AN INTERVIEW WITH BERNHARD TRENKLE

BERNHARD TRENKLE

ABSTRACT

This article summarizes the key points of a conversation between Bernhard Trenkle and Mark P. Jensen, in which Trenkle 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. As a psychologist in private practice, Trenkle has used hypnosis with clients presenting with a wide variety of symptoms and problems, including speech problems, depression, and anxiety, as well as with artists and athletes who want to improve their performance. He has found that it is very important to collect information about the client's daily activities, values, and goals, in order to make sure that the hypnotic suggestions, stories, and metaphors that are offered fit well into the client's life and value systems. In order for hypnosis to be effective, Trenkle notes that the client must take responsibility for the outcome of treatment, and should also hold positive outcome expectancies. General strategies that he uses include: (1) teaching self-hypnosis, (2) the 4-3-2-1 technique for entering a hypnotic state, (3) seeding and priming, (4) stabilizing, (5) the movie screenplay technique, and (6) incorporating the client's own metaphors into hypnotic suggestions.

Key words: self-hypnosis, seeding, priming, metaphors, screenplay technique

INTRODUCTION

Bernhard Trenkle first became interested in clinical hypnosis after he heard a lecture on family therapy over 35 years ago by Helm Stierlin, a professor at the University of Heidelberg. Professor Stierlin described the therapeutic approach of Jay Haley and how Haley was influenced by Milton Erickson. Trenkle began to read Erickson's works and became fascinated with Erickson's use of storytelling, reframing, and utilization for helping clients make rapid and lasting changes. In January 1979 he had his first direct experience with hypnosis during a workshop facilitated by Jeffrey Zeig, and his interest in hypnosis deepened. Together with a close colleague, Gunther Schmidt, Trenkle began organizing seminars and workshops in Germany, inviting luminaries such as Jeffrey Zeig, Stephen Lankton, and Stephen Gilligan to facilitate.

Over time, Trenkle's interest and experience with hypnosis grew and he soon began teaching and facilitating workshops himself. He has written extensively on hypnotic approaches over the years (e.g. Trenkle, 1986, 1988, 1994, 1997, 2008; Mrochen et al., 1993;

Holtz et al., 2007) and is particularly well known for his effective use of humour to communicate complex concepts of hypnosis and psychotherapy (e.g. Trenkle, 2001, 2007).

Mark Jensen: *How do you view hypnosis?*

Bernhard Trenkle: *HYPNOSIS ALLOWS INDIVIDUALS TO ACHIEVE THEIR FULL POTENTIAL*

Stephen Lankton once told me that in Sanskrit there are roughly 20 words describing different states of consciousness; so there are cultures that are much more able to describe the intricacies of hypnosis than ours. Our vocabulary limitations for describing hypnosis and hypnotic states make it challenging for those from western cultures to define hypnosis. I think that it may be better to describe hypnosis in terms of what it does; and one thing that hypnosis clearly does is allow clients to utilize their full potential.

I remember reading about a woman involved in an automobile accident with her young son. Right after the accident, she carried her son out of the burning automobile. In the hospital, she was in the waiting room for over an hour waiting to hear about the status of her child. After some time, the physicians came and told her that her child was unconscious but otherwise fine. It was only then that she began to experience the severe pain associated with the significant burns that she sustained while saving her child. This example clearly describes the potential that everyone has to block pain. With hypnosis, the clinician can activate this and other potentials to achieve treatment goals.

Here is another example. I once worked with a client who was a highly ranked sharpshooter. He had seen hypnotically induced catalepsy and came to me hoping that I could teach him to use hypnosis to be both 'stiff and relaxed' at the same time as a way to enhance his shooting accuracy. Following treatment, he became the highest ranked sharpshooter in Germany. For me, hypnosis is a collective term for accessing such special abilities and potential, including many potential abilities that we may not even be aware of.

I remember reading a newspaper article many years ago from the United States. It described a man who had a terrible accident. He was alone in a mill and caught both hands in a machine, resulting in a double amputation. He picked up a pencil with his mouth and dialled 911. But it took the ambulance an hour to get to him. He should have bled to death during this time, but in fact he was somehow able to stop the bleeding from his amputated wrists on his own; it was only when the ambulance arrived that the bleeding from his injuries started.

