AN INTERVIEW WITH ELGAN BAKER

ELGAN L. BAKER

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ABSTRACT

This article summarizes the key points of a conversation between Elgan L. Baker and Mark P. Jensen, during which Dr Baker discussed his views of hypnosis and what he has learned to be most important and effective as a clinician using hypnosis in his practice. Dr Baker has a general adult psychotherapeutic practice, and he is best known for this clinical work with patients who have some kind of character pathology. His ideas about hypnosis have changed dramatically over the years; he now views hypnosis primarily as something that happens between a patient and therapist. Although he sees a patient's hypnotic experience as resulting from an altered state of consciousness, he also understands that the factors that contribute to and make up that state vary from person to person—each trance state is unique to each individual. He uses hypnotic strategies in the context of longer-term analytically oriented work. In order for a clinician to use hypnosis effectively, he believes that it is critical for the therapist to understand the patient both cognitively and affectively. It is also necessary for the clinician to develop a formulation of the presenting problem using some theoretical orientation. Finally, it is necessary for the clinician to have a capacity for attunement and empathic connectedness. It also helps if the therapist has self-confidence and the capacity to be creative with hypnosis. Specific techniques that Dr Baker has found to be particularly helpful in his work include: (1) use of hypnosis to uncover an abreaction; (2) use of hypnosis to nurture self-mastery; and (3) use of hypnosis to facilitate internal structure building and development. The article concludes with some comments regarding the importance of empathic attunement to the process of therapy, and notes that hypnosis can be particularly effective in facilitating this critical component.

Key words: hypnosis techniques, hypnotherapy, borderline disorders, narcissistic disorders

INTRODUCTION

Elgan Baker has been studying and using hypnosis for more than 30 years. What first impressed him about hypnosis was the idea that it allows the patient and clinician to have greater access to the patient's unconsciousness. Under Gail Gardener's supervision as an intern at the University of Colorado Medical School in Denver, he used hypnosis to help children better manage chronic and acute pain, and was fascinated to see how hypnosis helped children gain control over what are usually involuntary physiological processes. These 'bridging' effects of hypnosis—both between the conscious and the unconscious mind and between the conscious mind and involuntary physiology—have been a continued source of fascination for him.

During his post-doctoral training, Dr Baker began working with more severely disturbed patients in an inpatient setting. Many of these patients had psychotic symptoms as well as a variety of somatic complaints, and he wondered whether hypnosis might be helpful when working with them. He now says he was too naive to know that, at that time, psychoanalytically oriented clinicians were not very supportive of incorporating hypnosis into their work, and clinicians who used hypnosis were not very positive about doing hypnotic work with severely disturbed or psychotic patients. Perhaps due in large part to this naivety, he forged ahead and began to use hypnosis with severely disturbed patients within a psychoanalytic theoretical frame, and he found that his patients benefited from this work. He submitted his positive findings for publication (e.g. Baker, 1981, 1983a, 1983b, 1983c, 2000; Baker et al., 1990) and for presentation at hypnosis meetings. He also met Erika Fromm around this time. She was an important contributor to the field of hypnosis; in particular in the use of self-hypnosis as a means of promoting psychological healing. She was very supportive of his work and encouraged him to develop his ideas concerning shifts in how to conceptualize hypnosis and new techniques for using hypnosis with patients who are markedly disturbed—a patient population for whom hypnotic approaches had not yet been adequately developed. He identifies Fromm's support and mentoring, in particular, for the development of his initial ideas into a major focus of his career.

Mark Jensen: *How do you view hypnosis?*

Elgan Baker: After all these years, I am still not completely sure what hypnosis is. I continue to be amazed by hypnosis. I certainly have a way of conceptualizing it, but my view of it has changed considerably over the years. Even now, I am not satisfied that I could tell someone exactly what hypnosis is. When I first started, I viewed hypnosis as something that happened in the patient because of what the hypnotherapist did. But I now think that hypnosis is something that happens between the patient and the therapist.

When I first started learning about hypnosis, everybody seemed to be looking for the critical variable that defines it—was it essentially relaxation, dissociation, enhanced suggestibility, or trance logic? The proponents of each of these essential ideas came and went. However, as I gained experience with hypnosis, I found that each of these factors seemed to play a role sometimes and in some patients' hypnotic experience. Over time, I have come to think of hypnosis as the development of an altered state of consciousness, or trance state, that results from the interaction of a number of different variables.

The exact configuration of the variables that work together to create a hypnotic state varies from person to person as a function of each individual's level of maturity, personality style, and motivation, as well as the quality of the therapeutic relationship at that moment. All of these factors play a role. Some are relatively fluid, while others are more static.

