PSYCHOSYNTHESIS SEMINARS

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207 Fairmount Rd.
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Subject: Does Hypnosis have a Place in Psychosynthesis?

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Dr. Cooper: Our speaker tonight is Dr. Bertha Phillips Rodger who is an anesthesiologist at the Valley Hospital in Ridgewood, N.J. She has been in the field of hypnosis for about ten years, a Fellow of the American Society of Clinical Hypnosis. She has been interested in psychosynthesis for some time, being introduced to it through our good friend, Evarts Loomis, M.D. of California.Her subject is "Does Hypnosis have a place in Psychosynthesis?"

Dr. Bertha Rodger:

I have been looking forward to this occasion ever since the suggestion was first made, for I am very much interested in your work. I have been receiving your papers and transcripts of your meetings and think they are most interesting. I have found them very valuable.

When the question was asked of me: "Does hypnosis have a place in psychosynthesis?" my first reaction was to say "Yes, certainly!" But when it comes to trying to define just what place it has, I find that difficult. I think it will be best to present my use of hypnosis in my own practice, and then let you see how it applies to you in your practice. I am sure that we have at least one thing in common: that we see many patients who have a good deal of anxiety. This is something with which an anesthesiologist is faced every day. We often have panicky patients. They are under various kinds of stress and we have to find some way of relieving them. Drugs do not do it. That was the main reason why I turned to hypnosis ten years or so ago because drugs were not adequately taking care of my patients. I had to find something else and I have found it.

One of the things that I find is that patients are disturbed by previous experiences. They react in the present situation to those earlier experiences. It is like a kind of delayed time bomb.

I am thinking particularly of one patient who came in to have a gall bladder removed. She was very much afraid. She was a very tense person anyhow. When I saw her on a pre-operative visit, she told me that her mother, several years before, had had the same kind of operation and my patient had nursed her through it - she was quite sick and had a great deal of distress and pain. My patient did not want to undergo this same experience. So I suggested to her: "Well, if you can relax a little you will certainly be more comfortable. Pain is always aggravated by tension and sometimes is even caused by it. I will show you how to relax, but I cannot do it for you and I can't do it to you."

Incidentally, I have found that if I say to patients "Now I will hypnotize you and everything will be fine" I have to give a little course on hypnosis before I proceed; but if I suggest to them that they can learn something about relaxing and becoming more comfortable, this they can understand, and it takes effect immediately.

My patient recognized that she was very tense, and said "Yes, my family doctor told me to relax but I just don't know how to do so." So I proceeded to tell her how to do it, and then I said "Now, you can use your imagination to help you. Your imagination has sort of run away with you, reminding you of your mother's experience, but you are not your mother. This is a different time and now we have different anesthetics. You can use your imagination to help you in this situation. Perhaps you would like to let a picture of a safe place come into your mind, a place where you can lock things up. You might like to have a safety

deposit box, a vault in the bank, or perhaps you would like a closet, or maybe a storage warehouse, depending on how much you have to lock up. When you lock things up in this safe place they can remain there until such time as you want to get them out. You can get them out in any proportion that you want - just a little bit or take out a whole lot when you need it. Just let your head nod when you begin to see a safe place in your mind's eye."

Very shortly her head began to nod - repetitive nodding that tells you that this is the subconscious, a subconscious reaction or gesture that is coming through. So I knew that she was in a nice light trance state at this point.

I suggested that she could lock up any memory of the previous operation, because she certainly didn't need that right now. She could lock up any anticipated difficulty, because again she did not need it right at that minute and she could get at it any time that she did need it. We went on in this way, putting away any memories and thoughts and painful thinking. I suggested that she lock this safe place up and put the key in a safe place; and that she let her head nod to show when she had finished. She did this.

I went over with her some of the pre-operative suggestions, telling her what to expect and how to respond. There is no need to go into further details of that case at this point. She did feel more comfortable and the whole procedure went off very nicely - much to her surprise and that of her surgeon who had anticipated trouble with her. She went through it all very smoothly, needing very little in the way of post-operative medication. She had a few doses of demerol, but she had very little in the way of post-operative complaints.

When you have patients "lock things up in a safe place," the vault or wherever they lock things up becomes something like McGee's closet. Things threaten to come tumbling out. One can use another imaginative technique of clearing out a pigeonholed desk. One can visualize a place like a post office with all the rows of boxes. The boxes are kept closed with springs on the doors. It takes psychic energy to keep them closed, to keep stored away the things that you do not know what to do with, the things that bother you so much that you do not want to bring them up into the conscious mind. I tell patients to see this and nod their heads to let me know when they see it. This is a very useful technique to get them participating. Also you can see how they are getting along. You can have them bring up details and describe them to you but this takes time. I never have so much time to spend with a patient. So I take the short cut and let them do it, and have them nod occasionally to show where they are. You don't have to catch up with them in between because although the speed of sound is quite fast, the speed of light is much faster, and the speed of thought is infinitely faster. Let them do the work with the speed of thought, and you can get quite a bit accomplished in a short space of time.

Frequently when patients seem to be bothered by many things - they don't know exactly what ails them and they are anxious about many things - I will have them clean out that psychic rubbish heap and have them open up the post office boxes one at a time and clear out what is there - throw away what they no longer need - things from the past when they were very little or even something last week that they perhaps put away but that they do not need any longer. If they look at them they can tell immediately whether they need them. There are some things that they know that they will want to keep, others they don't know what to do with. Put those away and just heave out the ones you don't want. Then close the place up, and so on.

