BE SENSIBLE and USE YOUR SENSES. Hypnosis, authority and transference

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INTRODUCTION

The purpose of this article is to pay some attention to relational and transference pheno-mena in clinical treatment and psychotherapies in which hypnosis, imagery, mindfulness and other focussing techniques are used as an adjunct. This is also relevant for Hypnotherapy, when such a title is legislated by a license, as in Austria. I will focus on the therapist as an authority figure and what that implies of power and transference.

My aim is to inspire you to reflect on the therapeutic relation in the light of transference and countertransference when suggestibility is enhanced through imagery and altered states of consciousness (ASC). This state of mind opens for suggestibility and change. Many therapy schools have discovered this; the psychoanalytic concept "reverie" means, as far as I understand, an open state of mind that facilitates healing and mental restructuring. In dynamic therapy, ASC is induced through perceptive and mental focusing, which is a crucial method in Intensive Short-term Dynamic Therapy, not the least the intensive focus on body sensations. Cognitive orientations have introduced ASC through "mindfulness".

As authorities in professional care we need to be sensible and as practitioners of the healing arts we need to use our senses: To be sensible means to use your mind. Using your senses means listen to your body. Your sensible mind assists you with reflections, informative associations and works as an internal supervisor. Your senses can offer you information about your resonance with the patient and countertransference.

AUTHORITY AND TRANSFERENCE

My personal motivation

Why did I choose this subject? I believe that most speakers have some personal motivation behind their choice of subject to present. I will declare my personal motivation for discussing authority and relation.

I have had two periods in my life when I have been emotionally dependent on authorities. First: As a child with a dominating mother, with whom I had no choice but admiring her, because she needed me to. I tell you this because it means that I have experienced from

within, the influence of parental abusive authority exerted by someone with power and possession of your existence. I became trained in sensitivity to my parents' modes.

Then, as an adolescent I became extremely independent and critical to authorities and eager to follow my own judgement and sensibility in every choice of life. Then there was a second period of authoritarian influence upon me, which may be of interest for this audience, and that was my student period. During that time I invested emotionally in my psychology studies; at last I had found people (i.e. teachers) who could conceptualize my own experiences, and structured in a language that made sense. Another motivational factor for my devotion to these teachers and their knowledge was a need to be accepted and confirmed by these wise teachers. Later on, thanks to life experience, individual therapy and natural maturation I made a habit of questioning even these authorities, the various schools and belief systems. I tried to understand *the underlying presuppositions, values and the consequential moral codes behind theories and concepts.*

I try to take responsibility of my choices, thus not giving myself the option to blame my mistakes on any authority. I think Einstein would agree.

Authority and social psychology

"Relying on authority is most dangerous for humanity". (Albert Einstein) 1879-1955

People can lose morality when they let go of personal responsibility. I will mention three authorities in the research on authority:

Theodor Adorno (1903-1969), a philosopher and sociologist, studied the authoritarian personality, the obedient person who trusts that authorities will take the responsibility of deciding and making choices, regardless of consequences.[1]

Stanley Milgram's (1933-1984) experiments on what people can do to other people just because they trust an expert, is a well-known example of low morality due to reliance upon authorities. [2]

Philip Zimbardo (1933-) studied how role playing prisoner and guards made academic students behave without any conscience, empathy or morality. He also investigated the real, not experimental cruelty at the Abu Ghraib prison in Iraq.[3]

Authority and Therapy

Are we beyond and above that, as psychotherapists? *How do we as therapists avoid authority traps?* We can at least try to reflect, be sensible and sensitive.

We who are attending hypnosis congresses have realised the profound benefits of using hypnosis in the clinical practice. Those of our colleagues who reject hypnosis, often express the opinion that hypnosis is authoritative or manipulative. We claim that they must have been misled by television and stage hypnosis.

So, how does clinical hypnosis relate to authority and manipulation? We know that all kinds of clinical treatments utilise the patients' confidence, trust and reliance upon the professional as an expert; which is a kind of authority. Psychotherapy is not an exception. Most solution oriented and cognitive behavioural therapies use communication strategies which aim at attaining consent from patients to accept and follow assignments.