When the variables that influence hypnosis are focused or evoked, and when the patient is able to experience those focused or evoked variables, then the patient moves easily and naturally into that altered state of consciousness. People with 'high hypnotic ability' are those who are capable of engaging in and experiencing, with a fair amount of ease, a wide array of hypnotic phenomena. Those who have lesser hypnotic ability are able to experience only a few hypnotic phenomena without feeling anxious, uncomfortable, or threatened in some way. The real skill of a clinician using hypnosis, as with any good clinician, is to be able to understand who the patient is well enough to tailor a pathway to that altered consciousness—a pathway that is a good fit for the individual patient.

I think about the notion of deepening in hypnosis as more like broadening. It is like dropping a pebble in a pond and seeing concentric circles move out, encompassing a broader and broader area. As people become more engaged or absorbed in hypnosis, as they go 'deeper'—or, as I see it, broader—they are able to experience a wider array of hypnotic phenomena without undue anxiety, regression, or decompensation. But the specific phenomena encountered in the first circle, the second circle, and the third circle are different for each person.

At the same time, there are some similarities among people who have similar character styles or character structures. Ideational characters, whether they are more obsessive, or paranoid, or schizoid, have certain similarities in what falls in the first, second, or third circle. What I call somato-affective characters, such as hysterics, dependants, and passive aggressives, share certain similarities as well. The anxieties produced by trying to do something in the second circle, before things that are in the first circle, are a function of how mature, flexible, resilient, stable, and organized the patient's internal character structure is. If you know your patient's personality style and level of characterological maturity, then you have a lot of information about how to tailor the induction and the deepening or broadening to be able to do the work at hand.

This is all a long way of saying that at one level I think of hypnosis primarily as resulting from the interaction of different factors. Hypnosis happens when the right variables are put together in the right configuration, allowing the person to alter his or her consciousness and regress to levels of experience that may be useful for clinical work and that are not typically available to him or her in normal waking consciousness.

Hypnosis is most powerful when used to help patients alter their consciousness on the basis of the clinician's understanding and awareness of each patient's inner world. When this happens, there is a process of mutual attuning. What is particularly special

about hypnosis is that it facilitates a greater and more rapid form of interpersonal attunement and empathy. We now know, based on research into the process and outcome of psychotherapy, that regardless of technique, the client–therapist relationship is of paramount importance to positive outcomes. And what is most special about the relationship is a sense of alliance, of being with another person who understands you and joins your experience and with whom you feel a special sense of connection.

Hypnosis facilitates this connection more than any kind of psychotherapy that I know of. It allows attunement to develop more powerfully and rapidly. To use some of the language of psychoanalysis, hypnosis creates a transitional space, one that allows patients to move across boundaries—between self and other, mind and body, verbal and pre-verbal, and conscious and unconscious—more easily.

All of this can occur because of the ability to join another person's experience without a loss of your own sense of self. This process, sometimes called *projective identification*, is the central mechanism in empathy. With hypnosis, I can feel with you what you are feeling without losing a sense that I am still me, and you can let me feel what you are feeling without believing that you cease to be you.

A fluidity and permeability develops in the boundaries between me and you, between self and other, and then expands to the boundaries between inner and outer, thought and feeling, and mind and body. Clinicians who use hypnosis engage this very powerful form of empathic attunement that allows us to move into this transitional space, which is itself a kind of altered consciousness in which one joins the experience of the other in a way that has many opportunities for shaping a therapeutic or even curative experience.

Hypnosis for me is more than a product of the interaction, within the patient, of these phenomenological variables that come together to create altered consciousness. It is also a product of the interaction between two people. It creates a space to contain the altered consciousness and makes the collaboration more creative, more empathically attuned, and more therapeutically powerful.

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

EB: I have a general adult psychotherapy practice. About two-thirds of my patients come wanting deeper, longer term and analytically oriented work. Because people in my community know that I work with hypnosis, there is also a portion of patients who come specifically wanting hypnotic work for a more targeted kind of application. These patients might come wanting help with smoking cessation, weight management, nail biting, public speaking anxiety, specific phobias, hair pulling—a wide range

of specific symptoms. With these patients I may use hypnosis for symptom control, but it is still always informed by psychodynamic principles and case formulation. I have also incorporated hypnosis from time to time into my more intensive ongoing psychoanalytic work, with patients who are depressed or anxious. But most typically I work with patients who also have some kind of character pathology. Because of my interest and reputation in working with individuals who are pre-neurotic, I see a lot of narcissistic and borderline spectrum patients. Since I am no longer doing inpatient work, I rarely see someone who is actively psychotic.

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

EB: Good psychotherapy comes from good case formulation. Diagnosis informs treatment. But I do not mean diagnosis in a DSM labelling kind of way. I mean diagnosis in the way Greeks talk about it: a thorough understanding. That understanding includes knowing the patient's character style and level of development, which makes it possible to craft a therapeutic approach based on inferences derived from developmental history and phenomenology, and to develop an idea of the most likely combination of experiences that will facilitate a patient being able to alter his or her consciousness and move to a therapeutic, transitional place.