Now this brings up another technique, and that is time distortion. Again, I have discovered that you can teach this to a patient in a short space of time. I often remind a patient that time proceeds at different rates according to what you are doing. Clock time is one thing and your own personal time is quite another. When you are happy and gay time goes by so fast that you look at your watch and say "Oh, an hour cannot possibly have gone by!" There are other times, perhaps when you are sitting listening to a teacher or a preacher, that you look at your watch and shake it to make sure that it hasn't stopped because that five minutes has seemed so long. You can allow your own personal time to go by very, very fast or slow it down. I give them an opportunity to practice it and count out the minutes, using ten second intervals. After giving them an hour's task to do, most of them will say "Well, it didn't seem like an hour." When I ask them how long did it seem, they will say "Well, maybe 15 minutes," so I answer "You just distorted time at the rate of 15 minutes to one. You can certainly do a great deal in a short space of clock time; and now we will do this clearing out of the pigeonhole!"

There is another technique, a favorite one of mine, called "Ideomotor finger questioning." This has to do with unconscious communication. Dr. Cheek in San Francisco has developed this technique. It is one that might be of value to you. By assigning answers to fingers and saying to the patient "Would you be willing to let your right index finger say 'Yes' and the left index finger answer 'No'; the right thumb to mean 'I don't know' and the left thumb 'I don't want to answer'? With this we can play a sort of game of Twenty Questions. It will be all right for me to ask you anything that I think might be helpful in this situation. It protects your privacy for it means that you will not have to communicate to me anything that you do not want me to know. You will not even have to communicate it to yourself until you are ready to know it. There are always things that you can almost catch but that are just outside your awareness and you are not quite ready to know them; they will come to you when you are ready. There might be something which might be very, very helpful to have me know, but which you might not yet want to know yourself."

Now this type of movement is a conscious movement (here Dr. Rodger placed both hands on the table and lifted the right index finger. Ed.) I raise the right one, saying "yes"; or this one, the left one, means I say "no". This thumb raised says "I don't know"; this other one raised says "I don't want to answer."

These are conscious movements, but an unconscious movement is a different kind of thing. For instance, if you just <u>think</u> "yes", "yes", your yes finger will begin to come up; but watch how it comes up - in sort of little jerks or waves. And the same thing happens if you think "no". This is the unconscious type of movement. So if you see a patient raise her finger like this (Dr. Rodger raised her finger in one smooth motion. Ed.) you know that this is a conscious communication; but when you see it moving in that jerky way or repetitive movement, you know that this is an unconscious movement. It can be very useful and very helpful.

We have learned a good deal about the mind through the study of cybernetics, the idea of the mind as a computer. Dr. Cheek presented the concept that the mind has a scanning device that is far more efficient than the FBI fingerprints matching system. It is a very useful technique; and the way that I use it is this: when I find people reacting in an odd way in the anesthesia situation -

when they are afraid of something and I cannot find out readily what it is they are afraid of - I have them scan a situation. I can say to the patient, "Now, will it be all right with you to lean back and just take a few deep breaths, and we will see what we can find out about this situation in such a way that it does not have to cause you any anxiety. Forget all about being yourself for a moment and just imagine that you are a nurse, a doctor or an orderly; and when you see a patient on an operating cart or table let your finger, your "yes" finger, raise up to tell me so. Then I would like to have you very quickly scan an audio-video tape, as it were, and see what this imagined patient is experiencing. You, as the nurse or the doctor, can see what the patient is going through and what is important in this particular situation. I would like to have you run through that tape from the time you see the patient on the operating stretcher until he is safely back in bed again. When you see him safely back in bed again let this finger raise up."

Patients will frequently do that, and this finger will come up and then very quickly the other one. I will say, "That is fine, you did very well. But now will you slow it down so that you can have a better look and see a little more clearly. You will find that you will be able to do it much better this time; so slow it down, scan it, look at it again."

It is as if you were stirring up the unconscious with one of these long spoons that goes down to the bottom of a tall glass of ice-cream soda. You stir it and things begin to float up. As they look at it at a deep level, removed by imagining, they don't have to experience physiologically what they went through at an earlier time. Now, if I ask them to remember this, if I ask them to experience it again, if I regress them to it, they may experience the same kind of physiological response that they had had before. Supposing someone had had an approaching cardiac arrest or coronary restriction, something that would not have bothered a six-year old child might bother a 50 year old man, but by removing them to the role of doctor or nurse they do not have to experience it again or <u>be</u> it.

After they have been through this a few times, slowing it down still more, I tell them: "Let your thumb raise up when you see something that is of particular importance to this patient on the stretcher." And after a bit this will happen and I ask, "What are you looking at, what is the patient doing, what is the patient feeling?" And they will tell me and give me a great deal of information. Dr. Cheek has done a great deal with this. He reviewed many cases that had had cardiac arrest and had been resuscitated successfully. He found very frequently that it was something that was said in the operating room to which they reacted - something that was said to the patient or about the patient. When doctors talk about their other cases the patient's unconscious is reaching out for any meaningful sound, applying it personally.

