*Psychotherapy with Psychotherapists*

# Hypnotherapy with Psychotherapists

John E. Churchill, M.S.W.

# HYPNOTHERAPY WITH PSYCHOTHERAPISTS —An "Innocuous" Means of Seeking Help

**John E. Churchill, M.S.W.**

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# CONTRIBUTORS

John E. Churchill, M.S.W., is Chief of the Hypnotherapy (Outpatient) Clinic, Departments of Mental Health and Social Work, Wilford Hall USAF Medical Center, Lackland Air Force Base, Texas.

Florence W. Kaslow, Ph.D., is in independent practice as a therapist and consultant in West Palm Beach, Florida. She is Director of the Florida Couples Family Institute and an adjunct professor in the Department of Psychiatry at Duke University Medical School, Durham, North Carolina.

# HYPNOTHERAPY WITH PSYCHOTHERAPISTS—AN "INNOCUOUS" MEANS OF SEEKING HELP

*John E. Churchill, M.S.W.*

In this chapter, hypnotherapy denotes the clinical use of hypnosis in the treatment of both physical and emotional problems of psychotherapists. Hypnosis is not practiced in a vacuum, but is used as an adjunctive measure to traditional medical and psychotherapeutic procedures. While treating other therapists, I prefer to combine hypnosis with certain behavioral modification and stress management techniques to help them further balance their lives. Such a combination is not uncommon, and is usually quite viable and effective. This process is explicated later in the chapter. I find the major medical center an ideal environment for employing hypnotherapy to treat a multiplicity of physical and emotional difficulties. Such an approach can afford psychotherapists a discreet yet liberal fashion of treatment, even in their own backyard. Pain and stress management, habit problems, and arousal control to enhance performance are among the most common issues addressed.

## CREDENTIALS IN THE FIELD

With referrals coming from virtually every department in the hospital, the professional hypnotherapist must be adequately and thoroughly trained. In

addition, he or she must have the proper credentials to teach and supervise other professionals within the medical setting. The hypnoclinician should be a member of one of two nationally recognized societies. They are the Society for Clinical and Experimental Hypnosis (SCEH) and the American Society of Clinical Hypnosis (ASCH). SCEH requires its members to have a doctorate in medicine, dentistry, osteopathy, or psychology or to possess a master's degree in social work with affiliation in one of two national clinical registries. Members must also have completed acceptable courses in hypnotic techniques and be actively practicing hypnosis in their respective settings. Certification of competence for membership must be corroborated by two sponsors who are professionals in the field and are familiar with the skills of the applicant. I belong to SCEH, which encourages its members to publish scientific articles in hypnosis as well as to teach it in a recognized medical facility.

## OVERVIEW AND CLARIFICATION

The history of hypnotherapy has been fully covered by early noted writers including Cutten (1911), Wolberg (1951), Bromberg (1954), Bramwell (1956), Conn (1958), and Rosen (1959). Contemporary authorities who have given detailed accounts of the history of clinical hypnosis include Kroger (1963, 1967), Crasilneck and Hall (1975), Spiegel (1978), and Edelstein (1981).

I have chosen to exclude a descriptive report on the various forms of individual hypnotherapy. Instead I refer to the elaborate and excellent work by Kroger (1963, 1967) in which he aptly describes these different areas. In a series of papers, Greenberg (1977) traces the development of group hypnotherapy. He also examines specific techniques when combining hypnosis with traditional group therapy modes.

In the field of hypnotherapy there are innumerable definitions of hypnosis with emphasis primarily on altered states of consciousness and misdirection of attention. I prefer the view espoused by Kline (1963), who describes it as both a state and a relationship. As a state, it possesses the characteristics of suggestibility, altered perception, availability of unconscious material, and increased awareness and sensitivity. As a relationship, hypnosis often facilitates therapy by intensifying the transference process.