Many of the techniques I use have to do with trying to maximize the patient's awareness of his or her ability to move across levels or arenas of phenomenology, and to move across the space between the two of us, to build various kinds of bridges that can get internalized in the service of changing structure or modifying affect. For example, moving from enacting (acting out) to speaking and communicating, or moving from intolerance of some memory, experience, or knowledge to an acceptance of that memory, experience, or knowledge. Even if I am treating a patient who wants to stop smoking, which is usually a pretty brief kind of treatment—I treat most of my smoking cases in 8–12 sessions—I still want to understand what internal functions smoking serves for this person, and how I can help him or her learn another way to deal with the tension or negative affect, or whatever else it may happen to be, that is driving the smoking behaviour. I seek to help the patient develop a changed sense of self, and one that is changed in relation to the world and to others.

In my way of thinking—and this really comes from the behavioural literature more than the analytic literature—you do not necessarily try to help someone stop smoking; you help him or her become a non-smoker. With treatment, there is not just a change in behaviour, but a change in the sense of self and how the patient is going to be in the world. Of course, with treatment, I give my patients post-hypnotic cues and a 'mantra' of suggestions to use when they feel they want to smoke, as well as suggestions for managing the side effects of withdrawal. But I do this within the context of changing the way in which they relate to themselves, to their inner experience, to their affect, and to the world. Hypnosis helps the patients and me go to a place where I can access and engage their experiences of self and the meaning of their symptoms or presenting problems much more directly and quickly than is possible with just talking psychotherapy, behaviour therapy, or any of the other techniques one might use with smoking cessation.

How I go about trying to understand the patient and the presenting problem is informed by everything I have learned about people from my reading and study, from my mentors, and during my years of clinical practice. How one develops an understanding of the patient is very much related to how one understands the nature of this metaphor that we call personality and also how one understands the development of character. There are hundreds of different ways that people have in which to think and engage information, to feel and express emotions, and to soothe feelings.

So, for example, I might start by asking a patient to tell me a little about why he or she has come to me for help. When a patient tells me that he or she is depressed, I ask him or her to tell me about the depression. The patient might say, 'When I feel depressed, I feel hopeless. I feel like there is nothing I can do to make things better. I feel immobilized and powerless, and I have no vitality and no energy.' At this point, I know a lot more about this particular patient's depression. I understand it as a particular kind of depression—specifically, in this case, one much like Seligman's helplessness/hopelessness. Next I would think, 'What do I know about that kind of depression?'

Based on my understanding of what I have read about and seen in patients with depression, I have classified depression into four main types: introjective depression, helpless/hopeless depression, analytic depression, and neolistic depression. Each of these tends to be correlated with certain determinates on the Rorschach and certain patterns on the Minnesota Multiphasic Personality Inventory, and each has certain kinds of etiological factors that are more common in people at different levels of characterological maturity. So when I hear a patient describe a helpless/hopeless depression, I think: 'If I gave this guy a Rorschach I know that I will get lots of C-prime. I know that he probably is organized in a narcissistic spectrum, and there probably has been some kind of narcissistic injury that has caused this devitalized self, which is the origin of the vulnerability against which he is defending by having the false self become more phenomenologically focused.' I then know that I would have to start working with this patient to help him or her learn to tolerate vulnerability, to be authentic and real, and develop a greater sense of efficacy and empowerment in the world. That sense of efficacy is not yet available to this patient because he or she was unable to manage contingencies reliably while growing up in his or her original family system, and as a result developed an empty and devitalized identity.

So there is a whole series of things that comes out of what I hear from the patient and how this relates to my understanding of personality, development, psychopathology, and psychological assessment. I develop from this a set of inferences that I then immediately begin to test. I might do this by asking specific questions or listening with an ear attuned to that phenomenology. If I am still confused I might do psychological testing, and my ability to interpret that test involves knowledge of other rules.

I think I have a complex approach to case formulation and developing hypnotic strategies based on this formulation, even for a 'simple' problem like nail biting. I view people as very complicated, and I view problems as having various meanings. My job is to try to understand the person and the meanings of the problem. I need to understand these in order to work effectively with the problem. I seek to understand

how the person can move to the place that allows him or her to work with it based on my understanding of who he or she is.

This understanding requires, I think, a deep understanding of personality theory, human development, psychopathology, psychological testing, and hypnotic technique. This understanding is based on reading and study in graduate school, and then on experience as a clinician. With this background and experience, it becomes possible to make inferences and synthesize the information into a case formulation that will inform the way to work with a particular patient.

