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MEETING OUR MENTORS

WHY THERAPEUTIC HYPNOSIS? A CONVERSATION BETWEEN MARK P. JENSEN AND HANSJÖRG EBELL

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Abstract

This article summarizes the key points of a conversation between Mark P. Jensen and Hansjörg Ebell, M.D., in which Dr. Ebell discussed his views of hypnosis and what he has learned to be most important and most effective as a clinician using hypnosis in his practice. His practice focuses on individuals seeking psychotherapy who also have significant medical illnesses. He finds it essential for effective hypnosis to be sure that the patient is the focus of attention in an intersubjective exchange in the context of a therapeutic relationship. To help facilitate the benefits of this, Dr. Ebell observes the patient very closely, while both following and leading the patient through the steps of therapy. Dr. Ebell believes that it is important to also maintain the patient's (and his own) curiosity – curiosity about how things will change and get better. He believes that true change primarily comes from inside the patient, so he begins therapy by enlisting the patient's help. He has found that significant change and healing can occur spontaneously and sometimes very quickly, so he seeks to facilitate this when possible. The article ends with an illustration of how he works - utilizing ideomotor signaling as major technique – with a case history of a patient with contracture due to Complex Regional Pain Syndrome Type I after elbow fracture.

Hansjörg Ebell

Introduction/Background

Hansjörg Ebell first became interested in hypnosis as an anesthesiologist in 1976, when he was looking for a way to help his pediatric patients be more comfortable before surgical anesthesia. When he began his medical career in a university hospital, he was taught to restrain the child and hold the anesthesia mask over his or her face until any struggling stopped. As a parent, Dr. Ebell found this practice intolerable—he was certain it was traumatic for the children. Around this time he had read Milton Erickson's selected papers, edited by Jay Haley, and was inspired by a story Haley cited as typical of Erickson's approach. Erickson's son Robert had split his lip and knocked his upper tooth back into the maxilla. He was bleeding and screaming with pain and fright. Erickson said to him, "That hurts awful, Robert. That hurts terrible." By this he demonstrated that he had understood the situation fully.

Then, step by step, he led his son with suggestions that "maybe it will stop hurting in a little while, in just a minute or two." He encouraged the boy to be

ready for any necessary medical procedures by asking his wife to "look carefully at the good, red, strong blood" of her son that had spilled on his hands and on the pavement. Finally, Erickson helped his son to reframe the situation from one of panic, pain, hurt, and danger into one of a healthy competition between him and his sister, who had a similar accident not too long ago. "When he went to the doctor for stitches, the question was whether he *would get as many as his sister had once been given. The suturing was done without anesthetic on a boy who was an interested participant in the procedure." (Erickson, 1967)*

Ebell knew there was something here, an approach and a professional attitude, that he should use with his pediatric patients. But he was not sure how and where to begin. At that time, hypnosis was viewed with great skepticism in Germany, and as far as he knew there was no one in the medical community offering training and supervision. So he improvised, and started using stories to capture his little patients' attention. For example, when beginning an anesthesia procedure with a child, he used as a basis one of Kipling's stories, and asked if the child was interested to hear how the elephant got his trunk, because at the beginning all elephants had noses like all of the other animals. Most children were curious and agreed.

As he told this story, and as the child became more and more absorbed in it, he could bring the anesthesia mask closer and closer to the child's face, saying that "elephants are very nosy (curious) animals, sniffing around everywhere at any object, even if it smells a little bit funny." He tried to make the story as captivating, funny, and dramatic as possible in order to engage the child's imagination. Pretty soon the child would close his or her eyes and relax, more due to halothane than hypnosis. But still, Ebell learned that the key to helping these children was to capture and focus their attention on something interesting and pleasant rather than the frightening surroundings and conditions of the medical setting.