Erickson, Rossi, and Rossi (1976) state that hypnotherapists share many common ideas with other psychotherapists. He emphasizes an understanding of unconscious dynamics in behavior and appreciation for experiential learning, as well as a high regard for the uniqueness of each patient. He also points out that modern hypnotherapy is quite different from the popular concept of hypnosis as a mysterious drama. Therapists who employ clinical hypnosis in their practices are not stage artists. Erickson

(1977) maintains that in hypnotherapy it is necessary to protect patients and approach them slowly in an effort to help them understand certain events taking place. He also advocates treatment at an unconscious level, but feels patients should be given an opportunity to transfer their insights to the conscious mind as needed.

## HYPNOTHERAPY FOR PSYCHOTHERAPISTS

There is no doubt that many hypnotherapists have treated other psychotherapists. With the exception of random cases by Erickson, as described by Haley (1967), there is a paucity of literature on the subject. It is my perception that therapists have been treated quite often with hypnosis and their cases even cited in books and journals, but their professional identities were not revealed. Perhaps this is because the medical and mental health communities still look askance at this particular treatment approach.

Within the medical center milieu, psychiatry residents, psychology interns, staff psychiatrists and psychologists, and professional social workers can be exposed to the utilization of hypnosis with individuals, families, and groups. Groups, in particular, are quite popular with therapists. I conduct two such groups. The first is an Autohypnosis Group aimed at eliminating such habit problems as smoking, overeating, and insomnia. The second is entitled "The Balanced Life Group" and focuses more on physical

and psychophysiological problems for pain management and control. Both groups combine clinical hypnosis with behavior modification. Fezler and Kroger (1976) discuss such an approach with their hypnobehavioral model in the treatment of phobias as well as obsessive compulsive, depressive, and hypochondriacal disorders. In the groups, problems are addressed from an unconscious perspective via heterohypnosis (hypnosis with others) and autohypnosis (self-hypnosis) as well as from a conscious viewpoint by way of modifying behavior through regular exercise, play, diet, and setting immediate and long-term goals.

Quite often staff members and psychotherapy residents or interns from the different disciplines will ask to be seen individually or in the groups as a means of "learning hypnosis to apply to our clinical practice." After all, "such a tool will be invaluable to our repertoire of treatment modalities." At times these therapists are genuinely seeking to learn an additional approach to help them with their patients. At other times they are verbalizing their desire for self-growth. With few exceptions, they are also asking for therapy under the guise of learning a particular skill. By virtue of its composition, the environment of a medical center is oriented towards the incessant quest for and acquisition of knowledge. Seeking the hypnotherapist either individually for "an hour's lesson" or in one of the groups as a "participant-observer" affords a safe channel through which professionals can learn about themselves.

Such an attitude is reinforced by the hypnotherapist who will often relate that in order to learn hypnotic skills effectively, clinicians must first select a problem area, physical or emotional, and begin work on it. In this treatment context the therapists are given the permission they need to concentrate on themselves within their own environment, with few questions asked by their professional colleagues. For example, a resident can say openly that he or she has decided to go through the balanced life or autohypnosis group or "visit" with this therapist one hour a week in order to learn hypnosis. Coping with headaches, anxiety, weight loss, surgical procedures, arousal level to enhance job performance, phobias, and close interpersonal relationships are just a few of the myriad physical, psychological, and psychophysiological complaints that often motivate therapists to seek treatment. These clinicians soon become comfortable with the rationale that it is permissible, even desirable, to acknowledge their personal problems in order to better learn hypnosis as an adjunct to psychotherapy—and all for the sake of education! Such a defense, in the service of the ego, is often unconscious; I think it is a necessary mechanism by which clinicians can ask for help from another therapist and still maintain their professional dignity.

### *Case 1*

One experienced therapist approached me regarding the use of hypnosis for

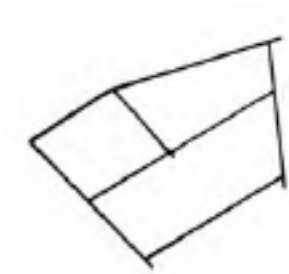
nausea while piloting a plane. He had recently invested in flying lessons and experienced nausea only when piloting the plane over long distances. After several hypnosis sessions it became evident that the nausea was more associated with his troubled marriage than his cross-country trips in an airplane. Flying over many miles of open land was symbolic of his need to be free of his perceived marital prison.