In analytically oriented therapies patients are allowed to regress to the age where their emotional maturation got stuck or arrested. Patients, who lack basic trust from early years in life, will often spontaneously develop a strong transference and attempt to repair their lack of trust, through regression until the therapists' holding function is eventually internalised by the patient, as an internal self-soothing capacity. During such a period

1. "The authoritarian personality"; extreme deference to superior authority and exercise of own authority over subordinate, conformity to group norms, tendency to manipulate and exploit people, stereotyped thinking. T W Adorno (1950) *The authoritarian personality.* New York: Harper
2. S Milgram (1964) Group Pressure and Action Against a Person. *Journal of Abnormal Social Psychology.* 69, 137-43.
3. P Zimbardo (2008) *The Lucifer Effect: Understanding How Good People Turn Evil.* Random House.

of therapeutic dependency, patients are using their therapist as an auxiliary ego, which can be regarded as a kind of authority.

In general; therapists' interventions are much more powerful than in equal relations. And when hypnosis, imagery and focussing techniques are used in the treatment, therapists' interventions and suggestions become even more influential. In the following text I will use the concept ASC (altered state of consciousness) for all those techniques which use relaxation and mind/body focussing.

Suggestions as powerful influence

With or without ASC, all therapies include suggestions and ASC enhances the impact of therapeutic suggestions.

Because of the power of therapeutic communication we construct our suggestions so they make sense to the patient. But even if suggestions are ever so sensible, the sensitive therapist will also catch subtle obstacles to suggestions.

When you discern obstacles – how do you react?

In most contemporary hypnotherapy educations within ESH and ISH[4], we teach that if you accept the apparent obstacles to change, as resources for the therapy, change is facilitated.

I use two different approaches to deal with persistent resistances and symptoms. One way is to explore their functions. Another way is to demonstrate the patient's capacity for change through non-directive hypnotic suggestions. I usually combine the two approaches, adjusting the proportions to patients' motivation.

An interesting question is: How do we deal with non-directive suggestions as a kind of manipulation?

The concept "manipulate" has a negative connotation; I could express myself more positive and say "influence", or "make a difference". But choice of words does not change the fact that indirective and non-directive suggestions work beyond the patient's conscious notice, addressing subconscious parts of the patient. I do that with patients who are obsessively pessimistic, when I want to convince them that they are able to experience new perspectives or possibilities. I do not inform about the expected outcome in any detail, I don't ask for "informed consent" for the interventions of each session, often because I cannot know the outcome beforehand and because it develops during our interaction.

All therapists who use ASC; hypnosis, imagery, mindfulness or other focussing interventions in order to evoke a meditational or hypnotic state of mind, sometimes use powerful suggestions without the clients' prior consent. We do not think of it as power abuse, because we make sure that these suggestions are congruent with contracted therapeutic goals, for which we do have informed consent.

Hypnotherapists are often ascribed more power than other therapists. We need to examine our personal motivation and self-image. Our professional language and vocabulary contain concepts related to authority. One such concept is rapport.

Rapport

"Rapport" is defined in Wikipedia as a feeling of being "in sync".[5] In most hypnosis educations, rapport means that a patient trusts a professional helper, which is a prerequisite for

4 ESH: European Society of Hypnosis. ISH: International Society of Hypnosis. För medlemskap i dessa föreningar krävs statlig legitimation i vårdyrke eller att man fullgjort minst ¾ av studierna till sådant yrke.

5. **Rapport** is a term used to describe, in common terms, that two or more people feel *in sync* or *on the same wavelength* because they feel alike.

It stems from an old French verb *rapporter* which means literally to carry something back; and in the sense of how people relate to each other means that what one person sends out the other sends back, for example they may realize that they share similar values, beliefs, knowledge, or behaviors around sports or politics.

There are a number of techniques that are supposed to be beneficial in building rapport such as: matching your body language (…). Some of these techniques are exploited in neuro-linguistic programming.

(…) psychotherapeutic intervention techniques of Milton Erickson. Erickson developed the ability to enter the world view of his patients and, from that vantage point (having established rapport), he was able to make extremely effective interventions (to help his patients overcome life problems).

suggestibility. There are strategies for building rapport, often described in the literature of Neurolinguistic Programming. I found an NLP institute on the internet, marketing their training for rapport building as not just mirroring, matching and pacing-leading, but more in the favour of controlling the communication and become skilled in the art of persuasion. My critique of techniques for building rapport is that in those educations it is rarely mentioned the value of being sensitively attentive to patients' doubts and resistances.

It is a professional art to create alliance with the patient's resources for change and also sensitively perceive even the slightest signs of doubts, fears and other so called resistances to progress. Listening to resistance with a respectful exploring attitude will help the patients understand themselves and their deeper motivations, *so that they eventually can trust themselves even more than they trust us and other authorities*.