A number of years ago I underwent surgery, and I took with me a cassette tape of a series of hypnotic suggestions to help control both the pain and bleeding during the surgery. I wanted to undergo the surgery without any anaesthesia whatsoever, and the doctor at first refused to allow this. But I held firm and the surgeon finally relented. Even then, though, as the procedure progressed, the surgeon kept asking me, 'Do you really have no pain? Should I give you an injection? How about now? Do you have any pain at all?'

I just ignored him and continued spending time in my special place. All of a sudden though, about halfway into the procedure, I noticed that the surgeon finally became quiet. He and two nurses assisting with the surgery just continued to work quietly until the procedure was over. This was much more pleasant than having to deal with the surgeon anxiously asking me if I was pain and if I was ready to have an analgesic. After the procedure was over and I was coming out of my trance, the surgeon commented, 'I was listening to your tape during the surgery, and the voice said, "On your blood vessels there is valve, and the valve is controlled by a big wheel. You are turning the wheel, and now any bleeding is stopping." And then I saw that all of your surgical wounds stopped bleeding. All at once, and at the same time. That's not possible.' The surgeon then asked me, 'What happened? Can you explain this to me?' I told him, 'I don't know what happened, exactly. Of course I know that there is no wheel that I can turn with my hand. But I do know that we all have an inherent mechanism for stopping bleeding and that with hypnosis and metaphors that mechanism can be activated.' This process of activating our potential is my operational definition of hypnosis.

ACCESSING THE UNCONSCIOUS TO UNDERSTAND WHAT THE CLIENT REALLY WANTS

Hypnosis is also a method for getting into contact with what people really want. Erickson said that the conscious mind is intelligent, but it is the unconscious mind that really knows what we want. Because problems often emerge as a result of us being unable to get what we really need, and not because of a lack of intelligence, it is usually more effective to work with a patient's unconscious. Hypnosis allows for a more direct interaction with the unconscious.

One of the first patients I had was a very unusual case. She was a 24-year-old athlete who became mute, and there was no biomedical explanation for her inability to speak. Three months after she became mute, she became paralysed. She had been seen in several clinics to solve this problem. At the time when I saw her she had been mute for 21 months and paraplegic for 18 months. She had been an inpatient in the psychiatric unit at the University

of Heidelberg hospital for four months without any improvement. She was referred to me at the University of Heidelberg speech unit, because the psychiatric ward had given up hope that they could help her. They hoped that we could do something.

I had read in her medical record that she had a strong tendency to do the opposite of whatever was suggested to her. So I decided to use a paradoxical approach in the first session. I told her that I did not think she should speak or walk, because she had already been on the psychiatric unit for four months and they usually discharge patients after three months. If she were to speak or walk at this point, she would be at risk of being discharged, and we would then not be able to learn why her unconscious mind wanted or needed her to be mute and paralysed. After this first session, the staff at the psychiatric unit contacted me and told me that she had begun speaking. In the next session I decided not to use a paradoxical approach, and began to work directly on her ability to focus on and move individual muscles in her legs, using strategies that Milton Erickson described using on himself to learn to walk as a child following his illness with polio. However, after this second session I was told that when she returned to the psychiatric unit she was no longer speaking.

So in the third session I elected not to focus so directly on her physical capabilities and went back to the focus of the first session: the goal was not to start speaking and walking, but to understand what her unconscious mind really wanted her to do. I told her that we would use time progression to learn about two possible outcomes in her life: a negative one and a positive one. We started with the negative one. I told her to just trust her unconscious and let one version of her life story unfold. I invited her to imagine her future, year after year, in which her life went in a very bad direction. I suggested that she simply allow the unconscious to create the images. She saw herself losing friends and becoming more and more alone. She became an alcoholic, and there was no one to take care of her any more. Her house was a mess. She finally committed suicide. But we did not stop there. I asked her to imagine the funeral. She was observing the funeral from far above, with mother and siblings in attendance. I asked her to notice the eyes of her mother and siblings, and tell me what she saw. She then pointed out that her father was dead, but that her mother was crying and grieving her death. We then came back to the present, and I asked her to imagine a future that was wonderful. In this positive imagination she attended the university and became a renowned writer. She saw herself living in a house in her mid-forties, and that she was happy. She was living without a husband in a house with two children. The house was on an estate with stables and horses. After this third session, the staff on the psychiatric unit called and

said that she was speaking again, and they reported that she was speaking in a very powerful and impressive way.