In the ensuing years, working with adult patients and during his time working in an intensive care unit (1978-83), Ebell learned that hypnosis could be a powerful adjunct to medical procedures and could provide significant comfort for his patients, so his interest in it blossomed. Two national hypnosis societies were founded around this time, and on a professional level hypnosis was starting to be more accepted in Germany. Workshops and training by experienced clinicians and researchers became available. In the years following 1983, Ebell taught hypnosis and was in charge of developing an interdisciplinary access to pain therapy for the Department of Anesthesiology at Munich University clinic. He was lucky enough to have a dean who supported his efforts to use and study hypnosis for the management of pain and symptoms, mostly with patients who had cancer. (Ebell 2009)

A critical basis for this practice and research was his clinical experience that suffering from pain is not only due to the "transference of nociceptive impulses into the brain." In his words, "As pain specialists or anesthesiologists we could do everything 'right' from a medical perspective, using all available traditional and efficient approaches (potent invasive procedures like peridural morphine included), and still some of our patients suffered from 'pain'—due to such factors as anxiety, depression, despair, and familial conflicts. But with the aid of hypnosis, self-hypnosis, and psychotherapeutic support, many of these patients were able to cope much better and experience significant relief; maybe simply because morphine works better under the condition of not being stressed ."

In 1986, Ebell completed his education as a psychotherapist parallel to his clinical work, and became less interested in providing traditional medical treatment as a physician, and more interested in the use of hypnosis to help his patients deal with the many psychological issues related to medical care; especially with patients suffering from cancer disease and chronic pain. This included a research project (1988-91), funded by the German Cancer Society, on the effects of self hypnosis as an adjunctive measure in patients

with cancer-related pain. (Ebell 1995, 2008) Since 1992 he has been working in private practice, mostly with the chronically ill, using hypnosis as a core element of his psychotherapy practice.

How do you view hypnosis?

The basic prerequisite of effective therapeutic hypnosis is the ability to put trust in the high regenerative potential, accessed through the relationship between client and therapist. On this basis, trance or hypnotic phenomena tend to emerge by themselves and can be 'utilized' for therapeutic goals. Or, putting it another way, the occurrence of hypnosis can be understood as a natural response to an appropriate interpersonal interaction.

I ask the patient for information and verify repeatedly that I have understood what the problem is. If I can establish this dialogue —like a back-and-forth in non-competitive table tennis— in which the patient is assured that I understand what is being said, trance or some relaxation responses tend to happen spontaneously. Take, for example, a typical situation on an oncological ward in the hospital: a patient with intractable pain cannot relax and fall asleep. The less sleep the patient gets, the more he or she will suffer from pain and fatigue. The more stressed the patient becomes, the less he or she will be able to relax and get to sleep. The patient is caught up in a vicious cycle.

If I succeed in interrupting the cycle, physiological homeostatic regulations will take over and this desperate person will find rest. I assist this process through focusing the patient's attention on my voice and rhythm. I can ask the patient to shut his or her eyes, to breathe a little bit deeper, and to be aware of how it feels to be just a little bit more comfortable than before, and refer to whatever behavior I can watch. All I have to do is to support and encourage the patient's tendency to let go.

This might even lead into a deep trance. What is decisive to help patients take initial steps is to focus their awareness on what is happening inside themselves, in order to let them discover that they have inherent resources and capabilities of which they were previously not aware.

In many situations—especially in emergencies and with invasive procedures in a medical setting—it is appropriate to execute hypnosis directly in a traditional way, demonstrating "power" to influence the patient's behavior, thoughts, and physiology. In my work with the chronically ill (Ebell 2010), I have found it most efficient to use hypnosis indirectly to help patients help themselves. I use hypnosis in a very natural way. Indeed, a casual observer might conclude that he or she is only witnessing an intense conversation in which one person is sitting (lying) with his or her eyes closed. Aside from the fact that one hand is rising (levitation) or fingers are lifting to signal "yes" and "no" answers to questions, the observer might ask, "where is the hypnosis here?" To my mind, therapeutic hypnosis is essentially a relational process of interaction between the therapist and the client.