Like probably most people in this field, I do not view hypnosis as its own brand or form of therapy. It is a technique that clinicians use within the context of the therapy that they have learned to do. It has taken me a lifetime to learn to do psychoanalytic work, and I use hypnosis from a psychoanalytic framework. Someone might observe me using hypnosis with a patient and view my approach as behavioural at one moment and 'Ericksonian' the next. But if he or she could hear what I was thinking as I was using hypnosis with a patient, I expect that he or she would probably have a very different concept of how I was viewing the patient, and my reasons for selecting one approach or another.

All of this comes back to what I began with: good psychotherapy comes from good case conceptualization. It is essential to have a clear understanding of the patient and the role that the presenting problem plays in the patient's life before proceeding with treatment. Because of my orientation and training, this involves understanding the patient's personality, development, and characterological maturity, and then linking this with what I have learned in order to develop a plan for helping the patient better deal with his or her feelings and urges.

MJ: What are the key elements of effective hypnosis?

EB: For a clinician to use hypnosis effectively, that clinician must have an ability to understand the patient both cognitively and affectively. The clinician must also develop a formulation of the presenting problem using some theoretical orientation. This formulation helps the clinician understand the patient cognitively. The clinician also needs to have a capacity for attunement and empathic connectedness that allows him or her to engage the patient at the necessary level of understanding.

I think hypnosis requires more of both (case formation and ability to connect with the patient) to be fully effective because it amplifies and intensifies the phenomenology of being with another person in a therapeutic way. That is why hypnosis works. If you can understand your patient really well, you can do hypnosis really well. On the other hand, if you cannot understand your patient, or you do not take the time to understand the patient, you cannot do hypnosis very well.

For me, a highly structured treatment that says you always begin with a relaxation induction, then do an arm heaviness deepening, then have the patient go to a safe place, then suggest two post-hypnotic cues to help the patient manage a symptom, and then finally waken the patient, would never be ideal. This approach would not be as effective as a more tailored approach for several reasons. First, I can imagine many patients for whom a relaxation induction would be tantamount to throwing them in a pool of piranhas. Some people are afraid to tune in to the

experiences of their bodies because they have been physically abused or raped, or they have had medical treatments that have disfigured their bodies. When you ask some patients with these experiences to 'notice the feelings in your chest' or 'focus on the feelings in your feet', what they become aware of is anxiety about what is going to come next. They are not necessarily going to be drifting to a safe and comfortable and self-soothing place. And when you suggest arm heaviness to patients with paranoid thinking who believe that there are external forces influencing them to do things they do not want to do, it will not take them to a place where they feel empathically understood and safe in your presence. Rather, such suggestions might elicit a state of heightened vigilance, defensive constriction, and interpersonal withdrawal and avoidance. In fact, this is in the opposite direction from hypnosis. The art of doing good psychotherapy and effective hypnosis is figuring out how to engage the patient where he or she is so that he or she can move to an intrapsychic and interpersonal space where change can be facilitated.

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

EB: *CONFIDENCE AND CREATIVITY*

It helps to have the self-confidence to be creative with hypnosis. Early on, when I had less experience, I was more inclined, if I started with induction 'A', to keep doing it, even when it appeared that the patient was not responding to it. 'A' is what I knew how to do, so I was not sure what else to do even if the person started squirming on the couch. With experience comes the confidence to turn the patient's squirming into an induction, to stop and enquire about what is going on, or to let the person know that you are with him or her in the experience of squirming, or to take whatever particular route you decide to take at that moment to turn that experience into something that facilitates moving to the therapeutic space, as opposed to something that blocks moving to that place.

Both confidence and creativity come from experience and modelling. One of the most important learning experiences for my students is observing me working with a patient and doing something different from what I normally might do or even told them I had planned to do. When discussing these situations, students not only learn about flexibility, but get 'permission' to do the same with the patients they work with. When I teach hypnosis now, I always try to have at least two or three live hypnotic sessions with a patient that students can watch through a mirror. When a patient responds in an unusual way, causing me to come up with a unique approach to better match that particular patient in that particular situation, it seems especially powerful.

This past summer I was teaching a course in hypnosis for graduate students at the University of Indianapolis and I had them come to my office and see me work with a relatively new patient who had conversional (pseudo) seizures. I had already had one hypnotic session with this patient in which I encouraged her to feel safe and connected to her body. My idea was that in conversion disorders, there is a kind of disconnection from the body, what I call *somatic dissociation*, which allows the body to then be used to convert conflicts or affects into physical symptoms. So we

had worked on that, and she responded quite well. But in the next treatment session, observed by the students, as soon as I induced the patient into hypnosis, she began to seize. I was unable to get her to stop until I woke her up from hypnosis. I then proceeded in that and subsequent sessions to try other approaches. I think the students learned much more from my continuing discussions of the complexities and difficulties of this case—including the different approaches I tried and the thinking that went into them, as well as the patient's responses—than they would have learned had the patient continued to respond well to the first approach that I used. The single most important aspect of this experience was that the students learned that things do not always go the way you think they will, and that this is okay. You can use the patient's response to come up with something new, and still help the patient.