In this case, she was able to get into touch with and experience in her imagination what she really wanted. She understood that because her father had passed away, she had needed to stop going to school and to work at the age of 14 to support her family. Her little siblings could go to school with the money she earned. She was the oldest and most talented child and still was not using her talent. Her unconscious mind seemed to have required her to stop being the breadwinner for her whole family. From this session her life started to move forward. I saw her a few more times, and she developed a plan to get back to evening school, while also working full time to make money. She started to walk using canes and was discharged from the hospital.

So for me, hypnosis is also a means of communicating with the part in the person who is *really* making all the decisions. The conscious mind thinks that it is making decisions and is in control, but in fact it is the unconscious mind that is actually in control. With hypnosis, you can access and influence the unconscious, allowing some material to become conscious and enabling the client to have more influence on his or her life.

MJ: What kinds of problems do you use hypnosis for?

BT: I have a general psychotherapeutic practice, although I am perhaps best known for my work with people who have speech difficulties, including stuttering or rehabilitation patients who have tongue paralysis and swallowing problems, and patients with reflex paralysis after strokes or brain surgery. I also work with artists and athletes who want to improve their performance, and I have developed a specialty in the treatment of anxiety, and have an expertise in working with children and adolescents. But my primary work right now is teaching and organizing hypnosis and psychotherapy conferences; I only have about one day a week that I see clients, and these are usually very special patients that others refer to me.

MJ: What do you seek to understand about or observe in clients as you develop your hypnosis treatments and interventions?

BT: First, I usually ask a lot of 'unnecessary' and random questions about the client and his or her life. My goal is to learn something about the client's worldview and daily experience. There is often some aspect of the client's worldview or his or her value system that I learn from the answers to these questions that can contribute to therapeutic success. This information is often invaluable for tailoring hypnotic suggestions. Also, because of my family system theory background, I ask a fair number of questions about the client's family structure. Sometimes I say to the client, 'I may not always need all of this information about your family, but I have found that it can be very important to better understand you so as to avoid recommending a

homework assignment that is not possible for you to complete because of your home environment.' I'll give you an example showing how this can be useful.

I was once treating an adolescent stutterer. He was also having problems with exams at school. He was able to complete the exams at home just fine, but would become blocked when he tried to complete the exam at school. He would fail the exam even though he knew the material quite well. The client had a special understanding with his teacher that he would not have to answer any oral exam questions—that all of the questions and answers could be written. However, he then became blocked even when responding to written exams. But I learned from my initial conversations with him that he was also a very good basketball player, and he had a dream of following Dirk Nowitzki (an NBA basketball player from Germany) and someday playing for a National Basketball Association team in the United States.

I used this. I told him, 'If you want to play for the NBA, you will have to learn how to perform at a high level in the worst conditions you might imagine. Spectators may be throwing drink cans at you, screaming at you, and calling you names. No matter what is happening around you, you will have to be able to perform on a very high level. Just look at professional athletes. They don't get disturbed. They are very focused. So instead of avoiding situations where you might stutter and become distracted, you should seek them out. And then practise being able to remain very focused even under these conditions.'

This posed a dilemma for him. On one hand, he really wanted to become a professional athlete. But in order to be a successful athlete, he must learn to be able to remain relaxed and focused, even if others are screaming at him or otherwise trying to distract him. So here I am utilizing a valued goal—his dream to be a good basketball player—in the service of achieving a therapeutic goal. At the next session he told me that during free-shot practice he made over 90% of the shots. His coach was astonished, and one of his teammates told him, 'You are now ready to play for the NBA. Better pack your bags.' And so I utilized this, and said, 'Okay, the next time you have a maths exam, take the first two or three minutes, and simply remember how everything you did during the free-shot practice was effortless. Remember the astonished face of your basketball coach.' It was helpful in this case that by coincidence the basketball coach was also his math teacher.

To be able to utilize a client's life experience to help achieve therapeutic goals, it is often useful to know something about the client that may not necessarily be directly linked to the presenting problem—to know about the sports they play or the hobbies they enjoy. So I often ask my clients random questions about their lives: what films they have seen or what music they might be listening to. It is often possible to utilize this information as a part of treatment.

MJ: What are the key elements of effective hypnosis?

