CONTEMPORARY HYPNOSIS
27(3):159–169 (2010)

FROM FERENCSZI TO LIVNAY: A SEARCH FOR THE DIFFERENT MODELS WE USE CONSCIOUSLY AND UNCONSCIOUSLY IN HYPNOTHERAPY

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ABSTRACT

A positivistic approach developed through working with patients suffering from performance anxieties led to an examination of the appropriateness of different hypnotic styles, based upon Ferencszi's father/mother hypnotist concept, and subsequent research by Banyai who isolated five different styles in experimental investigations. The elucidation of the styles was integrated into a two-stage model of hypnotherapy: (1) amelioration of symptoms through the teaching of self-hypnosis and (2) exploration of meaning, meeting the symptom, and integration. The different styles were inspected as they emerged in the different stages of treatment.

Key words: father/mother hypnosis, hypnotherapy, hypnosis styles, self-hypnosis, therapeutic integration.

From the outset of my psychotherapeutic work, subsequent to my training in hypnosis, I began to collect a series of patients exhibiting anxieties in various areas of performance: tests, concerts, public speaking, groups, and so on (Livnay, 2004). In attempting to deal with their concerns and difficulties, I found myself adjusting my usual open and permissive style to become more directly suggestive and authoritative. As I found most of these patients to have achieved a healthy balance in their lives (except for this one specific anxiety-arousing area), I was able to exhibit a total belief in their abilities to succeed in this area. I called this a *positivistic-authoritative approach*, which turned out to be successful in a vast majority of the cases.

This development brought me to consider my style and specific role in different cases. As I consider myself an integrative therapist (Norcross, 1986), I asked myself whether there were different styles connected to the various techniques and approaches I use. How could I conceptualize what I was doing? How applicable could this positivistic style be with other forms of anxiety, as well as with other difficulties that patients presented? This paper will explore these questions and seek to find appropriate answers.

Contemplating my style brought me back to considering the research I undertook for my doctoral dissertation (Livnay, 1983). The work was based upon previous research that had been done in Berkeley, California in the aftermath of the influx of hippies to the area in the late 1960s. Those individuals who settled in Berkeley and formed families displayed a very distinctive disciplinary style which produced children who were lacking in social adjustment. A local psychologist began to investigate this phenomenon and in a series of

experiments (Baumrind, 1966, 1975; Baumrind & Black, 1967) delineated three specific parental disciplinary patterns which were associated with the development of competence in children.

1. *Permissive* parents emphasize a benign acceptance of the child's behaviour, avoiding the exercise of control, and giving no encouragement to obeying externally defined standards. The parent is available as a resource but will not intervene unless asked. Maximum freedom (seen as absence of restraint) is granted.
2. *Authoritarian* parents are physically punitive, demanding obedience, stressing their word without allowing verbal give and take; acting by tradition and a strict moral code—an absolute standard of conduct derived from a higher authority. They are punitive when the child's actions or beliefs conflict with 'correct' conduct.
3. *Authoritative* parents direct their children in a rational, issue-oriented manner. They encourage verbal give and take and show respect for the child, but take responsibility for decisions. Autonomous self-will and disciplined conformity are valued. They will assert firm control during conflict without over-restricting the child.

Baumrind (1980) classified her three types along the dimensions of responsiveness and demandingness (akin to the expressive–instrumental dimension) (see Table 1). In her follow-up (Baumrind, personal communication,1980) she discovered a fourth type, *democratic or non-conforming*, which was high on responsiveness but only moderate on demands. These families were characterized by a harmonious atmosphere wherein they developed principles for resolving differences.

If we relate the parental disciplinary paradigm to the hypnotic situation, the *demandingness* is expressed by delineating specific tasks which the patient is expected to fulfil,