So it has been helpful to be able to scan and see what the patient has experienced before, and desensitize him to it. This may be of value to you in some of your experiences. Other psychologists or psychiatrists have reported that they will have a patient scan a particular span of life - their third year or whatever - and let the finger raise up when there is something of importance to this child. Or they will ask, "What does this situation or this feeling that you have now remind you of?" This technique means they can go back and scan without having to bring it all up to the conscious and taking all that time.

Several times at our American Society of Clinical Hypnosis meetings, Dr. John Hartland from West Bromwich, England, has come to speak to us; and one of

the things that he shared with us was his "ego-strengthening" technique. I find it very helpful for any patient under stress or any patient who is anxious. I don't use it with all my pre-operative patients but I do use it with patients who are referred for pain or tension or some of the other psychosomatic conditions. Dr. Hartland uses some of the induction techniques of hypnosis and then goes through a procedure something like this - I will read you a couple of paragraphs of what he said:

After they are relaxed he begins, "You will become physically stronger, fitter, you will become more alert, more wide awake, more energetic; you will become much less easily tired, much less easily fatigued, much less easily depressed, much less easily discouraged; every day you will become so deeply interested in what you are doing, so deeply interested in whatever is going on that your mind will become much less preoccupied with yourself and you will be much less conscious of yourself and your feelings."

Then he goes on: "Every day you will become emotionally much calmer" and so on; and he goes on putting these ideas in slightly different phraseology so that they are repetitive suggestions; and by putting it rather permissively - this that I have just read does sound rather definite, but it can be put more permissively - instead of saying "you will become physically stronger" you can say "you can or you may" and not be quite so insistent, whatever seems to suit. He finds, and some of us who have used this technique have found, that it seems to give considerable encouragement to patients.

Now having skipped around somewhat let us speak a little more about hypnosis and my concept of it. I find it a very valuable tool. It is not a treatment in itself. It is a tool; a means of communication. You know, Shopenhauer said that mankind is like a herd of porcupines huddling together to get warm. We get too close and prick one another or we get too far apart and we freeze. It is as if hypnosis shows us how to put down our quills and discover that we are not really porcupines, that it is safe to get a little closer. Also, hypnosis is an interpersonal relationship. It varies with the personalities of the users and the purposes for which it is used. It has controllability, which is an advantage in any tool. It has availability; it is always with you. You can use it and adapt it with great versatility and great flexibility.

The hypnotic state is very prevalent when you think about it. Dr. Ainsley Meares, psychiatrist from Australia, says that simple relaxation, a hypnoidal state, and the light trance state, form a continuum. They don't necessarily go in a straight line; rather they go in varying waves. It is often difficult to distinguish the stages, but it does not really make that much difference for practical clinical purposes.

We go in and out of trance states continually all day long. Dr. Wolberg says that it is small wonder we don't know much about hypnosis. We don't know a lot about consciousness or unconsciousness, and hypnosis swings like a hammock between the two. Every time you go to sleep you go through a stage of hypnosis; you may go through it so fast that you are not aware of it; and I think this is comparable to using open-drop ether anesthesia or some rapidly acting things like pentothol. We like to teach residents, or we did in the past, I am not sure if they do it nowadays, to give open-drop ether so that they could see the different stages of anesthesia and watch them develop. As you do this you get a much better idea of the patient and his responses. Now in general anesthesia we use most of

the time a very rapidly acting anesthetic, and patients go through these stages so fast that you don't see them. Nevertheless, if you know the stages, you can watch them in action and direct them. So in hypnosis, as you learn some of the induction techniques and the primary things about hypnosis, you see the process in slow motion. It teaches you to become very observant of patients, very aware of what they are doing and what state they are in, and the direction they are taking.

We speak a good deal of "tuning in" and picking up small clues from patients. Of course, as psychologists and psychiatrists you are taught to do this. It is nothing new, medical students also learn to do this. Yet, the study of hypnosis has taught me a great deal beyond this and helped me to develop my own capabilities.

But to go back to the normal trance states: whenever someone is concentrating deeply they are very likely to be in a hypnoidal state, a trance state perhaps. People commonly say "I was simply entranced by that speaker", and we very literally are. If you have the opportunity to sit in front of an audience when someone else is speaking, watch them - let your eyes just rove over the audience - and notice what states of relaxation or restlessness or light-trance states, hypnoidal states, they are in. You will see some people sitting there with their heads nodding, and it is that same unconscious movement that I showed you with the finger; it is a repetitive movement and they don't know that they are doing it.

Someone who was on a panel, a couple of years ago, in thanking us for inviting him, said it had been very exciting, that he could see "lights coming on all over the audience and a real dance of communication." They were reacting with the speakers, inter-acting.

Whenever there is an inward focussing of interest, as you narrow down the attention from things around you to things of inward interest, you tend towards a hypnotic state. We need to recognize hypnotic states and how important they are because they occur all the time. One of the things that I spend a good deal of my time doing is actually de-hypnotizing people from the responses which they have spontaneously picked up. A patient who is intensely interested in himself for any reason, very readily enters into a hypnotic state. We see this all the time with the patients in the hospital, particularly with surgical patients. As the time for anesthesia and the operation come near, their attention narrows down from the things around them, to what is important to them. Everything they hear or see, everything they feel is related to this. They may be very well hypnotized into unfortunate responses because they are in a state of increased suggestability.