BT: *THE CLIENT MUST TAKE RESPONSIBILITY FOR THE OUTCOME OF THE TREATMENT*
First, I think that there must be a clear treatment goal that the client is ready to take responsibility for. If the client takes responsibility for his or her symptom, hypnosis can be helpful. But if the client asks me, 'I always seem to be abusing my wife and my children. Can you hypnotize me so that I don't do this any more?' I would not

use hypnosis is this case. If I did, the next time the client is violent, he would simply say, 'Hypnosis was not powerful enough to stop me from abusing my family.' In this case, the client is putting the responsibility for dealing with the problem with me.

Have you heard Nicholas Cummings talk about 'onion' versus 'garlic' patients? Cummings points out that when you are cooking with onions, you may have tears, and sometimes you will have a bad taste in your mouth some hours later. With onions, you are the one who is suffering. On the other hand, if you eat garlic, you do not have any problems—it is the people around you who suffer. So there are people who suffer because of their problems, and there are people who cause others to suffer because of their problems. Cummings notes that in therapy, you should always treat the garlic aspect of the problem before you treat the onion aspect. If the client is trying to prove that whatever you are doing will never be enough, the client is unlikely to improve. Garlic clients do not respond well to hypnosis.

Erickson told an interesting story when he was asked to define psychotherapy. He said that when he was a young man, a horse came to his family's farm with a saddle but no rider. He got on the horse, but his father said, 'What are you doing? You don't know the horse and you don't know its owner. You have no idea where the horse needs to go.' Nevertheless, Erickson rode the horse directly to the owner's farm. The farmer was very happy to have his horse back, and asked Erickson, 'How did you know that I was the owner of this horse?' Erickson said, 'I did not know that you were the owner—the horse did. The only thing that I did was sit in the saddle and keep a strong grip on the reins. I was very careful to not allow the horse to eat grass for too long. I just kept him moving. That was my responsibility. It was the horse's job to find its own way home.' It is the client who knows where he or she needs to go. If he or she does not take this responsibility, I will first work towards the client identifying a goal that he or she can take responsibility for. I work first on the garlic aspect. Only then will I use hypnosis.

I once had a client who had a 16 year history of psychotherapy with many different therapists, and told me that none of the previous therapists had been of any help. At the sixth session, she told me that she was planning on killing herself, and that if she was successful, it would be very bad for my reputation. At the same time, she was a very religious person. I used a strategy described by Frank Farrelly, a proponent of provocative psychotherapy. I told her, 'Even Jesus lost one of his 12 disciples after three years.' She immediately asked me, 'Well then, what is your therapeutic responsibility, in this case?' I told her, 'My responsibility is to explain to you that success with treatment is your responsibility, not mine.' She was intelligent enough and honest enough to accept this, and then took what I call primary responsibility for her treatment. She was ready to stop playing this game, and start to discover what she really wanted out of life.

Treatment with her would not have been successful if I took responsibility for its outcome, including her suicide. As long as she was going to play this game, whatever I did, it would not have worked. But after I told her that I was not going to play along—that if she killed herself, she killed herself, and this was her responsibility—she decided that perhaps I was strong enough to work with her on the issues at hand. We had a four hour session following this during which she dealt deeply

and effectively with some old material. But this would not have been successful if I had not first dealt with the responsibility issue. Her treatment with me would have ended up like that of the many other therapists she had seen over the past 16 years.

Thus, if the client is not taking responsibility for the problem, not defining a treatment goal, and trying to give responsibility to me, I do not believe that hypnosis—or any therapy for that matter—can be successful.

EXPECTANCY IS IMPORTANT

Based on Irving Kirsch's research, I also think that positive outcome expectancy is important. The client must have hope and believe that the treatment is going to be effective. I think that it is possible to facilitate this hope by telling success stories. So every anxiety patient I see hears a story of a previous client who was able to overcome his anxiety with treatment. The client thinks, 'Oh my, I thought that I had a problem, but it is not as bad as this man's problem. If he could overcome his anxiety, then I might be able to as well.'