Resistance, doubts and fears

Patients tell us their hopes and fears through *symptoms* and *transference*.

Patients often describe their symptoms in detail. If you can give hope that symptoms will decrease, you build rapport with their conscious mind. Patients can learn self hypnosis, mindfulness, dream analysis, etc. and become their own authorities. That makes sense, doesn't it? It works quickly for those who have basic trust and good enough self-esteem.

Relevant important information comes also through transference: It takes years to develop a sensitive perception of transference, but in short, I could say that: The more you sense and perceive tacit or dissociated communication, the more you can realise when transference is part of the patient's relational problems, anxieties and symptoms. You can analyse how the transference influences the therapeutic relation and be explicit about it, and thus be trusted by the patient in a deeper perspective than in those contexts where rapport-building is taught as a key to success.

Example:
In my clinic I have a small entry for leaving coats and shoes, borrow slippers and then you see the waiting room with comfortable arm chairs. It happens that patients, on their first visit, either sit down by the entry door on a very simple chair or just stand still by the entry door. Often that means that they have difficulties making themselves at home and comfortable in new contexts. On my direct request, why a patient did not use the comfortable waiting chair, he replied "It looked so cosy, so I thought that cannot be for me, it must be private."

Some patients are weary, shy and withdrawn before session starts and if you prove genuinely empathetic and reliable during the session they demonstrate in various ways that they don't want to leave, for example by commenting your furniture, your dress, staying very long in the bathroom or chatting non-stop although the time is up. It is an art of sensibility and sensitivity to react professionally and with a high moral to such transferential communication.

Freud and Rapport

Freud was interested in understanding Rapport, and he used the word "acquiescent" as later physicians used the word compliant. Those days Freud was innocent of the power of transference. Freud wrote:

"One day ... One of my most acquiescent patients, with whom hypnotism had enabled me to bring about the most marvellous results, and whom I was engaged in relieving of her suffering by tracing back her attacks of pain to their origins, as she woke up on one occasion, threw her arms round my neck."

"The unexpected entrance of a servant relieved us from a painful discussion, but from that time onwards there was a tacit understanding between us that the hypnotic treatment should be discontinued ... I felt that I had now grasped the nature of the mysterious element that was at work behind hypnotism. In order to exclude it … it was necessary to abandon hypnotism."[6]

6. Selbstdarstellung. GW XIV, p 52, Autobiographical Study. SE XX, p 27.

Just as a parenthesis for your information: Freud has actually described elsewhere that he in many cases continued working with hypnosis, without using the word hypnosis.

Freud thus relied on "tacit understanding", instead of explicitly talking about the embrace either with the patient or with a supervisor. But it wasn't until later in his career that Freud developed his theories of transference and countertransference.

Let's hope that he retrospectively understood his countertransference and why he became so embarrassed.

Thomas Szasz' Anti-psychiatry and Freud

About 30 years ago, with referral to Aristotle, Thomas Szasz, now 91 years old professor emeritus of psychiatry, wrote some provocative critical books on psychiatry as an authoritarian abuse of power.
Szasz accused Freud of low morality. His reasoning was, abbreviated, that Freud pretended that psychotherapy was based on objective neurology and medical science, thus giving the doctor the power to define health and disease and the power of defining effective methods for treatment. Szasz claims that scientific medical language is a language of power. Psychotherapists who lean on medical language want power, and have a low morality. Szasz suggests that psychotherapy of high morality, should be studied as an art of rhetoric. His opinion of what constitutes high morality in psychotherapeutic rhetoric is interesting: Rhetoric of high morali-ty accustoms people to

- wean from authorities,
- encourage them to think and speak clearly and explicitly, and teaches them to
- become their own masters.

How is it today, 33 years after Szasz objections to the use of medical scientific language in psychotherapy and the problem of power abuse? How much does authority and power make psychotherapists accept that statistically based evidence for specific DSM diagnoses, is influencing the choice of psychological treatment?

I am concerned about the planned DSM V, which will increase the amount of diagnoses. There is a risk, that even symptoms that could be defined as normal, tolerable and possible to accept, now will be fulfilling the criteria for new psychiatric diagnoses. Such concerns have been formulated also by two of the founders of DSM III, Allen Frances and Robert Spitzer.

Since the days of Tomas Szasz' critique, a bridge between medicine and psychology has been constructed, that is neuropsychology! Neurological states and processes can be studied in order to understand the biological correlates to therapeutic healing, so Freud was not pretending, he actually hinted something. Nevertheless, despite a growing stock of objective scientific results, neuropsychology does not tell us anything about the art of practicing good therapy. The concept "evidence" has sometimes been used as if it could.