One of the most delightful introductions to hypnosis that was ever invented is the way you teach a child to pray. You get in an appropriate position, you fold your hands and put them just so, you close your eyes and listen to the leader. You join in the "Amen." This is just the way we teach a person to go into the hypnotic state. You lie down or sit down, put your feet flat on the floor or cross your ankles, place your hands lightly in your lap, fix your eyes on a fixed point or let them close. You listen; and you respond accordingly. There is quite a parallel there. Hypnosis makes an excellent background to deepened prayer and meditation.

Last year at the meetings of the American Society for Clinical Hypnosis one of the very interesting papers presented was by an anesthesiologist from

Massachusetts, Dr. Bartlett, on the idea of hypnosis being the "control of the control." This control of the control is common I understand in mathematics and physics. The thermostat on the wall is the control of the heating system; yet you can go to that control and change it, so that you "control the control." In hypnosis what we are doing is to show how you can use perfectly normal things that you do every day. I spoke about the imaginative techniques and this is something that will be excellent with children. You remember how we used to play "Let's pretend" and that chair was not just representing a horse but really was a horse - you could feel it moving under you and pat it and feel the softness of its mane. Children respond readily to direction of their pretending. Adults do also when they are reminded how well they could do it as children.

All the things which are hypnotic phenomena are things which occur to us at other times but now through hypnosis you learn to put them to use in a different way. That same imagination that runs away with you is harnessed and put to use creatively. The induction of hypnosis, the giving of suggestions, is a way of teaching patients how to respond, showing them what they can do, encouraging them, accepting them, and getting them to do something a little bit harder. You start with very, very easy things to show them they really can do something that they didn't think they could do, and then go on to show them something else.

I was so intrigued when I read Dr. Assagioli's book and found a paragraph where he stated that getting control, mental control of the physiological processes, is like using electricity that was previously ignored or unknown; and that reaching into the higher unconscious freed the psychic spiritual energies like releasing the atomic energy that is latent in matter. This is what you see when you work with hypnosis; you start with very simple things, point the way. When it is properly taught then the patients go ahead on their own inner resources. Rather than being under the control of another person - which is what is emphasized where charlatans use it or in the early way that hypnosis used to be taught or in the way they use it, unfortunately, in entertainment on the stage - what it really can do is to free power for a person; this is a very exciting thing, a very thrilling thing.

Another paper that was so interesting last Fall, was Dr. Spiegel's presentation. He says that we have tended in the past, and unfortunately still tend, to tell our patients when we want to use hypnosis with them: "Well now, I must explain that hypnotic sleep as we use the term is not really night-time sleep; it's not physiological sleep." We spend a good deal of time talking about this and then we proceed with an induction technique in which we say "Now sleep, sleep deeply." Then we wonder why they don't do what we want them to do! We go on with long winded induction techniques trying to get them to sleep deeper, wondering why they don't and finally we bore them and ourselves into a hypnoidal state, and then go ahead with suggestions.

What we really ought to do is to say "All right, for a particular purpose, you want me to help you and I will be glad to help you. Sit back, get comfortable, take a few deep breaths. Relax all over and forget about your body. Just let awareness of it fade. Now, wake up your mind - to extra-awakened consciousness. Let's get going. Your body has been speaking to you through pain and symptoms - speaking to you metaphorically. Now we are ready to listen. Forget your body and let your being speak more directly." "Relax, wake up your mind, and look at this whole situation, there is a great deal more information there than you can bring up into your consciousness. It isn't necessary that I know every detail,

but it would be helpful if you would look at the whole situation. Look at the back of it and see what the problem behind the problem really is. Look at whatever you are willing to. Then you can share with me whatever you wish to share. You can see what comment you want to make; or what questions you wish to ask; where you need help; what knowledge you need which I might be able to supply." So you can give a person a minute or two to look over the situation in depth as it were, and then rouse up ready to talk about it. I often have patients look at their problems and come up and tell me of things that are at the back of it. It works! And we should have found out about it long ago.

There is another technique that I might bring to your attention that may be of interest to you. This has been taught by Dr. Calvert Stein who is a psychiatrist at Springfield, Mass. He calls it the "clenched fist technique." He stumbled across this at a time when he was working with an epileptic boy. He was trying to get some idea of what feelings meant to the boy. In the process he had him hold his arm out with the fist clenched, reporting what feelings he had when he did so. The boy said that he felt a kind of strength and a feeling of control. There were some other feelings that he mentioned but I do not remember them. However, Stein began thinking that this might be of some value and he evolved this technique. He has the patient relax and then he suggests: "In a few moments when I give you the signal let your hand tighten up into a fist. As your hand tightens, allow a picture to come into your mind of a time when you felt very strong, very much in control, very comfortable and happy, when you felt loved and felt loving." He would tell them, "That is a nice feeling. Now go ahead and let your hand tighten up into a fist. The tighter it gets, the clearer the image will become - this image of the time when you were feeling very strong, very much in control, very happy and contented and very loving. When those feelings are all through you and you are really enjoying them, keep the feelings, but let your hand resume its normal tension and relax."

He would have the patient practice that several times and then he would say, "You don't need to tighten up your whole fist just tighten up your thumb and first finger; and then you don't even need to do this, just put the thumb and forefinger together." Later he would tell them that it was only necessary to do it in the mind, imagine doing it.

Incidentally, I demonstrated with my right hand because most people have a dominant right hand. Dr. Stein used the illustration of the epileptic because people who have epilepsy know or rather can sense an attack coming on, and even if they don't know very far ahead, if it is brought to their attention they can sense it.