### *Case 2*

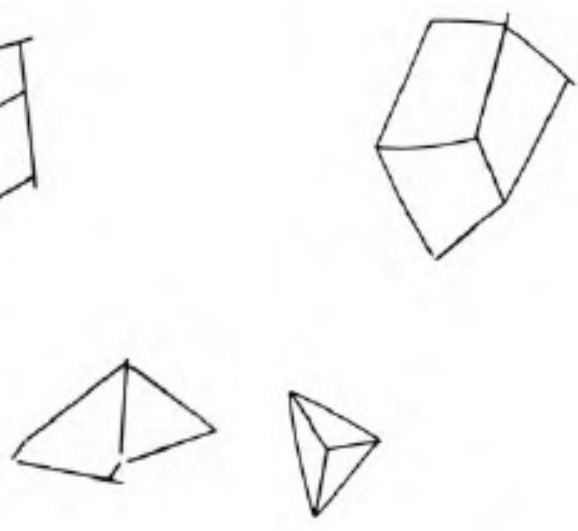
Several years ago a staff member asked me about the possibility of autohypnosis for purposes of relaxation. At the time he was being considered for a discharge from the military owing to a possible diagnosis of organic brain syndrome. There was a great deal of discrepancy between his neurological tests, which proved negative, and his neuropsychological tests, which indicated serious organic deficits. The officer proved to be a good hypnotic subject, and went beyond relaxation to control his arousal during reexamination. While in hypnosis he was able to achieve a marked difference in his performance, which also changed the diagnosis from an organic brain syndrome to an atypical learning disability/developmental disorder. He was subsequently retained in the Air Force. A portion of his testing is shown in Figure 1. The first drawing represents his repeated but futile efforts to draw a cube and a pyramid. These attempts were made prior to his being in hypnosis and controlling his arousal. He spent ten frustrated

and unsuccessful minutes trying to draw the geometric figures. The second drawing was made while in a somnambulistic (deep) and amnesic (without memory or recall of action) state of hypnosis. With the arousal under control, there was marked improvement in his performance; with no hesitation or difficulty he was able to draw the cube and pyramid quickly (several seconds).

**Figure 1:** Arousal control to enhance performance in a learning disability/developmental disorder. Drawings and spatial arrangements are reproductions of those made by the patient.



Attempted drawing of a cube and pyramid prior to hypnosis



Drawing of a cube and pyramid while in hypnosis

### *Case 3*

A reputable female therapist I had known for several years and to whom I had referred cases in the civilian community approached me about her difficulty in forming close, intimate relationships with men. She felt hypnosis might help her become more comfortable in her relationships. She also expressed that trust was a sensitive issue for her and indicated that she had a great deal of confidence in me because of what she had heard from our mutual clientele. She was quite responsive to hypnoanalysis, and within a brief, seven-session period she discovered that she had strong repressed feelings that perhaps she had experienced incestuous relations with her father at an early stage in the latency period. Being bright and motivated, as well as quite suggestible, she experienced revivication (reliving) of a scene from her past in which she and her father were lying in bed together. As she magnified the picture by way of a zoom lens on a camera she saw and experienced that her father was only cuddling her; and ideomotor responses (unconscious finger signals) revealed she had been harboring a distorted fantasy and not reality at all. She obtained immediate intrapsychic relief, which led to a closer relationship with her father and subsequent meaningful relationships with male suitors.

### *Case 4*

I was recently approached by a well-respected psychotherapist who had a

sincere desire to lose weight. She, too, was well aware of my hypnotherapy work within the medical center. As is often the case, her innermost feelings were accelerated while she was in hypnosis. In an emotional and enriching session, this bright and intuitive clinician allowed herself to discover what her unconscious was already wrestling with. She had to confront the reality that her weight was intricately mingled with her need for nurturance from her immediate family. Because of the nature of our relationship, she agreed to pursue this further with another hypnotherapist.