I work to create as much hope and positive outcome expectancy as possible. I let the client know that I have a great deal of experience, and that the treatment approach has proven efficacy. I describe the findings about hypnosis from brain imagery research. I explain a lot and give many examples. With anxiety patients I also almost always teach self-hypnosis in the very first session, so that by the end of the session the client has something that he or she can do that will have an immediate and noticeable effect on anxiety levels. I always say, honestly, that treatment outcome is not binary. Neither a complete success nor a complete failure are very likely outcomes. Panic will not be replaced with happiness. I tell the client that after treatment he or she will still be vulnerable to experiencing parts of the presenting symptom at times, even for many years to come. At the same time, however, he or she definitely will have learned some specific and effective skills to manage the symptom. I nurture as much hope and expectancy as possible to convince the client that we can do something together that will be effective. Although the symptom will not necessarily be completely gone, it will end up in a much more tolerable range. I think that what I say before I do a hypnosis is sometimes more important than what I do in hypnosis.

MJ: 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?

BT: *TEACH SELF-HYPNOSIS*

I teach practically every patient self-hypnosis very soon after treatment starts. I started doing this, in part, because I travel so much, and there may be two, three, or even four weeks between treatment sessions. If clients know how to use self-hypnosis, this gives them something to do between the treatment sessions to continue making progress. Also, people who live in this part of Germany are very thrifty. I tell them that if they do a lot of hypnosis on their own at home, it can save them a considerable amount of money!

Another benefit is that once clients learn self-hypnosis, I no longer need to start treatment with a formal induction. I simply tell them, 'You know how to do self-

hypnosis. Go ahead and start.' While they are doing this for three to five minutes or so, I can make myself ready for telling a story or making suggestions.

I treat a fair number of patients with the diagnosis of 'psychogenic voice disorder'. This has mostly been school teachers, town mayors, university professors, and priests who have been described in some psychoanalytic literature as very responsible and 'one-up'/domineering people; they are also often very generous individuals who can have a hard time accepting help for themselves. It is sometimes difficult to hypnotize such people. I developed an approach to teach self-hypnosis to these individuals that begins with us sitting side by side. I first explain hypnosis to them and then I model self-hypnosis myself. I ask them to watch me closely as I explain and then perform each step of self-hypnosis, inserting hypnotic language at each step. Often, the clients will have difficulty keeping their eyes open until the end of the explanation. After explaining self-hypnosis I start to demonstrate it. I ask the patient to follow the steps of self-hypnosis using me as a role model. During this process I gradually turn towards the client and continue with the hetero-hypnotic session while facing the client. I think that it is very useful to model self-hypnosis in this way, and I do this with almost every client.

THE 4-3-2-1 TECHNIQUE FOR ENTERING THE HYPNOTIC STATE

I often teach clients my own version of the 4-3-2-1 technique for entering the hypnotic state. It is easy to learn and easy to remember. First, I tell them to tell me four things they see—any four things in my office or out of the window. For example, they might see the sky outside the window, the colours in the carpet, a book on the bookshelf, and a lamp. Any four things at all—it does not really matter what they are. Then, they should count four things that they hear; again, any four things at all. Next, four things that they feel. After experiencing four things each of what they can see, hear, and feel, they should then experience three things they can see, three things they can hear, and three things they can feel. Then two, two, two, and finally one, one, one. For those that might need a little more time to enter a hypnotic state, they can start with five.

Next, I ask them to recall some experience in the past where they felt relaxed, safe, and secure. It might have been on vacation, or a particularly comfortable place in their home. While there, they should then repeat the 4-3-2-1 experience. While being in this place, hear four things, see four things, and feel four things. Then three, two, and one. Say the client chose to be on an island that they had visited on a vacation. They might tell me, 'I see the blue water. I see a brown island some miles away across the water. I see surfers. I see sailing boats. I hear the strong wind. I hear children's voices. I hear some music in the background. I hear the water from a waterfall. I feel the wind on my skin. I feel the sun. I feel my left elbow against the sand,' and so on. I encourage them to experience the place as if they were really there. To facilitate this, I tell them to 'go' to a place they have actually been, rather than imagine a place they would like to visit someday. It should be a place—perhaps a place where they went on their most recent vacation—where they remember feeling very relaxed and good.

SEEDING

Often, but especially when working with people who are used to being in control (e.g. managers) or people who may have just come from work, I use seeding to facilitate the hypnotic state. Social psychologists call this priming, and novelists or people in the theatre call it foreshadowing. Here's one example of how this works.

I treated a politician who had a voice disorder. Sometimes his driver would wait just outside the window with the motor running, suggesting to his boss that it was time to go. Sometimes this client would arrive from the office confused and angry and in middle of a political power struggle. Any of these could potentially interfere with his being able to experience hypnosis.