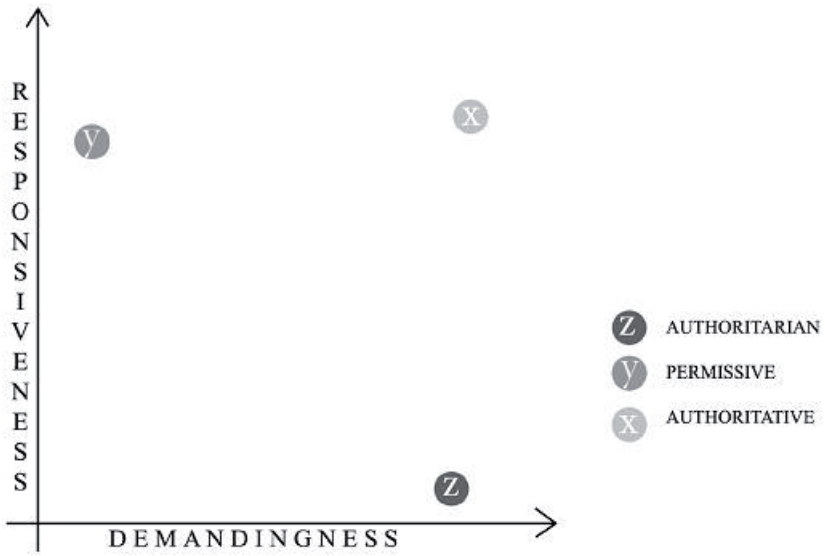

Table 1: The scatter of the three parental disciplinary styles on dimensions of responsiveness and demandingness

whether during the trance or during practice sessions between the sessions. The *responsiveness* is expressed by relating and encouraging the patient's initiative, modification, and translation of the therapist's suggestions. It turns out that these very same patterns have been replicated in the laboratory by Eva Banyai and her group in Budapest (see below), in continuation of Sándor Ferencszi's pioneering work at the beginning of the twentieth century.

Ferencszi (1965 [1909], 1916) distinguished between 'maternal' and 'paternal' hypnosis. He saw these two types of hypnosis as based on the patient's same feelings of love or fear, the same conviction of infallibility, as those his parents inspired in him as a child (Shor & Orne, 1965). Diamond (1987), in elaborating the interactional dimension of irrational alliance, spoke of the patient identifying with the therapist's omnipotent powers as being similar to paternal hypnosis—surrendering to a loved and frightening adversary (Ferencszi, 1916). Ferencszi took an active role in inviting the use of imaginal processes and even asking patients to 'fabricate' a fantasy if they could not readily provide one; that is, to tell all that comes into their mind without regard for objective reality. He sometimes offered fantasies which he felt patients should have been experiencing until the process took over in them. He claimed his forced fantasies had a great value because they brought about the production (or reproduction) of scenes quite unexpected by either patient or analyst (Healy et al., 1930). See Livnay (1992) for an extension of this approach.

Ferencszi's active stance emerged from the discovery that the typical 'anonymous' and 'neutral' posture of the analyst repeated elements of the parent–child relationship which had led to the patient's illness. This led him to develop a method of countertransference disclosure which eventually brought him to mutual analysis (Aron, 1996). Ferencszi and Rank (1924) proposed that for cure to occur, a phase of experience had to precede a phase of understanding (Aron, 1996) (see desciption of two-stage model below).

Eva Banyai and her colleagues (Banyai et al., 1990; Banyai, 1991, 1998, 2002; Varga et al., 1993, 2006) developed an interactional model of hypnosis, discovering that even during a relatively brief experimental encounter between hypnotist and subject, that hypnotists develop significant feelings and attitudes towards their subjects. They organized the latter into five articulated styles.

1. *Physical–organic style* (maternal): Hypnosis is built mainly on positive emotions (on love, according to Ferencszi) between the participants. The hypnotist is very much 'with' the hypnotized person. S/he wants mainly the hypnotized subject's desires and ideas to come true, and facilitates the independent initiatives of the hypnotized person. S/he places emphasis on the current condition and wishes of the subject. The atmosphere of hypnosis is emotionally comforting.
2. *Analytical–cognitive style* (paternal): Hypnosis is built mainly on respect of authority (on fear, according to Ferencszi). The hypnotist leads and directs the hypnotized person. S/he wants to realize mainly his/her own ideas and intentions, and slightly limits independent initiative of the hypnotized person. S/he does not place emphasis on the current condition and wishes of the subject. The atmosphere of hypnosis is mentally stimulating.
3. *Sibling style*: Hypnosis is built mainly on equality. The hypnotist almost goes together with the hypnotized person. S/he almost wishes to participate in the realization of the

desires and ideas of the hypnotized subject, and accepts the independent initiative of the hypnotized person. S/he places emphasis on togetherness. The atmosphere of hypnosis is intimate.