## RELUCTANCE, RESISTANCE, AND TECHNIQUE

It has been my experience that most mental health professionals, who are not familiar with hypnotherapy, tend to perceive this clinical tool with much the same illusions as the lay person. This is particularly true of the utilization of the unconscious mind while one is in a hypnotic state. Many therapists who do practice hypnotherapy will often refrain from utilizing the unconscious. Sometimes this is owing to a lack of training; at other times it is because their particular treatment philosophy is opposed to it. At still other times it is because of the lack of concrete scientific data to support this phenomenon. It is my opinion that such practitioners can make little progress without acknowledging the intrinsic value of the unconscious. Inability to deal directly and to learn to negotiate with this part of our mind is tantamount to the pursuit of any treatment approach/modality without

first acquiring certain basic skills in that area. In the mental health profession clinicians become quite familiar with unconscious conflicts and resistances. For most, this phenomenon is a hidden, intangible force to be reckoned with only in a distant, complicated, and often frustrating endeavor. The competent hypnotherapist employs graphic and direct means of communicating with the unconscious that often facilitate resolution of problems. I feel that such a skill also differentiates hypnotherapy from other forms of suggestive therapy.

There are many ways of uncovering or communicating with the unconscious, and these are readily available in most books and journals on clinical hypnosis. Among the most common are ideomotor finger signals, automatic writing, automatic drawing, automatic typing, and verbal responses. In isolated cases I have observed patients communicate unconscious responses through various colors. LeCron (1971) explains and clarifies seven specific psychodynamic areas in problematic behavior. He labels these conflict, motivation or secondary gain, prior suggestion, organ or body language, identification, masochism or self-punishment, and past experience. He then combines the knowledge of these seven areas with the techniques of uncovering mentioned in order to locate and deal with emotional difficulties effectively. To facilitate this, Cheek and LeCron (1968) advocate involuntary ideomotor finger signals from patients to indicate "Yes; No; I do not know; and I will not say" while they are in hypnosis. These

therapists contend, and I agree, that the unconscious mind in hypnosis can meaningfully answer questions that it is unable to while in the conscious or waking state.

### *Case 5*

Several months before transferring from Wilford Hall to another hospital, a nurse practitioner came to me seeking help for an increasing fear of thunderstorms. She related that she had always had some discomfort during storms but that recently her feelings had become more irrational and were quickly approaching phobic dimensions. Such feelings were most definitely creating obstacles to her job and life-style. She was also experiencing extreme difficulty driving to and from the hospital during the storms. On occasion, she would resort to having someone else drive her or waiting out the turbulence. It was also impossible for her to get out socially or perform routine tasks during this type of weather. She felt it ironic that her fears had increased since her new marriage of three months, because she thought being married would reduce her anxiety. When questioned consciously about experiences she associated with her fear, she related one experience at the age of fifteen in which lightning had flashed through her home and superficially grazed her arm. Other than this event, there was no other recollection of a problem. The patient proved to be an excellent hypnotic subject, and under hypnosis exhibited strong ideomotor finger signals. When

asked if her unconscious was aware of a past experience related to storms her "yes" finger responded. When asked if this was the same experience she had described at age fifteen, the "no" finger reacted. When asked if this experience had occurred before the age of fifteen there was another "yes" signal. Other "yes" responses were given when asked the same question about ages of before ten and six. The patient then spontaneously age-regressed to age five and she described extreme discomfort in the presence of her parents, who were having a serious quarrel. Asked if she wanted to tell me about it she replied verbally "no" and her involuntary ideomotor signal was the same. I asked if she would prefer we leave the subject alone for awhile, and she responded positively. Later, outside of hypnosis, the patient recalled her parents having an argument, but could not consciously tell me specifics about the incident. In a rather insouciant manner she then stated she felt they had experienced a "stormy marriage" at that time of her life, but fortunately had resolved their difficulties. I then asked if she had ever used the word "stormy" to describe her parents' earlier years of marriage, and she replied that she had not. Further ideomotor questioning led to the fact that she feared her new marriage might also become "stormy." The thunderstorms, of course, represented a diversion from this unwanted thought. Reassurance from her new spouse and the insight she gained from hypnosis brought a quick cessation of her fear. Several months later she was still doing well and reported she had intentionally gone shopping and had

socialized during several thunderstorms.

