Accessing the Power in the Patient with Hypnosis and EMDR

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Both Ernest Rossi’s ideodynamic accessing model of hypnosis and EMDR are intended to access information stored in the mind-body system. In this paper the author is suggesting that treatment effectiveness can be enhanced by combining these particular models. The similarities and the uniqueness of each method, both theoretically and in terms of the different protocols, are compared to provide a rationale for combining them. Verbatim examples from clinical cases are presented to demonstrate exactly how these models can be usefully combined in clinical practice.

Introduction

In his book, *The Power Is in the Patient*, Robert Goulding proposed that “the therapist’s real job is to allow the patient to find his own power and to put that power to use” (Goulding & Goulding, 1978, p.10). Irrespective of the diagnosis, a significant question for the therapist’s consideration is: Which technique(s) will best help the patient to find his or her inner power?

Sometimes it is our patients themselves who give the best descriptions of the empowerment process. For example, one patient reported that between sessions she had “become aware of another voice” which she associated with a picture of a part of an iceberg below the water; this part seemed to her to be a deeper and more pervasive part of her identity. She said that what the voice tells her about itself is that, “it’s always been there and is eternal.”

She also said that, at the same time, she became aware that, “When I come in here I become very much more eloquent, and I think it’s that part, the eternal witness part.” This patient’s words suggest that finding the inner power within each of our patients can be a question of, “Which technique will allow each person to become more articulate or, perhaps, even eloquent, in accessing healing power from his/her deeper and more pervasive self?”

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Though there may be many suitable therapeutic interventions for accessing patients’ inner resources, the remainder of this paper will focus on two specific therapeutic tools, hypnosis and EMDR, and on using these tools together to capitalize on the potential of the mind-body connection for achieving therapeutic change.

First, I will discuss hypnosis and the use of ideodynamic movement, and then, I will describe the underpinnings of EMDR and the protocol for its use. Finally, I will compare these methods, discussing how to choose which method to use first and when and how to combine them. Clinical examples will be presented to illustrate the choice point and the power of using both methods in combination.

Describing Relevant Aspects of Hypnosis and EMDR

Hypnosis and Ideodynamic Movement

Unlike EMDR, a method that became available in the past decade, hypnosis has a long and established history. The example of hypnosis to be presented here is an ideodynamic accessing model described by Ernest Rossi (Rossi, 1986; Rossi & Cheek, 1988; Rossi, 1992). Rossi’s model reflects a strong belief in the innate healing power within the patient and provides excellent examples of indirect and naturalistic induction (Rossi, 1986; Rossi & Cheek, 1988). