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The long and winding road from concept to practice:
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THE LONG AND WINDING ROAD
FROM CONCEPT TO PRACTICE:
The Intersubjective Shaping ofPsychoanalytically Informed Technique
in Contemporary Hypnosis—A Commentary
Upon and Extension of Baker's "Reflections
on the Hypnotic Relationship"

MICHAEL J. DIAMOND

I am delighted to comment on Elgan Baker's theoretically rich and clinically inviting paper (Baker, 2000 [this issue]). I have considerable admiration and respect for Dr. Baker, both as the theoretician as well as clinician who has arguably done the most to integrate into contemporary hypnosis so many of the great contributions stemming from the object relations as well as ego psychological schools of psychoanalysis. In this article, Baker is once again gently tweaking those in the clinical and research hypnosis fields to seriously consider the limitations of our working paradigms, and, in turn, to follow the lead of our psychoanalytic brethren in the midst of their radical paradigm upheaval.

Readers who are familiar with my work know that I am in complete agreement with Baker's intent, particularly as it pertains to examining the interactive nature of hypnosis in the clinical domain (see Diamond, 1984, 1987, 1988). Likewise, I maintain, along with Baker, that Winnicott's ideas regarding transitional phenomena and space are applicable to a deeper understanding of both trance experience itself and the subject-hypnotist (or client-therapist) interactive matrix. Moreover, I strongly concur that the relationship factors that Baker emphasizes (containment, attunement, and projective identification) have not been sufficiently considered in the hypnosis literature and, indeed, serve well to remind us that hypnosis requires a "two-person" perspective, as well as the more traditional "one-person paradigm of hypnotic experience."

For the most part, Baker is seeking to articulate and carry further the ideas that his own original and innovative clinical contributions are founded upon (particularly when he applies the aforementioned ideas to specific structural pathology). Baker tries to integrate his more intersubjective conceptualizations into the interactive, relational actuality of

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the hypnotherapeutic process by providing a case example. However, as I hope to elaborate, the long and winding road from concept to clinical application is not so easily traversed and, thus, Baker's important ideas unfortunately remain too far removed from the experiential realities of the clinical domain. I will, therefore, try to provide the kind of clinical data that I believe is necessary to carry Baker's intersubjective reflections more directly into our clinical encounters. In this respect, I hope to add to Baker's theoretical contribution by rendering it more clinically alive and therefore technically meaningful. Before doing so, however, I shall place Baker's effort in historical context.

**Baker's Reflections in Context: Postmodernism, Psychoanalysis, and Hypnosis**

In essence, Baker's article represents the application of the postmodern project of deconstructing enlightenment-era myths and ideals of scientific objectivity to clinical hypnosis (see Flax, 1990). This project has already spurred a renaissance in psychoanalytic theorizing, and Baker has taken up the gauntlet laid down by postmodern critics, hermeneutic scholars, and social constructivists. This fresh perspective has informed contemporary psychoanalytic therapy in terms of redefining the asymmetry of the therapeutic situation. As a result, Roshomon, in becoming the new cultural symbol of psychoanalysis, has replaced more archaeologically based images and myths that represent notions of historical truth. This redefinition of the therapeutic dyad has been cast as an intersubjective, interactive, reciprocal, and mutually informed relational process, whereas the plausibility of objectivity, anonymity, and neutrality has been seriously challenged from a dialectical position (see Greenberg, 1995; Goldberg, 1999).

Baker's ideas are rich, dense, and provocative, although I am afraid that because they are overly heady, they are not so easily translated into practically useful principles of hypnotherapeutic technique. Others have suggested that this is a problem with much of postmodern theorizing, in that its insights tend to be wrapped in highly abstract and abstruse philosophical formulations, which aren't easily accessible to clinicians (Bader, 1999). I do not believe that this is inevitable, but rather that it is most likely when the writer deviates too far from the give-and-take of the clinical dialogue and the actual "data" of the clinical process. In this respect, we all need to strive for a more down-to-earth, experience-near language in communicating our complicated psychological theories.

The best way that I know of achieving this technical intent is through a detailed presentation of the actual exchanges (verbalized and otherwise) of the two people involved in treatment. In fact, I submit that analytically informed, relational understanding of the clinical process demands a revised methodology and presentation of clinical data. This is not an
easy task, and Baker hardly stands alone in this oversight (I include myself herein in most of my own writings as well as nearly all others writing in the field of therapy, especially hypnotherapy). This exclusion of the most valuable clinical data of all—namely, the interactive, intersubjective dialogue and experience of each participant in the therapeutic dyad—severely restricts our understanding of the treatment process, while ordinarily causing our constructs to remain at a level of abstraction that is not particularly clinically meaningful. Of course, to present clinical work in its full intersubjective sense requires both a courageous act of self-disclosure on the therapist’s part and the overcoming of resistance to change by shifting our typical standpoint as to one’s own therapeutic authority and expertise.