So I began his sessions by asking questions that would seed the idea of entering a hypnotic trance: 'How many times did you practise self-hypnosis since our last session?' 'If I'm honest, only two times in the last two weeks.' 'And where did you practise?' 'One time in my office, one time at home.' 'And what was the difference between what we do here, what you did at home, and what you did at the office?' To answer these questions he has to orient to the trance state he experienced during therapy, to the trance state in his office, and to the trance state at home. I'm only partially interested in the actual answers to these questions. I am more interested in asking these questions to facilitate him getting closer to a hypnosis state. Twenty minutes later, when we start with hypnosis, it is easier for him to go in another state of mind.

STABILIZING

One strategy that I think is helpful to clients is in the category of what I call stabilizing techniques. The idea behind this simple technique is to give clients the feeling that I will always be there for them if needed. So, for example, as we are approaching the time to end treatment, some clients may start to express anxiety, and may wish to draw out treatment for more sessions than is really necessary. I will tell such patients that for former patients there will never be a waiting list for them if they ever need to see me again. Even if they come to me for a completely different problem than the one we have been working on, I will always make it possible to see the client again, and right away. Simply saying this, and of course following through if it is ever needed, seems to help stabilize the client. As it turns out, not many clients actually take advantage of this.

One former client saw me for a sexual problem (premature ejaculation) and this problem resolved after several sessions. Then I heard from him seven years later. He had heard that I was involved with a publishing business. He had written a book, and he wanted to have a session with me just to talk about how to negotiate with a publisher to have his book published. This 'problem' had nothing to do with his original problem. But because of my promise I scheduled him for a session, and met with him to provide him with advice about publishing his book.

Another stabilizing technique that I use sometimes, but not always, is to make a summary recording at the end of treatment. I prefer for my clients to be able to practise self-hypnosis on their own, without being distracted by or feel dependent on my voice. But I think that sometimes an audio recording that summarizes the most important stories and metaphors I offered during treatment, or a review of

some of the most important themes and what was achieved during therapy, can be helpful.

For a client with chronic pain, I might summarize the pain control techniques that we practised together. For cancer patients who want to stabilize their body's defence system, it can sometimes be helpful to have the suggestions on tape—especially for when they may feel too tired and exhausted to do it themselves.

THE MOVIE SCREENPLAY

I like to give clients something they can do to address their problem between sessions. One technique that I use fairly often is the screenplay technique. I tell the client, 'Imagine that somebody plans to make a film about your life—a very interesting and dramatic film. In this film, all of the problems you have been facing will be addressed. And imagine that even though there may be struggles and setbacks, the film will ultimately have a happy ending. I would like you to write out the scenario/screenplay for this happy-ending part of the film. Describe the critical scenes, including the rooms, the clothes and costumes of the actors, and the music. Provide enough detail so that the filmmaker could really make a film. And include many symbols—do not make it boring. Perhaps there is a shot of a book that is open. What is the book and what does it represent? Is it a book by Dostoevsky, which might foreshadow the happy ending that will occur? Maybe there will be a shot of you buying a newspaper, and the camera zooms in on the headline. What does the headline say, and what does this represent about your life? The symbols should be interesting enough so that the moviegoers will not only be intrigued and absorbed during the movie, but will have something interesting to discuss when the movie is over. Maybe the movie ends with a Beatles song. Which one, and why was that song chosen?'

I usually give them four weeks to accomplish this task. Often, the clients will start the project too late, and it is not ready when the time comes to discuss their movie with them. So I give them another four weeks. The client might say that they do not understand how to write symbols into the movie. So I give them an example. I might say, 'A couple is coming to see me for family therapy. They have three children who are 4, 6, and 8 years old, and she has had an affair with another man. Her husband did not respond well to hearing about the affair, and is starting to respond by physically abusing the wife. He moved out of the apartment, but missed the children so moved back to a flat that was nearby to be closer to the children. In the meantime, the wife stopped seeing her boyfriend. This situation had been going on for two years, so neither the husband nor the wife were wearing their rings any more. But they could not decide what to do. Should we get a divorce, or stay married? Should we live together or live apart? They kept going round and round in circles, and were not able to decide what to do. They came to me, asking, "Please help us to make a decision. We are always turning in circles, and we cannot make a decision." '