It should be clarified that many patients seek therapy but do not require intense uncovering techniques because they do not have serious and repressed unconscious conflicts. Although ideomotor signaling may initially be helpful to rule out any serious difficulties in these cases, relearning or reprogramming by way of positive imagery and behavior modification is all that is needed.

### *Case 6*

One psychiatric resident discovered the value of combining ideomotor responses with imagery. This physician had originally requested to meet with me one hour a week to learn hypnosis for purposes of self-relaxation and therapy with his patients. Within several sessions it had become apparent that during his on-call days his arousal would escalate and thereby reduce his performance. While in hypnosis he was asked to visualize a scale from one to ten with one being very calm and ten quite excited. By way of ideomotor finger responses he discovered he was functioning at the seven level while imaging himself during on-call days. He was amazed to find that through ideomotor signals he could raise and lower his arousal by raising and lowering the numbers on the scale. On his on-call days his unconscious revealed his arousal often remained at the seven level and would even

escalate to an eight level when he left the hospital for home. This obviously began to affect his family life as well. Through hypnotic cognitive rehearsal (imagery conditioning) techniques and posthypnotic suggestions, the resident soon learned to lower his arousal, which subsequently had a positive impact on his job and home life. It should be noted that his hypnosis sessions were combined with having him simultaneously manage his stress in a more well-rounded manner.

### *Case 7*

Another psychiatric resident, who was on heavy dosages of medication for vascular headaches, learned to decrease both the intensity and frequency of his malady through hypnotherapy. This resident was also surprised to find himself communicating with his unconscious through involuntary finger responses. While in hypnosis his forefinger responded "yes" to whether or not his headaches were directly correlated to stress. On a scale between one and ten with one signifying "no pain" and ten indicating "great pain," his responses were initially at the eight level. Later, as he learned to modify his behavior and work on his stress, his involuntary finger movements indicated a considerable reduction on the scale. Although his headaches have been allayed, he continues to use his ideomotor responses as a gauge to his stress and pain.

Psychotherapists, particularly analysts, are reluctant to use hypnotherapy because of the antiquated notion that it accomplishes only temporary symptom removal. They cling to the rationale that the underlying factors causing such symptoms are untouched and that the original symptoms will either return or be replaced by even worse ones. Freud, of course, perpetuated much of this belief with his simple approach of suggesting symptoms away and his subsequent failures to be able to do so. In the past, lack of time, training, and exposure in medical and graduate schools were other reasons why practitioners were reluctant to utilize hypnotherapy. Fortunately the two national societies mentioned earlier, ASCH and SCEH, and their respective journals are currently instrumental in educating professionals and providing valuable literature in the field of hypnotherapy.

In the treatment of therapists I have encountered resistance around the issue of conscious control. With few exceptions, psychotherapists tend to possess all the qualities of good hypnotic subjects. They are usually bright, motivated, and creative individuals who apply these characteristics in their personal and professional lives. These same strengths of character can also work for them in hypnotherapy, but they are often used, particularly in the early phases of treatment, to thwart the efforts of the hypnotherapist. In their enthusiasm these professional patients will frequently question both themselves and their therapist regarding every minute detail they

encounter. Such inquiry tends to force conscious screening or interference in the beginning sessions. Of course, the therapists are generally unaware that they are impeding therapy by their inquisitiveness.

I welcome early and overt resistance and perceive it as a healthy signal in most patients.

### *Case 8*

One therapist was eager to learn hypnosis for purposes of alleviating tension in himself as well as using the tool with his patients. He was an extremely compulsive individual, and after several minutes of the first induction he opened his eyes and blurted out "I do not feel any different than I did when we first began." After several sessions he continued to demonstrate his doubts in a rather obstreperous fashion. I then questioned if he was really interested in learning hypnosis for himself and his practice. He assured me he was genuinely motivated but could not seem to relax with the method. The point was emphasized that one does not always have to relax in hypnosis, as is true in other types of therapy. The patient was also made aware that there were no expectations of him and that, in fact, he had achieved altered states many times in his life throughout his childhood, in his academic pursuits, and even in his practice. He was then instructed to close his eyes and "not try to do anything." He could "either listen to me or

not listen to me; it does not make any difference." Also, any external thoughts were just further signals for him to enjoy himself. I then proceeded to give a long and monotonous discourse on how persons learn to be unconscious in their activities from childhood through adult life. The patient soon achieved a good, medium trance state.