After the patient had become confident in calling up the positive good feelings, he would then suggest: "Let your other hand tighten up, let the deep part of your mind bring up into your awareness the feelings that tell you that an epileptic attack is about to start. Before you get really uncomfortable, let it tighten up as tight as it will and experience whatever sensations and feelings you are willing to experience. Before it gets too uncomfortable,apply your own antidote by tightening up your right fist and let the other relax."

It is as if the strong feelings come through and drive the other feelings right out. This is adaptable in quite a number of ways. I use it with the pain states, particularly with migraine headaches - I don't know how you are going to use it or how you could use it, but it is something that might be of interest to you.

There are "confusion techniques" in hypnosis which are very intriguing - I find myself getting confused by them when I use them, but you can work them out nevertheless. One of my favorites is one which Dr. Milton Erickson brought to us; I use it with patients with pain. Although that might not be of particular interest to you, as you see the way in which I use it perhaps it will give you some ideas. For instance, a patient whom I know to be in terminal illness may or may not know it; he may not have been told or he may be afraid of it and denying it. Frequently I have patients referred to me because the surgeon cannot do much more; they are having a good deal of pain and getting frequent medication with little relief. They are too drowsy or many times the medication just doesn't work. One of the things I can do is this:

It is not necessary to develop any formal hypnosis through induction techniques; it is enough just to fix their attention, and then begin to say, "You know that you have pain and you know that you know it; but there are some things that you do not yet know that you know. You know that you have pain, but what you do not know is that you also have "no pain", and the time of "no pain" can get longer and longer, it can come more and more often; and the area of "no pain" you can discover more and more, and you can take great delight in discovering how large a part of your body has no pain, and how often you have no pain, and you can really enjoy it."

This is an orientation which never occurred to them. It redirects attention and raises the threshold of response to pain. I can also say to this same patient: "There are some things that you know and you know that you know them. There are some your doctor knows and you know that he knows them and he knows that you know this, but you do not wish to talk about it just now. You can talk about it whenever you wish to; but you can know that it is known."

I have a patient now in terminal illness in hospital. His wife does not want him to know that no further surgery can be done. He is a very intelligent man. I am certain and his surgeon is certain that he knows, but he never speaks of it. This can be a desperately difficult situation for everybody has to play a game and walk on eggs. Speaking to him in this fashion lets him decide when is the time to bring it into the open. He and I and his nurse, talk about things at a deep level, ambiguously. While it is being said, it does not come to conscious level. This man is being very busy enjoying his "no pain" or building a wall of numbness through which he can feel this pain. Every now and then that wall will crumble and he has to get some better insulating material between himself and the pain. He enjoys the time he has with his family. He is very busy straightening out his business affairs, gradually guiding his wife into acceptance of things which she had not been ready to accept. She is an extremely anxious person, and he is doing his best to help her. So it is a very interesting situation.

One more thing I will bring up and that is the question of amnesia, of forgetting. One technique of forgetting is the one I spoke of in the beginning, of locking things up in a safe place. We all have a very good "forgettory" as well as a very good memory, and we ought to learn to use it and to use it properly. You can lock things up there until such time as you have time to deal with them, have enough information to deal with them, have strength to deal with them or as you have the specific help that you need, and as you are ready to deal with them. And this is one way of suggesting amnesia. After talking to the patient a while

in the trance state, one may say "You can rouse up knowing you have heard everything that has been said. You can remember whatever you need to remember. You can forget whatever you need to forget - until such time as you need it." It is a little unwieldy. It gives them specific permission for them to do what they need to do - perhaps what they hadn't realized they could do; and they will do just that.

I think this would be a good place to stop and ask you people what you are particularly interested in and what you want to hear more about, what you agree or disagree with - whatever you want.

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DISCUSSION

Rodger: (In response to an unclear question regarding the use of the clenched fist and the right and left hand. Ed.) At first I had them clench the right hand because that is my domiant hand. Then I realized that for other people this may not be so; so now I tell them: "Clench the dominant hand for the positive feeling." I had one patient who got awfully confused; we had to start all over again and let her decide which was going to be for her the dominant hand. She was ambidextrous.

Cooper: There is a syndrome called the "thalamic syndrome". For instance, you have a pain on the left side and pinch yourself on the right side, and the pain will be reduced by the physiological mechanism of "over-riding".

Questioner: In a left handed person would the left be the dominant hand?

Rodger: Well, I would not know; I would just let the patient choose; let him think about these happy feelings and then let the hands decide which one will be the dominant one - just let the hand tighten up in response to the positive feelings.

Winston: Is it necessary to induce any degree of hypnosis in order to use this technique, or can you use a state of fairly deep relaxation?

Rodger: Yes, you certainly can. It isn't at all necessary to develop any depth. People are often much more suggestible in a light state - in a hypnoidal state, when they simply have a fixed attention - than in a deeper state. It is easier to communicate verbally at this level if you want your patient to speak. I think that anyone who uses hypnoidal or hypnotic states ought to recognize them and this holds true for clergy and psychologists because they do use them. They ought to recognize what is going on and to know some of the difficulties that people can get into and steer them clear from them. It is possible, for instance, for patients to go into very uncomfortable situations; one can get a spontaneous abreaction. A dentist spoke to me the other day about one of his patients who came up with a reaction that might well have been mistaken for a novacaine reaction. He recognized it as a reaction to an earlier experience, and that she was in a trance state and was showing the same behavior as she had at an earlier time. If he hadn't recognized it he might have just treated it as a reaction to novacaine. What he did with her was simply to redirect her so that she could be more comfortable and not have to react to that earlier experience.