4. *Lover-like style*: Hypnosis is built mainly on erotic attraction. For the hypnotist, it is mainly the feelings and emotions elicited in him/her by the hypnotized person that are important. He/she is almost indifferent as to whether the hypnotized subject's desires and ideas come true or not, or if the hypnotized person has independent initiatives. S/he places emphasis on his/her own feelings. The atmosphere of hypnosis depends on the response.
5. *Friend-like style*: Hypnosis is built mainly on an equal complementary relationship. The hypnotist accepts the role of the leader in the given situation, and helps the hypnotized subject to realize their desires and ideas, while respecting the patient's sovereignty. The atmosphere of hypnosis is friendly.

We might ponder what makes the hypnotist so susceptible to such positions. Is the style a result of the hypnotist's personality? Or is it a response to a specific patient or subject? The concept of *therapist trance* (see Erickson & Rossi, 1977; Diamond 1983, 1984, 1986; Gilligan, 1987; Livnay, 1995, 1996) emphasizes how the therapist is especially affected by the patient in a hypnotic situation. If I consider the different components of my own style or demeanour with patients, I find a combination of the many styles described by Banyai and her group: empathic-supportive, authoritative, determined and coaxing, playful, humorous, teasing and flirting. When does each component come into play? What stage in the therapeutic process does it become relevant? Let us turn to the two-stage model with respect to anxiety states to seek the answers.

ANXIETY STATES

As I reflect upon my work with patients suffering from states of anxiety, I have dealt with those suffering from panic states, generalized anxiety, focused anxieties or phobias, and performance anxieties. In these various cases, I discern two distinct stages of intervention: *amelioration* and *exploration*. In pondering what model of intervention I am applying, I am reminded of Heinz Werner's orthogenetic principle of development (Werner, 1957). He stipulates that all beings, organizations, nations, and so on undergo three different stages of development.

1. The first stage is global and undifferentiated. Things are seen and experienced in generalities: 'I am just terribly anxious!'
2. The second stage entails the differentiation of the whole into discrete parts or categories: 'I notice that whenever I am in a . . . I get terribly anxious.'
3. The third stage entails a reintegration of the separate parts into a complex whole. Werner emphasizes that this stage is not always attained.

Werner's model is especially applicable to hypnotherapy, as most often we utilize dissociation at the beginning of our hypnotic intervention and only later work towards integration.

THE AMELIORATION STAGE

Anxiety, acute pain, and debilitating symptoms bring about a regressive state wherein the patient is functioning at a primitive level. The initial stage of therapy requires a combination of authoritativeness and warm support.

1. All communication is kept to a very simple, succinct, and clear style.
2. The therapist is informative about the anxiety—bodily symptoms, their explanation in terms of fight/flight, and so on.
3. The therapist must be highly supportive and understanding of the suffering which the patient is experiencing.
4. The therapeutic model is more of a teacher and trainer, as the focus is placed upon teaching the patient self-hypnosis to deal with the various symptoms.

What style is being implemented at this stage? We have components of emphasizing authority in the communication style, being a teacher and trainer (father), as well as the need for support and warmth (mother). Both are contained in the authoritative stance described above. Probably, we can talk about shifts in emphasis or a sort of oscillation, where the therapist senses when to emphasize authority and when to apply succour.

A young female soldier came to me for treatment for an acute anxiety state whenever she was in a car (even as a passenger), subsequent to a series of accidents both as a driver and passenger. At the outset, I informed her that following her learning self-hypnosis to reduce the symptoms of her anxiety, we would be going out in a car to help her deal *in vivo* with her anxieties. She immediately vehemently protested and seemed upset. We postponed the discussion and she made good progress until I announced that we would be spending the next session 'just sitting' in my car. Despite an initial protest, she cooperated. This was followed, during the next session, by a brief drive through city streets in the neighbourhood. She then stipulated only 'not on a highway'! In the following session, I proceeded to drive to a 'highway-like' wide street, and 'found myself' telling her about the strange French habit of telling drivers seeking directions '*tout droit*' (go straight ahead). I repeated this message in many variations, and very quickly she entered a deep somnambulistic trance, eyes wide open but fixed straight ahead. Upon our return, she remarked that previously she had been so hyper-vigilant, not thinking that she could simply just keep her eyes straight ahead. Without going into the results of the hypnotic intervention, I adopted a very active, assertive, and challenging position in order to deal with and overcome the avoidance which perpetuated the symptomatic behaviour. The challenging, father-like stance followed much support and warmth in accepting and teaching the patient to deal with her symptoms.