After the hypnotic experience he related that he had become quite bored with my voice and drifted into a dream state similar to that he experienced while asleep. In his altered state he recalled a persistent dream in which he was a news anchorman on a nightly television show. Since he could easily capture this scene, I asked him to close his eyes again and do so. Within seconds he again found himself in a sound hypnotic state. He later expressed surprise that he could achieve hypnosis so quickly and that it was so similar to a dream state he had been experiencing for years.

This early apprehension can often be harnessed and channeled constructively by the skilled hypnotherapist as he or she meets the resistance with skills of diverting the conscious and utilizing more indirect suggestions. Kroger (1963) sees the diversion of conscious attention as the key to a successful hypnotic state and uses it extensively in both clinical and forensic areas of his practice. Erickson (1960) was a master at misdirecting conscious energy and giving indirect suggestions. Coue (1923), an early pioneer in the field, was another strong proponent of the nonspecific

suggestion, since he felt most patients would receive it uncritically. He also found it helpful to attach a strong emotion to the suggestion. In addition, Coue's suggestions would emphasize only the goal rather than a means of getting there.

There are also clinicians who utilize more direct suggestions. Crasilneck (1975) makes excellent use of commands in his work, giving direct and sometimes quite negative suggestions to his patients. The Spiegels (1978) offer numerous examples of direct suggestions and without application of the uncovering process. I prefer the features of misdirection of conscious attention, indirect suggestion, attaching a strong emotion to the suggestion, and emphasis on the results of a goal in dealing with professionals and their conscious resistance. Once therapists sense they are not giving up control but are actually gaining more control, their critical conscious screening begins to diffuse. When this occurs they are then in a position to take further advantage of their inner strengths.

### *Case 9*

A staff physician asked if I would see her prior to major surgery. She wanted to learn autohypnosis for purposes of deep relaxation and easing presurgical anxiety. Although she had taken a few courses on the subject, she was still quite skeptical about its merits. However, at the time she was "willing to try

anything." Since she had grown up on an island in the Pacific Ocean, it was quite easy for her to imagine a beach scene for purposes of the induction. When questioned about a particular sensation or feeling, she immediately replied she felt warm and secure. I then began a monologue on how nice it was to take time out from the busy roller coaster of life and drift peacefully, placidly, comfortably along. It was then suggested that her warmth and security had always been with her and would continue to be with her no matter where she went or what she did. Outside hypnosis the patient reported immediate relaxation. After only two sessions she was able to develop anesthesia in various parts of her body. Her new ability not only prepared her for surgery, but helped her during and afterwards.

This case also made use of imagery by having the subject fixate her conscious mind on a pleasurable interest while suggestions were given to her at the unconscious level. Although the skilled clinician can utilize imagery without hypnosis and hypnosis without imagery, it is my opinion that the combination of the two is most productive in countering conscious resistance, particularly in the early phases of treatment. The use of imagery is widespread not only in hypnotherapy but also in behavior therapy. Approximately twenty-five years ago, Wolpe (1958) described how persons could reduce their phobic condition merely by way of imagery and indicated that they did not have to be actively in the presence of the phobic stimulus. Erickson's interspersal technique (1966) often has the patient vacillate

between neutral imagery (pleasant scenes) and suggested imagery (pain management, emotional well-being) to reduce conscious critical screening. Fezler and Kroger (1976) show how their patients, in the hypnotized state, utilize positive fantasies to see themselves correcting their problems. Abramovitz and Lazarus (1962) demonstrate how positive imagery serves to countervail phobic reactions. In fact, Lazarus (1977) has presented a myriad of innovative and creative uses of imagery in therapeutic situations. Simonton (Creighton, Simonton, & Simonton 1978), in his provocative work with cancer patients, has them move from a pleasant scene to one in which they image their immune system combating the illness. Many professionals use the terms covert rehearsal or covert conditioning to describe imagery. For example, Cautela (1975) uses these words to describe how he combines imagery with behavior modification to treat phobias, alcoholism, and sexual disorders. In treating psychotherapists, I prefer the interspersing or vacillating technique of cognitive imagery combined with active modification of behavior as the most cogent means of dealing with the often-unruly conscious will.