Winston: As you described the hypnoidal state I thought that many psychotherapists in adopting the attitude of free floating attention must be in this relaxed state, where they are directing full attention to the patient, but not in an intense active way but being passive and relaxed and allowing what comes from the patient to come in. I wonder what the effect of the therapist would be in this state.

Rodger: I think that most of us who work with hypnosis a good deal find that we do our best work when we get into a hypnotic state with the patient. In other words, what you are doing is tuning in on what is pertinent to the situation, concentrating on the patient and tuning out the other things that simply don't matter. You are always tuned in by your ears, no matter how deeply you are relaxing; you have your radar tuned in to the situation around you and you know what is going on and you can redirect your attention when you need to. Then you pick up little cues and non-verbal unconscious communication. You sort it all out rapidly in your mind and respond to it.

Weiner: I am very struck by your picture of hypnosis as compared with the one many years ago - there have been so many changes. And I pick up from your description that you don't really suggest much to the patient. . . .You seem to provide more of an opportunity for the patient to use his own feelings, imagination and memory; it seems to tend towards more autonomous functioning by the patient, instead of being an object being manipulated; and there is something very nice about that.

Rodger: Yes, great changes have taken place over the past ten years. At the annual meetings papers are presented and the later ones are much more mature, more scientific. We are discovering it is a language of relationship that we are working with in hypnosis. It is someone caring enough about a person to give their real full attention to him; to pick up the little things that he is communicating in every possible way; to set the stage for him to discover his own inner resources, and to bring them up and use them. It has become much more creative, much more permissive and much more useful. But it has changed its character completely from what we used to think of as hypnosis - the authoritative sort of approach, which is very limited.

Haronian: I just wanted to comment that what you now call hypnosis, as compared to what we used to call it, is really a kind of an intense, shared, diadic relationship where one attempts to attain communication as deeply and as extensively as possible; and where at times it becomes a little difficult to differentiate between the operator and the subject.

Rodger: Dr. Spiegel called to mind that it is rather like a mother spoon-feeding a baby. When you look at a mother spoon-feeding a baby you think that the baby is passive and the mother is active - the baby just sits there and she shovels it in. If you watch a little while you will find that this is far from being so. The baby has several choices: as long as it pleases him he will accept what the mother feeds him and swallow it; when he gets a little tired of it he can either hold it in his mouth or blow it out; or he can clamp his jaws and not take a single thing in. He has those choices; and it is the same thing in hypnosis. The patient can go along with the operator as long as the suggestions are pleasing - you can carry right on and the subject will respond. But if you reach a point where you are disturbing something, then the subject will simply refuse to do anything further, or go into a physiological sleep and get out of touch with you - tune you right out.

Ahsen: As we know, the mind has many levels not only in terms of depth of process but essentially as an entity in itself. It is variously arranged and there are oppositional relationships at various levels; so as we descend we foster certain kinds of opposites which contend against each other; and as we go further down the deeper pair contends against the first pair. So as we go on analyzing the personality we find that sometimes we are dealing with very superficial pairs of opposites, and as we go further down we find that we have to reverse the position of the much less deeper pair of opposites. What I am trying to communicate is that the psyche perhaps has many, many levels. . . . particularly the opposites, and unless hypnosis has a very clear theory of operating through these different levels and oppositions within the psyche it may fall prey to a superficial approach to a problem, and in fact confirm the point of view in the psyche which may obstruct completely further growth in the personality. So hypnosis should be aided by a very clear theory of personality, and not only of the personality but also of the psyche, dealing with the arrangements of opposites which, as I said, at the superficial and the deeper level seem to contend against each other.

Rodger: Well,I think you have raised a very important point. Hypnosis not being a treatment in itself but being a means of applying treatment one must be very careful to apply it only within the limits of one's competency. I wouldn't try to use hypnosis for the kind of thing you are describing because I am an anesthesiologist. I can use it for the things I know; you, as a psychologist or psychiatrist, can use it in a different way at a much deeper level and for different purposes. I tried to give you my idea of how other people are using it - Dr. Stein's technique and others. I have to use these techniques in very limited ways within my understanding for I have no right to dig things up from people's past and try to straighten them all out. I should know enough about my own limitations to refer someone when they need that kind of therapy. But your patients are often also my patients, and I have to deal with them in my situation. I do what I can with them; I should not overstep my bounds, and you should not overstep your bounds. A dentist should not try to do psychotherapy except what applies immediately to his situation. It is only a means of applying treatment.

Winston: I was very interested in what Frank (Haronian) said about not knowing which is the operator and which is the subject, because I have an experience with a patient of mine - only with this particular patient - when he is with me I tend to go into a fairly deep trance; and when I reach the stage of being practically asleep it is the point at which he seems to be getting the deepest insight. And he has been bringing back memories; the latest memory was of being in the fallopian tubes. When I wake up then he cannot work so well. Interestingly enough, I have spoken to another therapist who had had a similar experience with him, but she is not as at home with this kind of thing as I am and she became frightened and refused to enter this situation with him. But I want to ask you this: have you any parallels to this or have you suggestions as to how to use this for the benefit of the patient?