The Intersubjective Basis of Hypnosis: Learning From Psychoanalysis

Despite this noteworthy omission, Baker has nonetheless offered a persuasive argument for the inherently interactive, intersubjective basis of hypnosis. Interestingly, Aron (1996b) has recently deconstructed Freud’s renunciation of hypnosis and concluded that his shift away from hypnotism was a result of his wish to learn from the patient in a way that he wasn’t able to when he was doing all the talking as a hypnotist. Freud essentially was seeking an understanding of his patient’s subjectivity that he couldn’t obtain through the authoritarian methods of hypnosis at his disposal. Today, we are witnessing a veritable paradigm shift in the therapeutic realm by dint of the fact that the subjectivity of both patient and therapist—the intersubjectivity of the therapeutic dyad—is deemed essential for generating effective interventions.

Baker’s contention that the experience of hypnosis can be better grasped as it arises from an interactive space parallels the postmodern insight that the analytic situation allows for mutual, optimal levels of alterations in consciousness for both members of the analytic dyad. Moreover, the “individuality” of the therapist is understood as an essential force in shaping the experiences of both participants in treatment (Aron, 1996a). Baker claims that a “two-person paradigm of hypnotic experience,” informing both our research and clinical work, is necessary to understand “the core mutuality” of the living, hypnotic process. This process of shared and coconstructed experience is, according to Baker, driven and framed by the three relational dynamics of containment, attunement, and projective identification. Although he doesn’t discuss more fully the domain in which these relational factors are played out, Baker, like his contemporary analytic colleagues, clearly recognizes the impact of each as it arises in the therapist’s countertransference, the mutual enactments that necessarily occur in any intensive therapeutic field and the specific contributions made by the therapist’s personal subjectivity.
Clinical Applications of Baker's Relational Concepts

At this point in our history, “technique lags behind conceptualization” (Greenberg, 1995, p. 12). Baker has written this paper to address the fact that the implications of an intersubjective, interactive model of the hypnotic process have not been well integrated into our thinking about clinical method. In considering then what we can learn from Baker’s article that might be helpful to us clinically, I would suggest that we must begin by acquiring more of a feel for the atmosphere of the hypnotherapeutic engagement. Specifically, we need to have a sense of the hypnotherapist’s subjectivity, as well as the patient’s subjective experience of the hypnotherapist’s interventions (including the specific hypnotic techniques and suggestions). How else can we possibly appreciate what is actually being coconstructed in the hypnotherapeutic transitional space? How could we otherwise understand what is actually happening in terms of the relational dynamics of containment, attunement, and projective identification? How can we possibly appreciate how a skilled clinician comes to formulate the specific hypnotic interventions employed unless we know his or her internal experience of the therapeutic process? And, how might we come to appreciate the complexity of the interactive matrix of the hypnotic experience without such data?

Unfortunately, as we read Baker’s clinical vignette, we are plunged back into the “one-person paradigm of hypnotic experience” where once again the therapist is considered the sole authority in deciding the meaning of the patient’s responses as well as of his or her own interventions. This is in stark contrast to the thesis offered by Baker, wherein the hypnotherapist’s and patient’s dyadic, intersubjective experience is regarded itself as being at the core of the therapeutic venture. Baker fails to illustrate the nuts and bolts of his thesis as to how the relational constructs operate in the real-life, give-and-take moments of hypnotherapy and how a particular hypnotic intervention emerges out of this relational space. In contrast then, I am insisting that what is needed is a good example of the two-person ontology that organizes the intersubjective process. In other words, we must examine, or at least speculate upon, the internal processes of both participants as well as their external manifestations as they are at play in the hypnotherapeutic space.

I will therefore conclude my discussion commentary by returning to Baker’s case example and this time try to contextualize it intersubjectively. To do so, I will, of course, speculate and undoubtedly vary considerably from Baker’s actual case in order to create a clinical illustration of the interactive nature of the hypnotherapeutic process. Naturally, I will be using my own subjectivity throughout and thereby rely on my understanding of the created patient’s experience as accrued through my clinical work, supervision, and personal experience as patient and therapist.
In short, I hope that this endeavor will prove useful for clinicians who wish to extend Baker’s significant relational ideas into practice.

So, how might this two-person exchange look with Sophia, the 27-year-old patient with borderline features?