So I told them, 'Create a film script for a film about this story. You first meet, and there is a big romance, followed by marriage and then the three children. Then there is the affair, followed by a big fight, and the husband moves away, and then moves again to be closer. Up to this point it is a great film; it is already a good story. But imagine that the director making the film wants the people in the audience to really feel this painful stagnation. He decides to loop a portion of the film, so that it shows

the same events over and over again. Maybe three, four, or even five times—just showing the same thing. So much so that the audience begins to think that there must be something wrong with the projector. The audience finally starts to get fed up, and some begin to leave. Then, all of the sudden, something new starts to happen. The audience feels a great relief: "Finally, something new is happening." The new thing may not even be a solution to the problem, but at least it is something new. Now, I want a script from both of you to tell me what this new thing is. Don't tell each other what you are writing. Bring it with you to the next session. But there must be something symbolic in the script. Something that will get everyone talking after the movie is over.

'Both of them were very surprised to find that they wrote the same scene, and even chose the same symbol. In both of their scripts, there were no children in the flat. They were with the grandparents, and the couple were both packing for a one week vacation together. They were going on a trip to travel together, just like they did before they had any children. And both of them had secretly packed their wedding ring in the luggage, without telling the other person, just in case they decided that they would need it while on vacation.

'In the third and final session both of them were wearing their wedding rings. They had decided to live together again, and in fact had already moved back in together. They told me that they had not necessarily decided not to get divorced, but they were going to see if they could manage to live together.' This is what I might tell a patient to describe what I mean by a story that has a symbol in it.

USING THE CLIENT'S METAPHORS IN HYPNOTIC SUGGESTIONS

Another little thing that I have found useful is to keep track of the metaphors that people use when describing their problems. If they have used special words to describe their symptom or a treatment goal, I will later use these in my hypnotic inductions. I have found that if people are in a deep trance, at the moment I begin to use their own words, sometimes I observe rapid eye movements. It seems to intensify their absorption. They are aware that at this point I am saying something that has particular relevance to them.

This is also a very good technique if you are working with groups. Let's say that I am telling the same story to a group of clients. I can, however, focus my attention on one client at a time while telling this story, and when looking directly at any one particular client, at that moment use the words that he or she used to describe his or her problems or to describe his or her goal. The client will be very aware that this part of the story, and the suggestions embedded in it, is directed right at him or her. And then you can move on to the next client. This makes it possible to have very intense contact with one person in a group, and at the same time be able to work with the whole group.

ERICKSON'S EARLY LEARNING METAPHORS

A final technique that I find very useful is one I borrowed from Erickson. This involves the use of 'early learning' metaphors. He would tell a client, 'Was it not interesting

learning the letters of the alphabet as a child? Does the letter "M" have two feet or three feet? Does the little "d" have its belly on the right side or on the left side? Of course, you sometimes made mistakes. Maybe your parents interrupted you, and your teacher became impatient. Some children cry. Other children might already know all the letters, while others know none of them. Yet the unconscious mind is forming pictures of all of the letters. With time … two weeks … four weeks … all of a sudden, you are reading and writing, automatically. You never again have to think about the "M" having two feet or three feet or about the side that the "d" has its belly on.' I will tell a client this or a similar story when they say they are having a difficult time learning something new or when they tell me that they feel 'dumb'.

This technique worked very well with a depressed client I saw a number of years ago. He was an accountant—a tax expert—who was depressed and having a very difficult time sleeping at night. He would be up all night and then stay in bed all day. And when he was in bed, he would mostly think suicidal thoughts. His brother-in-law would invite him to help him construct houses and friends would invite him to help them repair cars. But he refused them all.

His mother had committed suicide and his father was dying. I had worked with his sister previously, and was able to help her, so she referred her brother to me. But he was avoiding taking responsibility for treatment. He wanted me just to fix him using hypnosis. I was very hesitant to treat him. He asked me, 'You were able to help my sister, why aren't you going to help me?'

So I told him, 'Modern hypnosis is different from what you think it is. You will be very surprised by what I will tell you in hypnosis.' And then I told him learning metaphors—stories about learning how to read and write and how to ride a bike. That was all. He came back two weeks later and told me that since he was having a hard time sleeping at night he had decided to learn something new—that until he got his feet back on the ground, he would work as a night truck driver. In nine months no one had been able to activate him. Just hearing a couple of stories about learning to read and write, and he was already back to work. Simply reminding people that they have been, and therefore can be, successful is a very powerful intervention.