When I adopt such a firm, authoritative stance, I often wonder—following strong attempts by the patient to dissuade me from my insistence upon trying themselves out in certain anxiety-evoking situations—whether I have misjudged their strengths and abilities. Am I stuck in my own trance so that I misread the cues? However, each time I have persisted and found my 'instincts' to be reliable. My persistence led each time to a breakthrough.

THE EXPLORATORY STAGE

Once the patient achieves a moderate measure of control over their symptoms, the exploratory stage begins. It should be noted that in some cases, the patient is satisfied with the relative improvement and chooses to finish therapy at this point. However, since relative control includes episodes of regression, most patients agree to solidify their gains by completing the second stage.

If we look at the integrative approach, whereas the amelioration stage was supportive and primarily behavioural, the exploratory stage uses a combination of hypnoanalytic (psychodynamic), ego state, gestalt, and psychodrama techniques.

This stage is characterized by:

1. The therapist encouraging exploration of the significance and meaning of the various symptoms.
2. The therapist is supportive (mother) as well as gently leading (father).
3. The therapist encourages meeting the 'other side, the shadow, the tail'.
4. The stage entails integration and working through (Werner's (1957) third stage).

We begin with a discussion of my view of symptoms, which I see as an attempt by the patient to signal to himself that his development was not adequate to meet certain challenges, so that they provide a sign that something is amiss, that something needs to be changed. In that light, I introduce various ways of discovering their meaning.

Most patients who seek hypnosis come with a view of the therapist as expelling, removing, or destroying their symptoms. I propose an analogue (as opposed to digital) view of modifying, altering by degrees until the signal function is reached, to that level where the intensity is so low as to cease being disruptive, and yet noticeable so that the patient still knows that there is something amiss. Now, it is possible to concentrate upon 'meeting' without excess 'noise'.

I tell the story of the knight who, on a specific hot day, was feeling very uncomfortable in his armour. He decided to get off his horse and proceeded to put down his weapons and remove his armour. Then he discerned another knight galloping towards him, weapon raised! As the second knight came nearer, he was puzzled by this strange sight: a knight with his armour and weapons beside him. The first knight removed his glove and held out his hand. The second knight dismounted and found himself putting down his weapon and offering his hand. Thus was born the handshake ritual! Here we have all of the elements of drama: Can I risk letting down my defences to find out more about the 'other's' intentions? Can I be proactive by leading with a message of peace instead of war and aggression?

The meeting can be carried out by varied means.

1. *Ideo-motoric*: Using the pendulum, finger-signalling, or alternating hands. The patient is invited to enter the observer role, and told that I will be speaking with the side, part, or voice within that is in charge of the symptomatic behaviour. The patient is asked to report any relevant feelings or sensations, while refraining from consciously attempting to answer the questions. I then 'speak' to that part, asking whether it is willing to share with us (myself and the conscious mind) information about the symptomatic

behaviour. If there is a positive response, I go on to pose questions about the reasons for the behaviour or symptom, the conditions maintaining it, including sharing, bringing it up to consciousness, and so on. This kind of discourse is very suggestive, leads to a dissociation between the observing and experiencing ego, and invites a process of joining between conscious and unconscious.