When the interaction is effective, processes of required change begin, or relevant emotional issues hitherto repressed will become conscious. In many cases this awareness does not even need to be targeted through induction or suggestion. After a therapeutically relevant session and interpersonal exchange, a pain might disappear, or a conflict might be resolved.

The essence of therapeutic hypnosis (Ebell 2004) in the medical field is an exchange between two individuals who are working together in the social roles of therapist and client. The therapist is determined to hypnosis techniques and hypnotic phenomena to achieve those therapeutic goals to which both have agreed. Solutions must be found within the system of the patient (the patient's experiences, values, resources, and hindrances) and cannot be forced on the patient via hypnosis. I assume that it is always

worth trying to start and maintain this therapeutic dialog. It cannot be predicted whether the changes produced will turn out to be relevant – but often they are. Hypnosis and self-hypnosis in my experience are especially helpful, because they draw on intrinsic psychophysiological sources for well-being and change (Brown 1991), which cannot be accessed rationally (through logical reasoning) or induced by physical or chemical means.

What kinds of problems do you use hypnosis for?

For the most part I work with people who are motivated for psychotherapy and who suffer from significant medical illnesses (chronic pain syndromes and cancer disease, chronic psychosomatic and somatoform disorders). The German health insurance system provides for a collaboration of between 25 and 50 one hour-sessions to enhance coping or self management. Although therapeutic goals are geared toward the control of symptoms - often pain - they can also include other issues such as traumatic experience and relational conflicts.

What are the key elements of effective hypnosis?

First: The patient is the focus of attention

For therapeutic hypnosis to happen, the client needs to experience, consciously and unconsciously, that he or she is the focus of my full professional attention. The patient needs to experience that I, as the therapist, can really relate to him or her, that I care and genuinely want to achieve something valuable. This is, as I indicated before, central to encouraging trance or other hypnotic phenomena that we 'utilize' therapeutically. We have all experienced this kind of focused attention, I hope, at some time in our lives. Perhaps it was a nurturing mother or another person in a caring relationship. It permits the client to trust and let go. I know this might sound idealistic or romantic, but I am convinced that underlying an effective, meaningful therapeutic relationship, one human being is aware of the fact that someone else wishes him or her well. This can be felt, and it is what produces hypnosis and makes hypnosis work.

Second: Observe the patient and flexibly follow and lead him or her

Focusing my attention on the client encourages, facilitates, and enhances whatever spontaneous trance phenomena occur. I do not necessarily suggest specific trance phenomena, nor do I push the client; I just notice the occurrence of such phenomena and try to follow them. In fact, as I have gained experience I have suggested less and less, following the patient more and more. Although there are also many times, especially when exploring conflict-related issues, when I may take the initiative and, referring to the work of David Cheek (Cheek, 1994), work with ideomotor signaling.[1]

What are factors that, although they may not be essential, make hypnosis more effective?

Maintaining the patient's curiosity, and my own, about how things will change and get better.

In order to facilitate therapeutic change through hypnotic phenomena it is important to encourage the patient's curiosity about what is going to happen. Curiosity opens up the possibility of change, and when change is

[1] Ideomotor signaling is a technique widely used in hypnotherapy, with or without formal hypnosis induction. For example, answers are signaled through movements of fingers that represent "yes" or "no". The typically slow, often jerky or trembling movements are not the result of conscious reasoning. Their occurrence is experienced as involuntary and usually surprises the person who is sensing them or other similar ideomotor responses, such as levitation or catalepsy. (Damsbo 1987)

viewed as possible, it is more likely to occur. In order to facilitate the patient's curiosity, I try to uphold my own. Thus I see each patient as a new opportunity for learning. Too often, patients enter treatment with the goal of fighting their symptoms. When symptoms alone are the focus of attention, they tend to become more and more important. Consequently, the client is left with the feeling of being stuck. So instead of fighting the symptom, I want to help patients reorient for change and start to wonder about how the symptom is going to change, with the implicit suggestion that the only basic question is what the imagined change will look like.