Rodger: I think you have to follow the patient's lead, and to recognize that you still are the therapist and that no matter how deep both of you go into trance you still can guide the situation as it needs guidance. You can take your cues from your patient. As you relax into a deep state you quiet down, and the patient quiets down in the same way. It is like putting down the quills, so to speak. A relationship can develop so that he is then free to speak of what is deeper in his mind. I think it is a situation where there is no need to be frightened.

That is exactly one reason why more should be known about hypnosis, so that you have some idea of what is going on and of what you ought to treat, what the dangers are and what they are not, so that you can have confidence in the situation in which you find yourself and in your own abilities. As a therapist you certainly do have the ability to deal with it.

Haronian: How much is hypnosis being used today by anesthesiologists, and how useful do you think it really would be?

Rodger: I think it would be of great value. I don't know how many are using it. Increasingly they are using suggestion and getting interested in semantics, which is very important, recognizing that patients are in a hypnoidal state and that this is a good time to use therapeutic suggestion. It is not nearly as widely used as it ought to be, and I am very much concerned about this. We are getting many more anesthesiologists coming to workshops, but many of them have the attitude "Oh I don't have the time to bother with that." You do get anesthesiologists who are drawn into this particular aspect of medicine because they really don't like to deal with patients as persons. They like the mechanical, the "Just knock them out and don't bother me!" attitude. That kind of person shouldn't do much with it, but they should recognize that their patients are in hypnoidal states, so that they can protect them.

Haronian: When you say "hypnoidal state" do you mean because of their anxiety about their operation?

Rodger: Simply because they are in a situation that is an unknown situation.

Haronian: Like suggestibility? (Rodger: That's right.) I've read that with a mild induction procedure most surgery patients can be given perhaps a tenth or a quarter of the usual anesthesia and in this way the likelihood of mortality because of anesthesia is obviated. Would you say that this is true?

Rodger: Yes. You can go all the way and use hypnosis only, but we don't usually, because we have such good anesthetic agents. It takes time to train a patient. There are really very few situations where you shouldn't use any anesthesia. But by minimizing the quantity, recovery is much better and there is much less physiological disturbance. It makes a balanced anesthesia.

Haronian: Your remark about the hypnotic state, the spontaneous hypnotic state, suggests that there is a timing possibility here. When you see that the patient is anxious and really focussed on the problem and highly suggestible, if you as an anesthesiologist come in with the right words, at the right time, there will be need for far less chemical anesthesia; the patient will be far more relaxed and will probably have far less post-operative difficulties as well.

Rodger: Yes; I use the time that I ordinarily spend with the patient. When the patient is on the operating table and I am setting up the intravenous, instead of carrying on a casual conversation I have a meaningful conversation. I tell him what to expect and give suggestions: "I am going to start an intravenous, I'll inject something in the tubing which will let you close your eyes and go into a lovely, deep, restful sleep. You will stay completely relaxed and you will be relaxed even when you wake up in recovery room. You need pay attention only when someone speaks directly to you. You will be surprised how much more comfortable you are than you thought you would be. Your body functions will be restored

very rapidly. I would like you to begin breathing very deeply - deeply and easily at about the rate that you usually do when you go to sleep at night. You can swallow and clear your throat." And then I add any specific suggestions for the particular situation.

Munroe: Do you use this with children?

Rodger: Oh yes, children are wonderful. You do not necessarily use verbal techniques; you can stroke a baby into a nice hypnotic state.

Cooper: Some researchers are working with pregnant women now, checking if there is a response to communication to the child in utero. One thing the anesthetist can do - especially in an operating room - is to be aware of side remarks, laughter and jokes the patient may "tune in" on, and tune them out with proper remarks. Likewise when they are in the recovery room, the anesthetist can make suggestions to avoid future difficulties, which could be most helpful.

Haronian: You are saying that the anesthesiologist hypnotist might give the patient suggestions that he will not hear what the doctors are saying while they are operating on him?

Cooper: Or if something happens in the room and you see the patient reacting, you can then bring in a counter suggestion immediately.

Rodger: When you tell the patients that they need only pay attention when someone speaks directly to them, it helps to tune this out, to tune out the voice of the surgeon - and suggestions for the control of bleeding and swelling, and so forth can be given. It works beautifully. Dr. Cheek told us of one patient he had who was going to have an operation that was not too difficult and they did not expect any difficulty. He had trained her with hypnosis. The anesthesiologist remarked to him as he came in at the door after scrubbing "I've ordered two pints of blood for her, I hope it's all right." Dr. Cheek recognized immediately that the patient would be likely to pick that up and said, "Well, it's all right, but I am sure we won't need them; patients who are cold never bleed." In the recovery room - it was a hot day and everyone else was perspiring - she was cold and shivering!

Cooper: You can get in some difficult situations when other physicians walk into a room carrying on a conversation on an entirely different subject and the patient will pick it up. As an aside, I remember - when I was an intern - a nurse anesthesist who would carry patients on pure oxygen. She thought that oxygen was an anesthetic; I found she was using a hypnotic technique.

Hilton: Dr. Rodger, as you know, the concept of the will is fundamental to psychosynthesis, and in the past - or before you spoke tonight - I had gathered that the general understanding was that hypnosis tended to weaken the will of the patient; (Rodger: Not at all!) but you seem to be practicing a sort of selective - if I might use the word - a selective hypnosis which still leaves unaffected the will of the patient.