MJ: Anything else?

BT: Hope and positive expectation is of central importance in doing hypnosis, psychotherapy, or practising as a medical practitioner. The research of Irving Kirsch (e.g. Kirsch & Lynn, 1997; Kirsch, 2000) is important as well as the research of the social psychologist John Bargh and his colleagues (Bargh, 2006a, 2006b; Harris et al., 2009; Williams et al., 2009). Bargh's research demonstrates how little stories that appear undramatic but contain low-key suggestions that are embedded in the early learning set induction can induce significant differences and changes in clients. Hypnosis is often a state of relaxation combined with concentration. Although including hypnosis can amplify the effect, a level of deep trance does not seem to be very important because such effects can also occur without a deep hypnotic trance, or even without trance at all.

REFERENCES

Bargh JA (2006a). *Sociology Psychology and the Unconscious: The Automaticity of Higher Mental Processes*. Frontiers of Social Psychology Series. London: Psychology Press.

Bargh JA (2006b). What have we been priming all these years? On the development, mechanisms, and ecology of nonconscious social behavior. *European Journal of Social Psychology* 36: 147–168.

Harris JL, Bargh JA, Brownell KD (2009). Priming effects of television food advertising on eating behavior. *Health Psychology* 28: 404–413.

Holtz KL, Mrochen S, Nemetschek P, Trenkle B (2007). *Neugierig aufs Großwerden: Praxis der Hypnotherapie mit Kindern und Jugendlichen* (Becoming Curious: Hypnotherapy with Children and Adolescents). Heidelberg: Carl-Auer.

Kirsch I (2000). The response set theory of hypnosis. *American Journal of Clinical Hypnosis* 42: 274–292.

Kirsch I, Lynn SJ (1997). Hypnotic involuntariness and the automaticity of everyday life. *American Journal of Clinical Hypnosis* 40: 329–348.

Mrochen S, Holtz KL, Trenkle B (1993). *Die Pupille des Bettnässers: Hypnotherapeutische Arbeit mit Kindern und Jugendlichen* (The Pupil of a Bedwetter: Hypnotherapeutic Work with Children and Adolescents). Heidelberg: Carl-Auer.

Trenkle B (1986). Ansätze zur Fokussierung therapeutischer Interventionen und Stärkung der Therapiemotivation (Approaches in focusing therapeutic interventions and strengthening client motivation for therapy). *Hypnose und Kognition* 3: 29–35.

Trenkle B (1988). Charles Van Riper meets Milton H. Erickson: Approaches in the treatment of the adult stutterer. In Lankton SR, Zeig JK (eds) *Treatment of Special Populations with Ericksonian Approaches*. Philadelphia, PA: Brunner/Mazel, pp. 54–68.

Trenkle B (1994). The Ericksonian utilization approach for the rehabilitation of paralyzed patients. In Zeig JK (ed) *Ericksonian Methods: The Essence of the Story*. Philadelphia, PA: Brunner/Mazel, pp. 445–461.

Trenkle B (1997). *Die Löwen-Geschichte: Hypnotisch-metaphorische Kommunikation und Selbsthypnosetraining*. Heidelberg: Carl-Auer.

Trenkle B. (2001). *The Ha-Ha Handbook: A Serious Funny Collection of Jokes from Here, There, and Everywhere*. Phoenix, AZ: Zeig, Tucker, & Theisen.

Trenkle B (2007). *Das zweite Ha-Handbuch der Witze zu Hypnose und Psychotherapie*. Heidelberg: Carl-Auer.

Trenkle B (2008). *Das Aha!-Handbuch der Aphorismen und Sprüche für Therapie, Beratung und Hängematte*. Heidelberg: Carl-Auer.

Williams LE, Huang JY, Bargh JA (2009). The scaffolded mind: Higher mental processes are grounded in early experience of the physical world. *European Journal of Social Psychology* 39: 1257–1267.

Correspondence to Bernhard Trenkle, Trenkle Organisation GmbH, Bahnhofstraße 44, D-78628 Rottweil, Germany
Email: Bernhard Trenkle (mail@bernhard-trenkle.de)
Phone: +49 0741 2068899-0
Fax: +49 0741 2068899-9