis, my colleague Professor-Vladimir Gheorghiu has simultaneously hosted the 3rd International Symposium on Suggestion and Suggestibility. We can ask whether suggestibility in its various forms is the essential ingredient in hypnosis? How does the use of suggestibility allow us to enter into the mind-body interface where both physiological and psychological changes occur? To the degree that suggestibility plays a role, how do we define it and what are its specific effects (Georghiu, 2000)? Good questions, difficult answers.

Second, there are reports that with the development of PET scans, dampening of activity of the anterior cingulate gyrus in the frontal lobe occurs in response to narcotic medication to alleviate the perception of pain stimuli. Of greater interest is that the same dampening occurs with the sole use of hypnotic interventions under similar circumstances (Rainville et al., 1997). We are beginning to see the neurophysiological responses to hypnotic interventions.

There is also evidence which describes how hypnotic visual illusions alter color processing in the brain. The authors conclude "among highly hypnotizable subjects, observed changes in subjective experience achieved during hypnosis were reflected by changes in brain function similar to those that occur in perception. These findings support the claim that hypnosis is a psychological state with distinct neural correlates and is not just the result of adopting a role (Kosslyn et al., 2000)." We are finally looking into the "black box" which to date has hidden how simple images and words change actual brain function. Do these examples help us decide whether hypnosis should be a stand-alone therapy, or do all therapies demonstrate these phenomena when hypnosis is used adjunctively? Again, the question remains unanswered in my opinion.

On another front, the United States federal health insurance (Medicare) plan for those over 65 years old, pays a higher fee for hypnotherapy for psychiatric illnesses than it does for psychotherapy. This recognition of hypnotherapy is not complete as there is no reimbursement for hypnosis in the pain management alone - one of the hallmarks of our work. However, while hypnotherapy (versus its use as an adjunct) awaits acceptance in many countries, the US Medicare program is already recognizing and paying for this modality as such.

Hypnosis societies in the world including the Australian, both American societies and the International Society of Hypnosis regard hypnosis as an adjunct. However as noted above, we are now faced with new scientific research that may suggest that the hypnotic experience can change neuro-physiological processes. Do these studies support the idea of hypnosis as therapy or not? Finally, clinicians practicing in Germany are faced with a major legislative issue. The law will require hypnosis be practiced

under the current licensing for behavioral therapy unless it can be approved as a stand-alone therapy. For non-behaviorists using hypnosis, this law could present fundamental problems in clinical and experimental hypnosis.

My only hope, shared by Professor Bongartz, is that whichever view on this matter prevails (hypnosis as adjunct or stand alone therapy), only qualified, licensed physicians, psychologists and other health professions be permitted to use this potent modality while delivering health care to those who seek our services. This is not the time to allow anyone to call them selves a hypnotherapist - an unlicensed designation in most countries - to practice dentistry, medicine, or psychology without the appropriate governmental licenses and governance.

Whichever view one adopts, adjunct or therapy, the opportunity for flexibility, bonding, and personal change in the therapist must override the specific context which the clinician favors.

4. Personal comment in conclusion:

At the end of this meeting, the 15th International Congress of Hypnosis and Psychosomatic Medicine (we are letting this last part of the title slip from our usage), I will complete 20 years as an officer of ISH. In 1979, I began serving a 12 year term as Secretary Treasurer. I am now completing my term as President-Elect, President, and Immediate Past President What a wonderful experience it has been! I have had the unique opportunity to travel the world repeatedly, to make international friendships, and to realize we are all world citizens.

I have learned that the International Society of Hypnosis provides us all with an opportunity to build bridges of understanding - a phrase I recommended to the Board of Directors of ISH during my Presidency. I am very pleased that Walter Bongartz supported its continued use as our logo during his presidency as well. My very close friend, Dr. Peo Wikstrom, jointly and independently cherished this phrase as he saw the early European seeds of hypnosis planted in America and then return with further growth to Europe many years later. All of us now share this opportunity to study the mind-body interface in a way that no other modality is prepared to do. Hypnosis does give us special advantage in our work in both the laboratory and in the clinic. Perhaps in some small way, our collective life in the ISH has made the world a better place to live and work by promoting human understanding and providing better health care for all. I hope so.

I cannot adequately summarize my feelings now. However, I have the satisfaction of knowing that ISH will continue for years to come with powerful leadership and vigorous support from the world community of clinicians and scientists as evidenced so clearly this week in Munich. This Congress is the largest ever held by ISH - and the depth and substance of your contributions have been outstanding. Burkhard Peter and his committees have done an outstanding job.

I conclude these remarks by celebrating the need to balance structure and freedom.

While I personally strive for increased flexibility and creativity in my own work, I now look to the future, and wonder how what lies ahead in our understanding of this magnificent modality in our therapy. In the final analysis, however, it is the unique needs of our patients that matter most. We need to maintain our freedom to be ourselves while we balance the demands of the structures of our disciplines to well serve those who seek our care.

In closing, I thank the members of the International Society of Hypnosis. I will never forget the privilege you granted me to serve our Society these many years. It has forever shaped my life.

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The application of hypnosis to children and adolescents traumatized by war

Julie H. Linden

Hypnosis has been applied to many areas of trauma treatment. This paper will explore the utilization of hypnosis and hypnoidal techniques with children and adolescents traumatized by war. Attention will be given to cross cultural issues as they interact with and affect adjustment and psychological healing experienced by refugee, "refugee-like" and orphaned populations.

African storytellers have a venerable tradition of conveying through metaphor images capable of painting pictures for the listener (Godwin, 2000). An example of this is a particularly poignant African saying "When elephants fight, it is the grass that suffers" (Reidesser, Walter, Adam & Verderber, 1996, p.13), a reminder of the helplessness of the young (Brooks, 1996) in the face of massive, destructive forces abusing power. We do not have words large enough, intense enough, emotional enough to describe the horrors of war. This may be the reason that hypnosis became my treatment of choice in working with victims of war. Hypnosis permits us to bypass the logical conscious brain and go directly to that feeling, creative, pictorial brain where most traumatic memories are lodged.

There are many events that can be considered traumatic. Natural disasters, physical and sexual abuse, chronic illness, death of a loved one are a few. We have learned that trauma at the hands of a fellow human is far worse than trauma from nature. But war may be the worst of all traumas.

War is a traumatic event that, more than causing physiological and psychological pain, destroys the social structure. It takes away the very communal structures that the growing child requires for socialization, for identity formation. War removes the traditional support systems which stimulate and sustain resilience in children, from where they draw their coping mechanisms (Dyregrov, Gupta, Gjestad & Mukanheliet, 2000).

The psychic traumatization of children and adolescents from exposure to war is of great concern (Pynoos, 1994; Apfel & Simon, 1996; Reidesser, et al, 1996; Northwood, 1998; Abu-Saba, 1999) because we have entered an era in which civilians are increasingly the targets of war (Garbarino, Kostelny & Dubrow, 1991; Husain, Nair, Hol-