Rodger: When you attach an emotion to an idea, a suggestion, it can be carried out much better. When the will and the imagination are in conflict, the imagination wins every time. So, connect them and use it for reinforcement or power; and that is exactly what we are trying to do. It strengthens it very greatly.

Cooper: In essence, the will is standing aside, observing and watching the particular show. The use of imagination in moving to a safe place, a closet, a room, a warehouse, reduces the will-imagination conflict.

Hilton: So you can use your hypnotic techniques to strengthen the will of the patient?

Rodger: I think you see this in the ego strengthening technique of Dr. John Hartland showing a patient how to add imagination to what they desire, to do what with their conscious will they decide they want to carry out. You see this in helping people to give up smoking. So often the more determined you are to do something the sooner you reach a point of no return where you simply cannot do it. The harder you try the less you succeed. You reach a point of no return just the same as you do with physical exercise if you do it too much. So by going around that block, you can go on your way.

Hilton: In the technique of the positive and the negative clenched fists were the patients in a comparatively light hypnoidal state when this was presented to them?

Rodger: It can be just a light hypnoidal state or a light or medium trance state. It doesn't make much difference. (Hilton: Not deep hypnosis?) Well, they may be in a deep state; it doesn't matter, for individual people respond in different ways and as you work with a patient you discover how he is responding. The only difficulty with a deep trance state is that sometimes the patients seem to get a little bit slow. There is a bit of lag, so I have to waken them up a little to speed things along. I don't have that much time.

Bailin: Have you been particularly successful with that "don't try too hard" with smoking, or hypnosis; or have you found any other techniques particularly successful?

Rodger: There are a number of techniques and I think for most people you have to call out the whole barrage. Some people come to you just ready and simply need your encouragement, to have someone working with them and caring enough about them. Other people are really up against it due to some deeper thing and you have just got to show them ways to deal with stress, and ways to displace the satisfaction that they have attached to smoking - imaginative ways and so forth.

Incidentally, I would like to thank Dr. Assagioli very much for that "Dis-identification" technique - "I have a pain but the pain is not myself" - it works wonders with pain.

Haronian: Do you use it with a hypnotic state?

Rodger: Or just in talking with a patient.

Mrs. Hilton: Do you find the patients will accept that?

Rodger: Yes, indeed they are startled to find that "Why, yes! This is true!" and it gives them a marvelous feeling of freedom.

Haronian: Then you are saying that the hypnotic procedure does help the patient to attain a sense of himself, of his self?

Rodger: Yes, he discovers that there is much more to himself than he had any idea. He can gain control of something. He gains control of some little thing, and then gains control of something else. As you point the way, he goes on. It's something like music: you sing somebody a tune and you may sing it too low for me but I can transpose it to a higher key without knowing harmonics, I just do it. I show the patient how to do something, and he can transpose it for his own needs. I purposely teach my patients in this fashion, to give them an idea that they can use it, and then they go ahead with it.

Cooper: It seems to me that we can "strengthen" the will if we reduce the negative effects of imagination, and neutralizing imagination in this way will thereby allow the will free play.

__?__: I'd like to say something about pain. At the age of 10 I had migraine headaches every two or three weeks and it has bothered me most of my adult years. I had had all sorts of tests, going from one doctor to another. . .and then one week-end I was so sick I decided I would put the pain "somewhere out there", and that it could not touch my center. And I think that I only had four or five migraine headaches after that, and I haven't had any for about ten years. It was connected with this decision about pain. (Rodger: Yes, dis-identifying from it.) Yes.

Cooper: Disidentifying and becoming aware of the part of your body that doesn't have pain will activate the "over riding" mechanism of the thalamus, bringing relief from the painful stimulus.

Rodger: Speaking of migraine headaches we use "time distortion". Rather than take away something - I have no right to take away pain from a person; it is his pain. I can help him to give it up but I cannot take it away. It may be serving some purpose that I don't understand. So I can say to a patient: "You can have your migraine headache whenever you need it but wouldn't you like to have it at a time that is convenient for you? Use your own personal time. When you are aware that you are probably going to get a migraine headache, find some place where you can be by yourself. Settle down and go into a nice trance state the way I have shown you, and have your headache. Have it as long as you need it, as intensely as you need it. Have it for hours if you need it or even for days - and be very, very surprised to find that it's only three to five minutes by the clock and you find yourself rested and refreshed!"

(Questioner unknown:) Are all the operators equally skilled in this technique?

Rodger: There is tremendous variation - as much variation as there are persons who use it. And there is some very poor training in hypnosis. Anyone interested in it should be very very careful where they get it. There are not too many places where you can get any sound training. There are a few universities who are sponsoring courses for physicians, dentists and psychologists; but the courses offered under lay sponsorship - the ones like the Institute of Hypnosis - are very unfortunate. Incidentally, I am not sure of the name of it, but there is an institute of hypnosis here in New York, and I was not speaking of that. I was speaking of the one at which Bryant is the head because one gets literature from this all the time and I would just like to give you a warning on this, because I think it is important.

Cooper: I think the answer would be that hypnosis is a tool or method of communication and at the level of interpersonal relationships. It is a definite skill and requires attention to one's own capacity to communicate and react objectively to the patient.

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