An Intersubjective, Hypnotherapy Vignette: A Revised, Hypothetical Case

Relevant background information. Sophia had been particularly troubled by her therapist’s (Dr. Generic’s) upcoming vacation and had, in the therapist’s view, been fragmenting in response to the impending separation. Sophia and Dr. G. agreed that she had been very emotionally labile, was dissociative, and had been acting out impulsively through excessive drinking and angry outbursts at work. In this session, Sophia was presenting herself as rather confused and stated that she wasn’t sure if she “was actually inside [her] own body.” The therapist was quite concerned about her and felt anxious about leaving her for two weeks (although he had another therapist covering for him).

Note to Readers. It is at this point that we’ll pick up on the actual clinical process as well as the specific hypnotic intervention. Of particular importance is the presentation of the internal, nonverbalized subjective experiences of both participants, along with a few notations stating the relational constructs in play. The actual dialogue as well as observable behavior between Sophia and Dr. Generic is advanced in standard font on the left while the subjective experience of each is italicized on the right. In addition, several relational constructs are briefly noted on the right column in boldface to more fully link the clinical data with Baker’s theoretical ideas.
**The Intersubjective, Clinical Process of Therapist and Patient**

<table>
<thead>
<tr>
<th>Observable Clinical Process (Primarily Verbalized)</th>
<th>Subjective Experience of Patient and Therapist as Well as Pertinent Theoretical Constructs</th>
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<tr>
<td>Patient/Sophia: I can't stand thinking about your leaving me alone. Why do you have to go off knowing how crazy I become when you aren't around to help me? Last night, I totally spaced out—I came to around midnight realizing that I had polished off nearly a bottle of wine and apparently had lost all sense of time. It really scares me when I do that, and I start feeling very fuzzy about everything. Please help me with this.</td>
<td>Sophia was also thinking and fantasizing about losing herself completely...perhaps cutting herself on the wrists or gorging on junk food as she had in the past to hold herself together. The thought of cutting her wrists began to seem peaceful and rather (self-) hypnotic for her to think about. She imagined herself disappearing and not having to feel anything. Then she suddenly began to feel very angry towards Dr. G.—how could he care so little about her? Why would he leave now? &quot;Oh, fuck him,&quot; she thought, &quot;He is not so special, and I can certainly find someone better to help me. Maybe,&quot; she continued, &quot;I can even find a new and better therapist while he's away entertaining himself and his family. That would show him!&quot; But then Sophia realized that she cannot survive without him. She began to feel very trapped—she needed him but hated him and wanted him to just disappear. &quot;Oh God,&quot; she thought, &quot;please help me... please, I am desperate.&quot;</td>
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Feeling very put upon by Sophia’s angst, beginning to feel very tight in his chest, and thinking about his upcoming vacation to the Caribbean. . . . “God,” he thought, “why does she have to be falling apart now. I need a vacation badly. Things have been difficult enough the last few months and she has absolutely no idea about that. Oh, I feel so much pressure. What can I do to help her? I am afraid she could really do damage to herself this time. The spacing out and drinking is scary. I need to get some perspective here. I feel like I am falling into some kind of tornado myself, and I doubt that I can help anyone right now. I better say something soon though. I can’t just let Sophia sit in all this chaos.”

NOTE: Dr. G. has projectively identified with Sophia and is now trying to find some way to contain them both.

Dr. G. felt that what he had said seemed kind of lame, even trite, but, nonetheless, he knew something had to be said and at least he didn’t “disappear” himself.

“You know something Sophia, I believe that you really do feel like you need my help in holding you together. Damn right, I do.”

“Duh!” Sophia thought, “Does this guy have any idea what he’s doing? Can he help me at all? Come on, Dr. G., you can do better than that!”
Dr. G.: (gazing downward) Sensing that Sophia seemed quite angry and feeling his own anxiety as he anticipated being criticized, Dr. G. then had an image of Sophia as a starving little girl in torn clothing. He thought about her now as being very "hungry" for something, though not sure what it might be nor what to do about it. He began to feel pressured and demanded upon, and he hated feeling that way. He became concerned that Sophia would pick up on his feeling uptight with her, even a little frightened of her.

NOTE: Another example of the projective identification process and an opportunity for the therapist's attunement to his patient's state of mind.

Dr. G. began to be very concerned about Sophia's reading him and knowing how disturbed he was becoming. He thought about whether or not he could let her know and then said to himself, "No, I had better not—I am afraid if she knows that I'm so agitated and confused, she'll really go downhill. So, I'll contain myself—fake it if I have to. Is that a good idea? I'm not sure, but I think she really needs to know that I am not like her mother, ready to fall apart whenever Sophia became distressed.
Yes, I understand that you need my help now, but I'm not yet sure just exactly what it is that you seem to be needing from me. I do believe though that it is important for me to find out and see if I can find a way to help you.