In an effort to facilitate the hypnotic process, I spend a great deal of time with therapists exploring their particular individual cue words or sensations. The therapist's inattention to such valuable gateways can lead to patient frustration. It has been my experience that all patients experience uniquely different cues to help them relax and/or go deeper into hypnosis. I

prefer to use their own personal and instinctive hints rather than some general clues they may have read or heard. For some individuals these guides may involve different colors or the same color; for others, certain words may be a key; and for still others, certain sounds and/or feelings may create a sense of well-being. Sometimes it is a combination of several of these. Ideally, these comfortable signals are located early in therapy, but many persons have to struggle to find them. While patients are in hypnosis, I often make the suggestion that their unconscious minds will spontaneously find the cue that is most secure for them. To the surprise of patients this is a rather frequent occurrence: "While my eyes were closed this purple triangle just popped into my head"; "I felt a sudden glow or warmth"; "This relaxed heaviness or lightness just covered me like a blanket." When this phenomenon does occur I will have them immediately return to the hypnotic state by using their personal key. Again conscious energy is being distracted and the unconscious becomes receptive to further stimuli. My opinion is that such cues are extremely valuable and necessary assets to both the misdirection of conscious attention and to interspersal imagery in dealing with control issues of mental health professionals.

## SUMMARY

Hypnotherapy, particularly in a major medical center, can offer psychotherapists a rich and rewarding experience under the heading of

treatment and/or training. Through the guidance of the skilled hypnoclinician, staff, residents, and interns in the various disciplines can take advantage of a creative and unique form of therapy with little or no stigmatizing by their peers. With judicious acceptance of the unconscious phenomena that often occur during hypnotherapy, practitioners can take enormous strides in facilitating their own treatment or in working with their patients. If they concurrently take advantage of the national and international exposure to hypnotherapy they place themselves in an even stronger position to enhance their learning. With frequent practice of the various hypnotic techniques mentioned, psychotherapists can become more proficient with hypnotherapy in their personal lives and in the lives of those they treat.

## *References*


Abramovitz, A. & Lazarus, A. The use of "emotive imagery" in the treatment of children's phobias. *Journal of Mental Science*, 1962, 108:109.

Bramwell, J. M. *Hypnotism: Its history, practice and therapy*. New York: Julian Press, 1956.

Bromberg, W. *Man above humanity*. Philadelphia: J. B. Lippincott, 1954.

Cautela, J. R. The use of covert conditioning in hypnotherapy. *International Journal of Clinical & Experimental Hypnosis*, 1975, 23, 15-27.

Cheek, D. B., & LeCron, L. M. *Clinical hypnotherapy*. New York: Grune & Stratton, 1968.

Conn, J. On the history of hypnosis. In *Introductory Lectures on Medical Hypnosis*. The Institute of

Research in Hypnosis, 1958, 80-89.

Coue, E. *How to practice suggestion and autosuggestion*. New York: American Library Service, 1923.

Crasilneck, H. B. & Hall, J. A. *Clinical hypnosis principles and applications*. New York: Grune & Stratton, 1975.

Creighton, J., Simonton, O. C., & Simonton, S. M. *Getting well again*. Los Angeles: J. P. Tarcher, 1978.

Cutten, G. B. *Three thousand years of mental healing*. New York: Scribner, 1911.

Edelstein, G. M. *Trauma, trance and transformation: A clinical guide to hypnotherapy*. New York: Brunner/Mazel, 1981.

Erickson, M. H. Special techniques of brief hypnotherapy, *Journal of Clinical & Experimental Hypnosis*, 1960, 8, 3-16.

Erickson, M. H. The interpersonal hypnotic technique for symptom correction and pain control. *American Journal of Clinical Hypnosis*, 1966, 8, 198-209.