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?

EB: *USING HYPNOSIS TO UNCOVER AN ABREACTION*

The idea of using hypnosis to facilitate the uncovering of an abreaction is based on older models about the origin of psychopathology and how to fix it, but it can still be a very effective strategy. With this approach, you are using the regressive aspects of hypnosis to gain access to unconscious material, to dilate or reduce defences, and to then bring the affect more clearly into focus and develop pathways for its discharge. These days, I probably use this model and approach mostly in the treatment of trauma. For example, I use hypnosis to help patients with post-traumatic stress disorder revisit the trauma in a safe environment, and then construct a narrative around the trauma to help deal with the affect associated with it. My goal with this approach is not necessarily to 'discharge' excessive affective energy associated with the trauma, but more to change the patient's relationship to the experience from helplessness into efficacy.

USING HYPNOSIS TO BUILD SELF-MASTERY

With many of my patients, I tend to use what I think of as a *mastery paradigm* that comes from ego psychology. The idea here is that there are a variety of functions or ways to manage traumatic events, and that a person may not have used the most adaptive way of exercising those functions when the trauma first occurred. The goal, then, is to teach the patient more adaptive ways of exercising those functions so he or she can experience a greater sense of mastery. From an ego-psychological point of view, these are ego functions. You help the patient learn better how to self-soothe and manage affect, to deal with relationships and establish intimacy, and to control impulses and not act out. Here you can use a combination of exercises that allow the patient to practise and demonstrate efficacy, and then imagery that lets the patient generalize and rehearse those exercises in order to increase mastery in the world.

For example, I might start with encouraging the patient to experience changing his or her hand from being very tight and in a fist to being very relaxed. This is something he or she can learn to do during focused attention and suggestion in trance. The patient can then generalize this to imagining changing his or her emotions from

anger to contentment. From there, the patient can imagine being in a variety of situations in which it is possible to alter his or her own affect states in the same way he or she can alter the tension in his or her hand.

USING HYPNOSIS TO FACILITATE INTERNAL STRUCTURE BUILDING AND DEVELOPMENT

Clinicians can also use hypnosis for internal structure building. This use of hypnosis is perhaps what I am most known for. This approach is based on a simple idea: that arrests in character structure, which are the result of unfinished character development, can be corrected by re-engaging the developmental work within the interactive crucible of trance. One can go back and finish what did not get finished. This helps patients develop a more integrated internal organizational world, and creates more adaptive capacities to function due to that greater degree of structural maturity.

Here I use sensorimotor experience and the capacity to move that experience to internal representation through imagery, and then use the patient's ability to elaborate that imagery symbolically with words. Finally I integrate these with directed fantasies of rehearsal and imagery as a way of practising work around various sorts of evocative unfinished developmental issues. For example, say you are working with a patient who has not developed self and object constancy; that is, the ability to recognize that different experiences of self are not different selves, but different aspect of the same self. One of the techniques I might use in this situation that I think recapitulates the normal course of development is to begin by creating a sensorimotor experience in trance, focusing the person's attention on it. I then help him or her to internally represent what he or she has just done, elaborating that representation with symbols that provide meaning and practising, through imagery, the application of that particular experience to everyday life. I might suggest that the patient go back to a focus on the feelings in his or her hand when it is a tight fist and the feelings when it is relaxed, moving on to recognize that the fist and the relaxed hand are the same hand, and that the experiences of tightness and relaxation are both the experiences of self; that in the patient's ability to change this experience of self, he or she can exercise control over shifts in physical feelings, and ultimately in emotions as well.

Think, for instance, about patients who do not have object and self constancy—borderline patients in whom certain affect states are intolerable and remain 'split off' from the rest of the person or his or her experience. These patients do not have a cohesive, integrated sense of self. When the self that feels angry or the self that feels vulnerable are intolerable, and when affect shifts in these directions, these patients will act out. They might dissociate or somatosize, because they cannot bear to own these aspects of their self-experience. A lot of energy then goes into defending against these experiences because they do not have identity cohesion. These patients are not at first able to integrate the fist and the relaxed hand, the anger and the vulnerability.

I work with patients to accumulate experiences of being able to integrate different states into the self. I seek to help these patients bring different experiences of the self into waking therapy, and encourage the patients to talk about the relevance

of these different experiences. For example, of being aware of physical experiences in their bodies or being aware of how the physical experiences of their bodies are represented in their heads; or imagining the meanings of these experiences for their lives. We then talk about how this relates to their problems, the origins of those problems in their histories, and their ability to be different in the present in various temporal, figural, relational, and affective contexts.