2. *Ego state* (Watkins, 1992): Inviting a dialogue with the symptom. After the patient is brought into trance, I invite the ego state responsible for the symptom to come forth. A dialogue develops along the lines described above for ideo-motor signalling.
3. *Gestalt hot seat* (Perls, 1966; Polster & Polster, 1973): A further variation of the ego state is to invite a dialogue with the symptom by imagining it seated in a chair opposite the patient. The patient is hypnotically induced to produce a hallucination of the figure, and then invited to begin a dialogue to enquire about the meaning of the behaviour. The patient is requested to change seats when a response is required, to enter 'the symptom's shoes' and to respond for it. To the extent that the patient enters the role and the discourse, a meaningful experience is created. Hypnosis serves as a useful enhancement to the standard gestalt technique. The coach/director role is here dominant.
4. *Hypno-projective*: For example, using the Theatre Technique (Wolberg, 1945) to invite the patient to project onto a stage the reasons behind and around the symptom, and subsequently find new solutions to dealing with the problem.
5. *Age regression*: Regressing the patient to the age wherein the problem was created.
   A 60-year-old woman came to me to deal with a driving phobia which she had been suffering for thirty years. Several sessions of hypnotherapy led to a considerable remission in the symptoms, until we went onto a highway, when she felt again overwhelmed by anxiety while in the middle lane. I told her that we had to 'listen to the symptom' by turning to other methods. Previous attempts at utilizing ideo-motor questioning had failed to yield any results. She reiterated her feeling that she had built a fortress around her childhood. When she reported increasing tension in her stomach, I chose to use Watkins's Affect Bridge (Watkins, 1992), inviting her to amplify the feelings in her stomach until they brought her back to an earlier time (or first time) when she felt likewise. She found herself in the shower at 15, with extreme tension. She then began to talk about how her mother had warned her to be aware of her father after puberty. This opened up an onrush of highly painful memories during the following sessions centred around a hyper-critical and rejecting mother who had great difficulty accepting her daughter's sexuality and individuality (even as a young child). Significant oedipal issues emerged which had led to avoidance of marriage and close intimate relationships with appropriately available men. On the highway, she found herself intimidated and almost paralysed by 'wild' male drivers speeding on the highway! Working through the issues that came up enabled her to separate driving for driving's sake from the symbolic input that had loaded the driving to create and maintain the phobia.
6. *Work with the gong*: A further means of working towards dialogue and integration is by utilizing the gong (Livnay, 1995). The non-verbal mode lends itself to depth and transcending the usual defences to provide a unique means of connecting to the symptom. My role in this work is more of a coach, standing next to the patient, holding the frame, encouraging letting go and flowing with the 'playing'. Inviting the patient to

'speak with the symptom' through hitting the gong, to enter the anxiety-provoking area and to transcend it, often leads to significant breakthroughs. This serves as a sort of unique psychodrama (Blatner, 1997), wherein the patient enters into the momentum of the striking motion, interacting with the emanating tones and vibrations, and flowing by imagining a dialogue without words.

A 37-year-old woman was struggling with the aftermath of escaping from a very abusive relationship with a man. In beginning to work with the gong, she experienced several regressive images of a difficult relationship with a very abusive mother. When I invited her to 'speak' with her mother through the gong, she became very reluctant and asked me to do the playing. I received a strange sensation around my midsection, and shared with her a peculiar impulse that had come into my mind to take off my belt. She was astounded and immediately produced several painful memories of having been beaten by her mother with a belt. Following these disclosures, she was able to return to the gong and find a release and some closure with her mother.

This is also an example of enactment, as mentioned above (Ferenczi, 1916; Livnay, 1992), wherein the therapist allows himself to be taken into the drama and play a part in enabling the events to come to a resolution. The non-verbal medium provided by the gong opens both parties to access further dimensions.

I have briefly described different means to bring about an integrative trend, by encouraging the patient to turn the ego-alien symptom into an accepted, purposeful force within. One of the prime metaphors I utilize during the integrative phase is that of the host, or orchestra conductor. In each case, the message is to accept all parts and sides, while creating order and directing the interaction between the different sides, voices, parts, towards achieving harmony. In this phase, I act as a kind of director to the director within the patient, encouraging ego-synthetic functioning, facilitating tolerance, furthering reorganization, and enhancing the self as a unified whole.

OTHER CONDITIONS

While this discussion has concentrated on the treatment of patients suffering from various anxieties, the model is also appropriate for more general conditions, including pain and personality disorders. In the latter, the process is much more extended, with the first phase concentrating on the formation of the therapeutic alliance, stabilizing the relationship by enhancing object constancy, and teaching self-soothing. The second stage entails extended work with introjects, stabilization, and integration. See Baker (1981) for an excellent elaboration of a hypno-developmental model, as well as Livnay (1992, 2001, 2002).

This paper has attempted to raise our consciousness and awareness about how and what role we take in re-enacting the patient's drama towards a more successful and conducive resolution. I contend that we pick up minimal or unconscious cues from the patient as to their needs at each stage of treatment. The use of the therapist trance facilitates this sort of communication and attunement. We translate these cues into a style of interaction, which could be distinguished along the dimensions of responsiveness and demandingness as proposed by Baumrind. These correspond to several of the styles found by Banyai and her group.

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