If I feel that the patient cannot change, I will no longer be able to provide effective help. When this is the case, I seek out collegial supervision in order to find out whether my feeling of being stuck relates to our relationship, or sometimes my medical knowledge and training may lead me to believe that the patient cannot improve (especially in cancer patients with progressive disease). A number of extraordinary patients have convinced me that I have to take care that my medical knowledge does not create or maintain negative suggestions of this kind. I cannot foretell the future; no one can. That is why I think it is important to maintain a sense of curiosity, and thus be able to maintain a hope that things are going to get better for the patient – but accept to be powerless, too.

DEMONSTRATION IN MANCHESTER. PICTURE: WITH PERMISSION BOTH OF DR BRAID AND MIKE GOW

Are there specific techniques or exercises that you have found particularly useful that you use routinely in many or most cases, or in particular situations?

Change comes from inside the patient, so start by enlisting the patient's help

I always try to enlist the patient's help. I may be an expert on different hypnotic techniques and psychotherapeutic interventions, and I also have scientific knowledge through my medical training and clinical experience, but the patient is and will always remain the expert on himself or herself. So I try to take full advantage of my client's expertise.

The longer the patient's medical history with a particular condition, and the more experience he or she has with failed therapeutic interventions, the more desperate he or she may feel about the experience of chronification, the more it is necessary to start enlisting the patient's help. There must be lots of experiences that can be utilized for therapeutic change, but access to them has to be gained in a context of looking for solutions rather than one of describing the development of symptoms and problems.

I remember a patient suffering from chronic intractable pain with a long history of treatment failures. When I asked her, "Do you want things to change?" she answered, "Yes." I said, "I do, too. But how?" I talked with her about how she had tried everything that medical science had to offer, including multiple surgeries and many different drugs, and nothing had worked. Although I repeated a history of bad news, she agreed openly (creating a "Yes-Set"), and her attention was focused on what I was saying. Technically this strategy is called 'pacing'. Then I started 'leading': I told her there was something that we had not tried yet. This made her curious, and she wanted to know what it was.

At this point, she was well prepared to accept a suggestion. I told her that we had not yet asked her "unconscious" (meaning all the knowledge and resources we have accumulated all our life, that we cannot put into words) for help and/or cooperation.

She seemed to become very curious at this point. I then suggested that we might do this with a finger signal (one finger for "yes," one for "no," and a third for "maybe"), and that this reaction only would take place if there was something inside her which held a promise that her symptoms could change. This might be a big or a small change, but it would still be a change. She was not sure what I meant, so I suggested, "If your unconscious mind is prepared to help us, then one of the hands will feel a little bit different than the other." She noticed here that her left hand started to feel a little warmer.

This was interesting to both of us, since she had many medical problems and significant feelings of helplessness. Yet now we had had a small sign, a promise of change. And with a beginning as promising as this, it became possible to generate changes throughout her whole "system." Over time, and after many months of complex cooperation on many medical and psychotherapeutic levels, she changed from suffering with chronic, daily, severe pain, to a person who enjoyed life, married, and had a baby. And this positive change began with a single question asking her unconscious for help.

When using this technique to signal messages from the so-called "unconscious," one has the choice of many different involuntary movements. One can ask for a levitation of one hand, or ask the patient to put both hands in front of him or her and for the hands to move together when or if the unconscious mind is prepared to give an answer. It is a fail-safe method, for if a question or situation is not appropriate, nothing will happen. When the feeling in the hands does not change at all, or a finger does not lift, this too can be useful and valuable. In this case, I can proceed by asking about which experiences, thoughts, or feelings might be contributing to the patient not being ready for change or not believing in the possibility of change. On the other hand, when the patient sees or feels the signal, he or she is convincing himself or herself that there is a possibility for change. Sometimes, with this simple technique the patient can experience decisive changes; perhaps just because I, in the context of a good relationship, dared to ask the unconscious about a possibility for change.