"Whew, that is true!" he thought, "I sense that Sophia is really afraid of something right now (beneath her angry protectiveness), though I am not sure what it is. Still, I think she can appreciate that I am trying to feel along with her right now."

NOTE: Dr. G. was well attuned to Sophia's needs for containment.

Dr. G. wondered whether he was terrified of her anger at this point or just worried that she might fall apart if he failed to intervene sufficiently. He mused to himself about the possibility that perhaps Sophia's anger actually serves to hold her together. Then he began to notice himself drifting off, away from her, and brought himself back as he realized he couldn't really stray too far in his own associations. He thought that he wasn't very clear about what was going on, but he was certain that he needed to do something.

NOTE: Once again, partially as a result of his skill in making use of his own subjective experience of the projective identification, Dr. G. was attuned to Sophia's needs for containment.

Sophia: Nothing is happening here, and I am starting to think I am just going to fall into a void.

Sophia: Nothing is happening here, and I am starting to think I am just going to fall into a void. After initially feeling some relief when Dr. G. spoke to her, Sophia noticed that she was getting more and more afraid. She then thought, "This is nowhere. This is bullshit. He can't help me. Why won't he do something? I am scared that something really bad will happen."
Dr. G.: (silently reflecting to himself) "Wait a minute," Dr. G. thought, "Now I remember how she loses the sense of me as someone helpful to her when she's upset with me, particularly when we have to separate. Like last Christmas when I was away. Hmm, I wonder if I am (projectively) identifying with her lost self-object? I bet I am and that she needs to find that good internal object once more. I think perhaps that hypnosis would be helpful at this point. It sure has been helpful at other times when Sophia loses all sense of me." Dr. G. then imagined a kind of body envelope that he placed around Sophia that could hold her together and help her to feel safe again.

NOTE: Dr. G. was continuing to use his own subjective experience of the projective identification, this time in the form of his imagery, to develop a means to contain Sophia's terrifying affective world.

Sophia: (a small smile appearing on her mouth) "Oh," she thought, "that might be very good. I didn't even think of that. It usually feels great when Dr. G. hypnotizes me. I feel so cared for, so understood. Like in a womb even. He always seems so caring when he puts me into trance." Sophia then recalled her grandfather putting her to bed when she was a young child and telling her bedtime stories. A warm smile came over her insides as she felt her love for her "Grandpa" and felt sad when she realized that he had died at the very time when she still needed him so much.
OK, fine—let’s do some hypnosis.

Dr. G.: Very well. Let’s use the induction that has been so helpful before.

Sophia: I’m ready. Let the hypnosis begin!

Dr. G.: Imagine the wave beginning at the top of your head, just allowing it to drift through your body, and then slowly, through your mind. Waves of warmth, relaxation . . . and as I count down from 10 to 1, you can allow yourself to go once again into that safe, calm, and restorative place.

10 . . . 9 . . . 8 . . . 7 . . . 6 . . . half way, more calm, more relaxed . . . 4 . . . 3 . . . 2 . . . 1 . . . letting yourself be in that space, with yourself, quiet, relaxed, and calm as you need be.

NOTE: Here, Sophia and Dr. G. have begun a mutual attunement process involving the projective identification of a safe, warm, and contained relational space.

Thinking of the wave of relaxation that they’ve used together and his counting her down from 10 to 1.

“Oh, I love that wave,” she thought as she began to just let her body relax while settling herself into the couch. It seemed so freeing to even anticipate closing her eyes and letting herself go with Dr. G.’s strong presence in the background.

Dr. G. began to feel more relaxed himself, anticipating his own internal alterations as he lets himself accompany Sophia into a kind of mutual trance, where he can feel more relaxed and centered on Sophia.
Sophia: (reclining with her eyes closed and her breathing becoming louder and more rhythmic)

Dr. G.: Now . . . Sophia, while remaining relaxed and quiet, focus your attention on the feelings in your feet. Note if they feel warm . . . or heavy . . . or tingly. Compare the sensations in your right foot to your left.

Sophia: (grimacing slightly though continuing to appear very relaxed)

Dr. G.: Good. Now picture an image of your feet in your mind’s eye; each foot firmly connected to the rest of you.

Feeling calmer and quieter inside as she thought, “It is so nice . . . like coming home . . . How do I lose this place so easily?” Sophia imagined herself running on the lakefront, feeling the wind blowing in her face, and Dr. G.’s voice felt soothing and warm, like sounds coming from a piano played on a warm summer afternoon.