Erickson, M. H. Hypnotic approaches to therapy. *American Journal of Clinical Hypnosis*, 1977, 20, 20-35.

Erickson, M. H., Rossi, E. L., & Rossi, S. I. *Hypnotic realities*. New York: Irvington Publishers, 1976.

Fezler, W., & Kroger, W. S. *Hypnosis and behavior modification*. Philadelphia: J. B. Lippincott, 1976.

Greenberg, Ira A. (Ed.). *Group hypnotherapy and hypnodrama*. Chicago, Ill.: Nelson-Hall, 1977.

Haley, J. (Ed.). *Advanced techniques of hypnosis and therapy: Selected papers of Milton H. Erickson, M. D.* New York: Grune & Stratton, 1967.

Kline, M. V. *Clinical correlations of experimental hypnosis*. Springfield, Ill.: Charles C. Thomas, 1963.

Kroger, W. S. *Clinical and experimental hypnosis in medicine, dentistry, and psychology*. Philadelphia: J. B. Lippincott, 1963 & 1967.

Lazarus, A. *In the mind's eye*. New York: Rawson Associates, 1977.

LeCron, L. M. *The complete guide to hypnosis*. New York: Barnes and Noble Books, 1971.

Rosen, G. History of medical hypnosis. In J M. Schneck (Ed.), *Hypnosis in Modern Medicine*. Springfield, Ill.: Charles C. Thomas, 1959.

Spiegel, D., and Spiegel, H. *Trance and management: Clinical uses of hypnosis*. New York: Basic Books, 1978.

Wolberg, L. *Medical hypnosis*. New York: Grune & Stratton, 1951.

Wolpe, J. *Psychotherapy in reciprocal inhibition*. California: Stanford University Press, 1958.

# EDITOR'S COMMENTARY
# ANOTHER ROUTE TOWARD KNOWING THYSELF

*Florence Kaslow Ph.D.*

Because Churchill is probably one of the few people in this country based in an interdisciplinary training setting who both directs a unit for hypnotherapy and practices it, and whose clientele is composed largely of therapy trainees and practitioners, he brought a vast amount of knowledge, experience, and insight to writing this chapter. The many referrals he receives from his medical colleagues plus the self-referrals of staff and interns attest to the respect for his competence. During my several week-long stays at Wilford Hall as a Distinguished Visiting Professor in the past few years, it became quite obvious to me that Churchill is considered an outstanding "therapist's therapist."

He elucidates a phenomenon alluded to in several other chapters—namely, that many clinicians, both neophyte and experienced, frame their request for hypnotherapy in the form of seeking knowledge of the technique as part of their education. And indeed it is and becomes an aspect of their experiential training! But what is also significant is the denial, conscious or unconscious, of the desire for therapy qua therapy to deal with some personal problems or issues—perhaps more rapidly and in what they assume is a more disguised way. Why does this denial that therapy is being

sought for therapeutic reasons surface so often? Is it because despite the field's spoken avowal of its importance as a core training component in many, but definitely not all programs, there is still a stigma attached to really "needing" therapy? Perhaps we are still so involved in old concepts of illness, pathology and dysfunction, and long-term treatment that the growth-producing, greater health potential inherent in some therapies, including brief therapy, is overlooked. More emphasis on the latter might enable therapists to enter treatment more realistically for personal and professional gain.

Churchill persuasively makes the case for hypnotherapy as an intervention strategy in its own right as well as an adjunct to other therapies. Its particular value of being able to break through rapidly to central disturbing material commends its usage for those who want and can tolerate its rapid, surgery-like, precise entry. Fortunately, as Churchill indicates, clients will not delve into material with which they are not yet ready to deal, nor will they behave in therapy in ways that are truly ego dystonic. The wonder of personality is this built-in safety defense system.

Wisely, Churchill cautions that practitioners of this healing art, as of all other forms, should be extremely well trained and professionally allied with one of the two major national hypnotherapy professional organizations. For, ultimately, the currency in which we are all dealing is human lives, and this

is, indeed, precious stuff.