I remember a cancer patient who had good pain relief through morphine. But his dreams under morphine felt as if they were real, and in them he relived horrifying experiences from his youth as a soldier in World War II. So it seemed as if he had to decide either to suffer from physical pain now (without morphine) or his emotional pain from the past (with morphine). Asking the unconscious to help find a solution for this dilemma resulted in slow and hesitating movements of the little finger. After that, with no other intervention at all, morphine no longer produced any unwanted side effects. I assume a causal relation. (Ebell 2008)

Asking the unconscious mind—in other words, our implicit memories and our basic homeostatic regulation processes—for help is one of the primary techniques I use. This has much to do with my basic assumption that the solution for most any problem exists in the personal system. From outside the system, therapists cannot really control the process, though they can provide input and encouragement. But you don't have to control it.

Healing can occur spontaneously, and sometimes very quickly

If you prepare the field to make change possible, then positive changes can come about quickly, and sometimes in big ways. I view the individual as a homeostatic system that is perfectly regulated, even if it's producing problems or symptoms. The problem is actually the best possible solution under the given circumstances. The symptom always has a reason, a

sense. And of course I, as an outsider, cannot know the reason. I cannot know, ahead of time, if the system can function without the symptom or replace it with another that is "better" in subjective experience or that is more manageable. I have to work with the conditions of the client's system. This is my challenge and basic function. By offering my curiosity about possible changes, in the context of a close therapeutic relationship, I can provide stimuli that allow or help a system to regulate itself in a different, "better" way.

Case history:

Contracture (Complex Regional Pain Syndrome) after fracture of the right elbow

A 46-year-old man had had a right elbow fracture that caused significant muscle contractures. The elbow joint had become so stiff that he was unable to move the forearm at all. The man was working as a computer specialist and would lose his job if he could not be treated successfully. Under anesthesia, the elbow was moved and mobilized so that there was no longer any mechanical hindrance. After the patient came out of anesthesia, his caregivers were ready to begin physiotherapy in order to strengthen his arm. However, he was still so anxious about moving the arm that he was unable to participate cooperatively in therapy.

The surgeon was afraid that the elbow was going to stiffen again, and felt angry because the patient was being uncooperative. While he was forcing the elbow to move with the patient awake and resisting, the surgeon broke the joint fracture again. Even worse, the surgeon did not admit that he had caused the second fracture. Of course this was traumatizing for the patient, so further therapeutic measures were extremely difficult. The patient's trust seemed to be completely destroyed. The physiotherapist who was working on this case knew of my interest in using hypnosis in difficult cases and asked if I would help.

When I first met the patient, he was panicking. He already saw himself as a wreck, unable to ever move his arm again and losing his job. He had a good relationship with the physiotherapist and trusted her, allowing her to touch his arm although he no longer allowed the surgeon to do so. We both explained to him that he would be unable to heal or move his joint and arm at all if he did not stretch it and use it. We also assured him that we understood his concerns, and we reframed his "problem" as a basic and entirely understandable wish to protect himself from further injury. At the same time we made it clear that, by avoiding the use of his arm, he was preventing progress. I then suggested to him that he allow the physiotherapist to move his arm. He agreed.

I also added that she would stop at once if she encountered significant resistance or risked going too far, or whenever he asked her to stop. I then suggested that, providing he trusted her to stop whenever she encountered physical resistance, it would be better for him to pay less attention to the arm. In fact, it would be better to imagine he were somewhere else. So I suggested a dissociative experience: that he close his eyes and go on vacation someplace where he might feel relaxed and have a good time, leaving behind this hospital ward where they had damaged his arm. He agreed that all of this seemed a good idea. We tried this out for some minutes, and it worked fine. We demonstrated to him that it was possible to move his arm without pain and damage, and with greater success than when his anxious attention had been focused on the traumatized joint.