Neuropsychology as a science can offer general theories for academic knowledge, but the art of doing therapy is not on the same abstraction level as objective scientific generalised data. The art of practicing good therapy is not developed through general conclusions about the human mind and body; the art is about how to be sensitive to unique individuals.

In the clinical practice we are exploring and collecting utterly subjective data such as patients' intentions, dreams, memories, feelings, thoughts and needs. Our tools for acquiring clinical competence are not objective instruments but empathetic attempts to understand what patients tell us. Psychotherapy deals with reciprocal subjective and relational experiences on conscious and subconscious levels and the only way to safeguard the patient against abuse of our rhetorical power and authority, is to avoid generalisations and sensitively perceive communication.

The art of collecting subjective data in therapy are developed when you listen to your senses and encourage patients to listen to theirs.
Then a critical question from a medical scientific discipline can be: How can your senses, subjective as they must be, contribute to your professional competence? My answer is: By

developing and exercising a skill to discriminate your resonance with the patient's nonverbal communication from your personal reactions. Thus you can become more humble to the fantastic subjective development of each unique patient – a development you never can predict, but must be open to explore anew, again and again, with each patient.

Relation, medical hypnosis and authority

So far, I have discussed Hypnosis in Psychotherapy. How then, do we deal with authority and relation in "*medical* hypnosis"?

Medical hypnosis is an art of rhetoric in the sense that the hypnotist's suggestions will enhance healing through expectancy – or – in other words: mind over matter. We now know that expectancy and placebo effects are not self-deception but organic healing, via mind body neuro-psycho-hormonal connections. In medical hypnosis the healing also has relational qualities: When you for instance suggest organic pain to decrease in intensity by teaching patients how they can influence their perception, you combine "expertise autho-rity" and rhetoric.

Medical clinical hypnosis deals with subjective experiential phenomena, just as psychotherapy does. We focus on what patients subjectively experience with their senses interpreted through their emotional reactions and their mental interpretation: in other words; the patients' subjective perception.

Those trained in medical hypnosis probably avoid behaving in an authoritarian way, by informing the patient that hypnosis is a mutual collaboration, you tell them about mind body neurological connection so that they understand the mental impact on symptoms. The patient is expected to be active and to practise self-hypnosis and thus be her own authority.

Those who benefit most from medical hypnosis are patients with a mainly organic disorder. When symptoms have no psychological function and there is no unconscious need to keep the symptom, the clinician – patient relation is rarely complicated by transference, given that the hypnotherapist is empathetic and respectful. But there are also somatic patients with stress related or psychosomatic disorders.

Patients with a functional medical diagnosis, like IBS[7], can be somatising psychological problems through somatic dysfunction. From a holistic perspective they need help also to, eventually, express their emotional and relational problems. But, you may ask, how come that IBS patients often benefit from directive hypnosis for symptom relief? They do, and my clinical observations give me reason to believe that those with psychological issues can also benefit from symptom-oriented directive hypnosis, because when they have decreased their IBS symptoms, they shift channel for expressing their psychological problems. I used to believe that Freud's stipulated "symptom substitution" was exaggerated, but clinical experience has made me humble to the reality of somatic symptom as a language for unconscious emotional problems.

This is probably what happens when IBS patients who benefit from gut focussed hypnotic suggestions develop migraine or anxiety for which they seek treatment somewhere else, without reporting this to their previous doctor or therapist. They just don't see the connection!

How do I help the somatising patient to be explicit and wean from authoritarian dependency?

The question is presupposing that a somatising patient is able to be explicit, which is a paradox. The somatising patient in medical care is rarely aware of psychological or social stressors beneath the somatic symptoms.

Many patients with psychosomatic problems do not discriminate between cause and symptom, but they feel sure that there is an organic error. It is a challenge to reach a mu

7. Irritable Bowel Syndrome; latin: Colon Irritable; svenska: irriterad tjocktarm.

tual communication; informing sensibly and listening sensitively.

High morality in medical hypnosis is a combination of

- rhetoric: Sensibly presenting objective data & your theory and also
- listening to a unique history of previous therapeutic attempts and failures (transference / relation) and
- unique experience of the problem (subjectivity).

I recommend you to read about suggestive communication in medical care in: *Beyond the Words: Communication and Suggestion in Medical Practice. (2011)* Editor: K Varga. www.novapublishers.com

Nonverbal cues of transference. Seize the moment.