This approach is similar to what in analysis clinicians might call 'working through'. It involves applying what is learned in therapy to the problems of living. This can be done so powerfully in trance because in trance people are much more able to shift their focus of attention. They can easily move between the experience of the body and its representation in the mind. With hypnosis, it is possible to work very directly with symbols and symbolization. Also, if affect ever gets too intense or disruptive, it is often easier to reduce it directly in trance. So the experiences that are created that are repetitions of traumatic negative events and affect can now be associated with positive, self-soothing experiences. Rather than separating one self from the other, as the patient processes experience, he or she connects and integrates his or her affect and experience, both positive and negative, into the self.

The goal is for patients to begin to know their bodies, feel their feelings, and think and speak about their bodies and feelings in a way that makes them feel bigger, better, and stronger. This can create a sense of relatedness to others, rather than a sense of disconnectedness from others. Those little elements of experiences are built on one another across time to create the internal structure of how we organize our sense of self in the world. In the real world this occurs, for example, when a baby is experiencing the world and sucking his or her thumb and learning that the thumb is a part of him or her and the blanket is not; because it feels different to suck one as opposed to the other, and the image of the thumb and the image of the blanket in the baby's mind are different things. So the baby can learn to use the thumb for some things and the blanket for others. Hypnosis lets me go to a place where I can engage that kind of activity much more directly and much more safely with my patients than I can if we are just talking in psychoanalytic psychotherapy. I use hypnosis in this way particularly when I am dealing with character pathology and pre-neurotic, narcissistic, borderline, schizotypal, and psychotic patients.

Ever since Piaget, all the models of development have been essentially epigenetic, meaning that development is seen to occur as a series of stages that have a relatively lawful pattern in a particular culture, and success at a later stage is predicated on the success of an earlier stage. It's kind of like building a tower with one block on top of another. For each developmental line, whether it is identity formation, affect modulation, cognitive development, or moral value development, a fair amount of research has taught us, at least for our culture, what the epigenesis is along that developmental line.

When I work with a patient, I try to understand the origin of his or her earliest unfinished developmental business. I begin there, and go through a series of stages in the order my theoretical understanding and experiences lead me to think is most appropriate. How quickly we move with therapy depends mostly on how much the patient can tolerate and process. Sometimes the patient cannot engage the task at all, and becomes blank, dissociates, or becomes anxious and distracts himself or

herself from the task. When this happens, we have work to do in order to engage the patient in the needed task. At other times, the patient is able to engage in the task, but the affect that comes afterwards makes it hard for him or her to engage it again, and so we have to work on managing that affect. And sometimes the patient is able to engage the task in hypnosis, but cannot remember the experience after coming out of hypnosis, making it impossible or at least extremely difficult to process the experience in a waking state.

Moving on to the next developmental task is predicated on the patient's ability to (1) complete the first task, (2) tolerate and modulate his or her affect while doing the task, (3) remember it outside of hypnosis, and (4) process it with me in waking therapy. When we have done all of that, we move to the next task. So this is not something that occurs all in one hour, or even in a continuous series of hypnotic hours. It may be an hour of hypnosis and then an hour of talking, and then going back and doing part of the same work in another hour of hypnosis and then a couple hours of talking, and then going back and moving to the next step in an hour of hypnosis. This process usually occurs over a series of months; working with people who are narcissistic, borderline, schizotypal, or psychotic can take years of analytic work.

I would not be doing that kind of structure building work with someone who comes in just for smoking cessation. But if someone comes to me and says, 'My life is falling apart and I want to kill myself, I'm addicted to cocaine and I'm cutting up my legs,' I know I am going to be working with that person for a long time.

However, I am also certain that the work is facilitated, and occurs faster and better, in hypnosis. I say that because I've just finished an analysis of 20 years of 20 cases that I treated. In 10 of the cases I used hypnosis the way we are talking about, and in 10 of them I did not use hypnosis. I looked at the total number of sessions it took patients to get well and when they completed the treatment. I looked at 3 to 10 years of follow-up to see what kind of lives they have had since they were in therapy. In a very significant way, the people who had hypnosis as part of their treatment had shorter treatments and better outcomes.

Some of the tasks I ask patients to do in this process are evocative of developmental issues, and others arise organically from the work with any one patient. Sometimes the patient starts talking about a particular experience, or using a particular symbol, and I think that would be great to incorporate into what we are going to do. Some of the time I work from my own experience around things that work well, and other times I find myself going with what the person suggests.

It would take a long time, and many pages, to review the dozens of tasks across each of the eight developmental lines that I help patients work through. The developmental lines are relatively independent of one another, and each has its own maturational course. The maturation of intellectual functioning has its pathway, and the maturation of affect regulation has a different pathway, and the maturation of conscious or moral development has yet another pathway. Because they are relatively independent, you can see, in older children and in adults, people who might be precocious and advanced in some functions (for example, intellectual functioning) but who are very delayed in others (for example, affect regulation or capacity for intimacy).