The next day I suggested that it would be good for him to go even deeper into the dissociative experience of feeling completely relaxed and well, and that something inside of him would be able to monitor the arm automatically even better without his conscious attention, and provide the physiotherapist with a signal to stop or a signal to continue. I established finger signals using the healthy left hand by saying, "if the hand is

prepared to collaborate on this, then the hand will feel a little bit funny," and I held it in an unusual but comfortable position. After a while, when the hand felt pretty stiff (due to the hypnotic phenomenon of catalepsy) I removed my hand without any formal hypnosis induction. I then suggested specific finger signals to indicate "stop" (index finger) and "go on" (little finger) for the physiotherapist, just like red and green on a traffic light.

During this physiotherapy session I provided the patient with suggestions for imagery and relaxation. The physiotherapist could then estimate how far the patient's arm could move safely, and we watched the fingers of his other hand to determine when to continue and when to stop.

The physiotherapist was instructed to stop as soon as she saw the "stop" signal. When the patient's hand gave the "go" signal, she had permission to continue a little bit longer, extend the range of motion even further. I accompanied the first few sessions, and was then no longer needed. They had a good relationship, and the patient was able to use his own imagination to go to a comforting place, which he used from then on as a self-hypnosis ritual. The communication conducive to this good progress—which, by the way, was a big relief for the surgeon and the whole ward—had become available through delegating control to ideomotor signaling. Several months later I received a thank-you card from this patient, telling me that he had progressed enough to be able to return to work.

This patient was initially on his way to a lengthy bout with chronic pain and disability, as well as many medical treatments with a high probability of failure, time and energy consuming legal retaliation efforts, etc. By acknowledging the catastrophe, and by looking for change against all odds, we were able to reframe a horrifying dread of permanent disability into the challenge of achieving complete rehabilitation - with the help of the unconscious mind. My task was to facilitate conscious and "unconscious" cooperation, and give optimal directions during physiotherapy.

A 1,000-mile walk begins with one step, followed by a second step, and so on. After finding trust in the relationships with me and the physiotherapist and learning to use his ability to dissociate, and to use ideomotor stop and go signals, the patient was able to progress rapidly. This involved the enlistment of the patient's help, rather than forcing treatment on him—which had been tried already, with very negative results.

Understanding current medical treatment as potentially traumatizing

In my work I have met many patients who have been traumatized by medical treatments such as invasive procedures, surgery, and chemotherapy. These can be traumatizing even when (although?) they are necessary for life or health and cognitively accepted. I have also met many patients who experienced conflicts in their relationships with physicians and institutions as 'traumatizing', especially when medical treatments did not go well. It is important in these cases not to blame the patient, the doctors, or the institutions, for there are always relevant and understandable contributing factors. But being traumatized often contributes to a psychophysiology or even pathophysiology that might explain many of these patients' symptoms. Because biologically a primary coping mechanism for trauma is dissociation, many patients who have symptoms related to their history of experience with the medical system can be seen as skilled in hypnosis – rather negative hypnosis.

I try to help these patients understand that dissociation is a natural resource and, despite the fact that they became acquainted with it in a problematic context, it can be useful to help them feel better, and even to reintegrate traumatic memories. So hypnosis is not only helpful for patients who have classic dissociative problems or Post-Traumatic Stress Disorder; it is also useful for patients who present with general distress or who have medical problems and a history of medical treatments.

Anything else?

Hypnotic skills can be used for coping. They are part of the equipment we are born with for life management. For those patients who are aware of this equipment and use it, it can make life easier, especially in relation to chronic illness (resilience). Part of my job as a medically trained psychotherapist is to help patients unaware of these possibilities and skills become aware of them, and to help those who know or come to know that they have these resources to use them more effectively. It is easier to climb a mountain with the right equipment; it is also easier to climb a difficult mountain with a guide. I see myself as a guide for my patients, as a travelling companion for a while on the path of life.

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