Noticing Sophia’s responsiveness and enjoying seeing the tightness of her face loosen while thinking how pretty she is when she can allow herself to soften and safely open up. Dr. G. remembered again why he liked working with Sophia and felt good about being able to be helpful to her.

Going along with Dr. G.’s suggestion, although thinking to herself, “This is kind of boring. I really don’t like comparing bodily sensations. I wish we could go somewhere else.”

Assuming that Sophia was tracking along with his suggestions (and not aware of her subtle facial grimace).
Sophia: (her facial grimace dissipating and, again, a small smile appearing)  

Thinking, "Yuck, I hate my feet. But I see them in my mind's eye. I see them now like when I have just showered, dried them off, and manicured them. They look pretty. They are connected to my body and are nicely shaped."

Dr. G.: Can you imagine them there?  

Dr. G. thinks, "Sophia and I are together on this, at least I think that we are... but I am not sure so I had better check to see where she is internally."

NOTE: Dr G. is trying to ensure that he is attuned to Sophia and that she is being sufficiently contained in the transitional space of the hypnotic state.

Sophia: (nodding in response to Dr. G.'s question)  

Thinking that she can indeed see her feet there along with her body.

Dr. G.: Good.  

"We are together in this," he thinks to himself while visualizing the very image he suggested to Sophia.
Now I want you to move your attention back and forth from the sensations in your feet to the image in your mind while focusing on how my voice sounds just the same and my presence feels just as near regardless of the focus of your attention.

Sophia: (a very peaceful look on her face)

Dr. G.: Some aspects of your experience will change while others stay the same, and that can feel comforting, soothing and secure.

Sophia: (her eyes fluttering slightly as she moves her position in her chair)

Thinking to himself of the importance of helping Sophia to better establish some kind of object constancy wherein a caring other can continue to basically remain consistently there for her despite the emotional turbulence going on inside of her. Soon, Dr. G. sadly began picturing Sophia as a small child being very angry when her mother would virtually disappear into her own all-consuming depression, and simultaneously Sophia would begin experiencing her anger toward her unavailable mother as making her mommy go away.

Picturing the images of her feet while hearing Dr. G.’s voice as very soothing in its caring and protective strength.

NOTE: Here we see a poignant example of therapist-patient attunement.

Thinking to himself about his comings and goings to and from the treatment, wondering if Sophia can still know that he is the same person, knowing that in fact he is mostly present for her when he is with her, despite the emotional changes in both his own and her experience of one another.

Imagining her body as sometimes feeling light, sometimes feeling heavy, then remembering how Dr. G. sometimes looks tired, sometimes looks refreshed and light. Sophia next felt a wave of love toward Dr. G. and toward her own boyfriend, who she realized basically did love her and want the best for her.
Dr. G.: Just focus heavy... picture your feet... warm... picture the right and the left... tingly... a feeling in your body and an image in your mind can be experienced together just as you and I continue to be together in this room.

Sophia: (becoming tearful and pulls out a Kleenex to wipe her nose)

Thinking about saying something to further assist Sophia to integrate more of her bodily sensory awareness with a sense of her own identity, along with the holding, steady presence of himself in empathic attunement to her.

Closely following along with Dr. G.'s suggestive, evocative images and imagining herself as one complex set of connective tissues, bones, and skin while picturing herself with Dr. G. in his office. Sophia felt very good and had the thought that this experience was very healing for her. She noticed that she no longer was feeling terrified and could even imagine Dr. G. relaxing himself on a Caribbean beach while she got along very well herself during the upcoming break from therapy. Another expansive smile seemed to come over her insides and she let her breathing carry her along further to what she noticed was a calm and yet aware state of mind.

Dr. G.: (a caring smile appearing on his face and becoming slightly tearful himself)

Noticing how good he was feeling toward Sophia, and aware that his own state of mind had changed considerably during the trance work, particularly as he was now feeling that Sophia would be alright during the forthcoming break from therapy. He then realized that he would need to find out more about Sophia's inner experiences during the hypnosis work, yet he felt quite certain that something important had shifted.
CONCLUSION

This is a good place to end my commentary upon and extension of Dr. Baker's important article. By including this intersubjectively based, micro-level process dialogue, it has been my intent to lead the reader toward a deeper comprehension of, as well as an advancement in clinically applying, the fruitful relational insights delivered in Baker's work. In particular, I have sought to provide the kind of clinical data that will facilitate technical understanding among both clinicians and researchers alike as to the intersubjective, relational bedrock underlying the shaping of psychoanalytically informed hypnotic interventions.

REFERENCES