With the case "Leonard" I want to illustrate the crucial meaning of listening to senses for restoring a narrative personal history and build a feeling of coherence and self-understanding. Leonard suffered from Irritable Bowel Syndrome.

He had consulted a psychodynamic therapist during three years, before coming to me. He had appreciated it, but wanted hypnosis this time. His own interpretation of his IBS symptoms was that they emanated from his early relation to his mother who – he knew – had left him to various babysitters, because she started working immediately after his birth. We used hypnoanalysis for two years, and Leonard's main problems can be summarised in his questions on one particular session late in therapy. His three questions this session were:

- Why do I never trust anybody?
- Why do I withdraw when I feel the least questioned?
- Why did I betray my ex-wife and seduce other women, although I did not want to?

Summary from one session:

I count backwards in an age regression and ask his unconscious mind to halter when we reach a crucial period of his life. He stops at infancy. I ask him to focus on his senses.
Leonard says: "I am cold, I am extremely cold, my heart is almost still, almost no heart rhythm."

"What is there around you?"

"A big room, someone took me here, I don't know who." (Silence) "Now a man is putting a spatula on my tongue, examining my throat. He is opposite me, he is old, has a white coat. A doctor." (Silence) "I am alone, in a bed, yellow walls, big empty room, a hospital. I have something in my body now, something has been given me, a shot or a drink, I don't know, it makes me warmer."

I ask: "Your feeling?"
Leonard: "Getting warmer, but lonely. I am very lonely, I have to hold myself. I don't think anyone holds me. Strange. I feel alone. I even cannot feel that you are sitting there beside me."

I am silent, thinking that Leonard is re-experiencing an utterly lonely situation and cannot take in my presence as soothing.

I ask: "May I touch your arm, in order to explore what that evokes?"

"Yes."

So I touch Leonards forearm.

He says: "Strange. I do not feel your presence and I feel your hand is warm, but I cannot take in that warmth."

I accept and say: "No, you cannot take it in. That is ok."

Tears are running down his face.

He says: "But I feel sad, I don't know what makes me feel sad."

Leonard was helped by this therapy, is now remarried, faithful to his wife, enjoying life and also able to be less acquiescent to people and more apt to listen to his own senses.

My next illustration is about making patient material public, in articles like this. I had an excellent case which I hoped to publish, because her communication was subtle and she presented good examples of the necessity to attend to senses. She had an issue regarding the conflict between listening to her deepest emotions versus her need to please authorities.

I gave her this article with an anonymized illustration of a session with her. I asked her to consider if it was OK to publish the excerpt from her therapy. I told her that any doubt she felt would be respected and mean a no to publication. Her first reaction was that she felt flattered to be such an interesting case. A week later, when I asked for her decision to publish or not, she could not utter the word "no", but had a high level of anxiety, felt scared and told me it was because she felt used at work. She needed some time and persistent inquiry from my part, to let me know how exposed she felt in the article, although her logic and reason knew that her identity was not exposed at all and also that her "adult part" wanted to admit publication. I suggested her to explore if a "no" to publication would give her some relief, and when she explored this, her anxiety raised. A strong negative transference was revealed; she had hated me, ripped the article, and imagined me to be in need of her admiration; just as her parents had. We dealt with this on a transference level, but also on a here-and-now level. Her trust in me was shaken; I apologized for my insensitive idea to publish her material. I apologized for having used part of her previous session for this project of mine, and for not having listened to my gut feeling, my intuitive sense (which had been there all the time!) that she was not someone I should ask this.

Of course, one can have a meta perspective and say my mistake was also therapeutic – she gained a new experience when I apologized; she had never experienced that before and she was deeply touched. She hated me for my mistake, she could express her distrust and she gained respect for these feelings. She relied on my true empathetic guilt feeling and my wish to admit and, if possible, repair my lack of empathy and she appreciated my confession that I had lacked professional respect for her vulnerable position, and that I had neglected my gut sensations which tried to communicate to me her deepest feelings regarding the privacy of her relation with me.

CONCLUDING REMARKS

Be sensible and use your senses; for reflection, resonance with the patient's needs and for your development of therapeutic empathy. Reflect upon the vulnerability in the patient's position.

A relevant question for which I have no definite answer, but nevertheless hope to evoke your interest for further discussion is: If you agree that some patients need absolute privacy in the therapeutic relation: How do you find out when or if it is sensible and sensitive to ask for informed consent for a publication in a journal, or to record therapy on video for later "publication" in educational or supervisory contexts?

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