At the same time, although the developmental lines are relatively independent, there are also particular junctures where they intersect, and experience at such points impacts the course on multiple developmental lines—perhaps all of them. If you can successfully negotiate that developmental task, it is possible to move up a notch, across the board. In developmental psychology we call those critical periods, or critical events in development. There are two particularly important ones for the structuralization of character. One of these is object permanence and the other is object constancy.

The initial research on these topics this was done by Margaret Mahler and her colleagues Annie Bergman and Fred Pine. Their findings were published in the book *Psychological Birth of the Human Infant* in 1975. They reported the results of a 20-year prospective study of a group of infants in and around Boston. Their findings have been amplified and repeated a dozen times by other scientists since then.

Object permanence refers to the ability to recognize that things endure, that they remain even when we cannot see them, taste them, or smell them. Object permanence allows us to hold on to some sense of security and safety, of freedom from annihilation, when the person with whom we have been attached and who provides an anchor of security for us is not present.

For every experience of self, there is an experience of other, and for every experience of other, there is an experience of self. Other, or object constancy and permanence, is also self constancy and permanence. One of the things I often do in working with patients whose issues have to do with permanence is to suggest, once they are in hypnosis, that they open their eyes and look at something in the room. They can choose what it is. Then I ask them to close their eyes and get an image of the thing they looked at, then open their eyes and see that it is still there, and then close their eyes and get an image of it. The idea is that even when you do not see the object, you can reassure yourself that it is still there. Children playing peek-a-boo are practising the mastery of permanence. If you have ever done infant screening, you know about tests like the Bayley Scales of Infant Development, which tests for object permanence by using a rattle to get the child's attention, then moving the rattle behind a screen and holding it still so the baby cannot see it, touch it, or hear it. The evaluator observes whether the child's gaze stays fixed at the point where the rattle disappeared, indicating that the child is waiting for the rattle to return and knows that it is still there. As another example, we know that early in development there is a time in which, when the baby's ball falls out of the crib, the ball ceases to exist for that baby. Then, beginning between 3 and 6 months of age, and maturing by 12 to 18 months of age, the child realizes that the ball still exists even when he or she does not see it. We know this because once the ball disappears, the child will look for it—for example, reach under the couch.

Knowing that the object endures across space and time means knowing that the self can endure across space and time as well, which means that we can learn to tolerate the anxiety of being separated from another person on whom we have come to depend. Object and self permanence facilitate a variety of things like boundary formation, tolerance for separation, and soothing the affect associated with separation. For a patient who has difficulties with permanence, I might begin with a sensorimotor experience of an object, then move to asking the patient to develop an

internal representation of the object and then, finally, talking about the object, giving it words. So, for example, I may ask the patient to imagine the lamp (or the picture or the book, whatever object was selected) when he or she is not in my office, and then use this image to soothe anxiety or to help the patient to stop dissociating or cutting himself or herself; to help the patient feel safe and secure as when he or she is in my office. That is to say, I ask the patient to use the internal representation of the object as a kind of transitional object, like a teddy bear or security blanket that a child uses for self-soothing when mom is not in the room. This is one example of the kind of work I do to help patients develop object permanence.

Once a person has a sense that things endure and that self will endure even as separate from others, then that person can begin to practise being separate by differentiating self and other, by forming the boundaries. The idea is that one can not only differentiate and stabilize boundaries, but make them permeable, have some control over them, not keep everything out or everything in but let some things in and keep some things out. I might work on this by having the person develop rigidity in an arm and feel the strength in those muscles as a kind of barrier. When doing this, I purposely choose the arm nearest to me, so now there is this evocative experience that the patient has erected a wall, a barrier, between the two of us. Then I ask the patient to gradually allow that arm to relax and come down, to experience that he or she can control how quickly and completely the arm relaxes and comes down, and then, when the patient is ready, he or she can make it stiff and rigid again, and then let it come down again.

We then use this as the focus of imagery. I ask the patient to imagine seeing what he or she has just done. And then we might elaborate it, under hypnosis, with other symbolic images like opening and shutting a window and a door. Then outside of hypnosis we talk about the meaning of these symbols; that it is possible to have control over what you let in and what you let out. That the patient is in charge of the window, the door, and the arm. Then I usually talk with the patient about what relevance this has, and ask him or her to go through a series of images to rehearse applying that particular strategy of boundary permeability and efficacy in a variety of places and across time, and in relation to different affect states and different relational configurations.

On the other end of the continuum, constancy has to do with the ability to recognize that the different experiences of self are not, in fact, different selves. When working on this developmental task with patients, I might ask them to focus on holding both of their arms out in front of them, doing what Paul Sacerdoti used to call 'double simultaneous direct' and 'reverse arm levitation'. One hand becomes light and one becomes heavy, but they are still both the patient's hands. Then you reverse it and the light hand becomes heavy and the heavy hand becomes light, and the hand that was heavy and now is light is still the same hand. I might have the patient feel each hand, look at it, see that it is still attached to his or her arm. The point I am trying to help the patient understand here is that the sensory experience of an aspect of self can shift and the position of self in the world can change; yet the person stays the same. I then move on to imagining this again during a hypnotic trance, and then ask the patient to discuss and elaborate on these ideas in terms of affect states. Finally, I ask the patient to imagine the shifting of affect states inter-

nally while at the same time maintaining a constant sense of who he or she is across space, time, relationships, and affect states.

We do the steps along the developmental path one at a time. First, we experience the step. We then imagine it and elaborate on it symbolically. Finally, we talk about what it means, its relevance, and how it applies to the patient's problems and issues. Early on, when I started doing this work and I was videotaping it and showing it at conferences, people had a number of interesting reactions. One of the things they asked was, 'Don't your patients think it's weird that you are having them bend their arms, having them picture bending their arms, and talking about the relationship between bending their arms and changing their feelings?' The question surprised me because no patient, not one, has ever told me that he or she thought it was weird. In fact, just the opposite occurred: my patients often talked about how well it fit with their experience, and how empathically attuned it felt.

Another person said, while watching my work, 'You remind me of Mr Rogers.' As I responded to this comment, I recalled that Mr Rogers aimed his TV programme at 3-, 4-, and 5-year-olds. In fact, Mr Rogers actually went to the Pittsburgh Analytic Institute and took courses in child development. The things he did, like putting on his sweater and taking it off, changing his shoes, and doing all the same things at the start of every show, provided permanence and constancy that were very tuned in to what kids who are 2, 3, 4, and 5 are dealing with developmentally. I always noticed that when kids who were this age watched *Mister Rogers' Neighborhood*, they were just glued to the TV. But when they were 7 or 8, they thought he was a weirdo. He was not only uninteresting and unengaging for a 7-year-old, but seemed downright stupid and weird.

Once we have gone beyond a particular developmental level, it feels infantilizing and regressive and weird because it is not attuned to our current experience. But when you are at that level, it feels just right. So, if I have correctly identified where my patients are developmentally, when I begin to work in a way that matches their level of development, it feels just right to them.

MJ: Anything else?

EB: I guess I would add an extension of what I have already said about why it is important to use hypnosis in psychotherapy. We know that so much of the variance of psychotherapy—regardless of who the therapist is or his or her theoretical orientation or what kind of problems he or she is working on—has to do with relationship factors. There has been a lot of research on different relationship factors that affect the outcome of psychotherapy, including self-disclosure, warmth, and empathy; and empathy always wins.

Empathic attunement seems to be the variable that accounts for the greatest amount of variance between a curative relationship and one that is either neutral or negative. The relationship is a vital component in any kind of psychotherapy, no matter how you conceive of therapy, of how you are going to work, what the therapeutic action is, or what you are going to focus on. Moreover, hypnosis has the ability to affect the relationship in a very powerful way. That, I think, is why we do it, whether we think of it as intensifying the transference or as creating a shared space

for a more intense attunement and mutual sharing of experiences. There is no question in my mind that when we introduce hypnosis into psychotherapy, something about the *way* we are with the patient and *who* we are for the patient shifts, and that shift almost always has a profoundly positive effect for patients.

Having another person who will attend to you so closely that he or she will notice when you swallow or twitch a finger, who is so connected to you that he or she will match the pace of his or her voice to the rhythm of your breathing, who will engage your symbols and your language in the way he or she talks about the experience that you are sharing—having someone who is that present has to be evocative of what it is like when you are an infant in your mother's arms. For me, that sense of holding and connection is probably the central way that hypnosis makes a difference for people.

I think that each of us, no matter how much we grow up, yearns to feel again that profound sense of gratification and security that we really only get to know if we have a good enough mother and father when we are in the first year of life, when it feels as if everything we want and need is there. The sense of safety and being valued and loved is so profound. Certainly just the process of having someone talking to you in a soothing way and encouraging you to feel good and safe, and offering opportunities to escape physical or psychic pain, even if just for a little while, creates a particular sense of what it is like to be with another person in a way that many people who have had more malevolent or uncaring figures in their lives have never experienced before. That has to have a profound effect on one's sense of what his or her possibilities are in the world and who one could be to another person, and therefore who one could become for oneself.

I think what might be most important about hypnosis is that the rituals, the style of relating, and the way of being with the other all affect that relational component and can have a powerful effect on any therapeutic process.

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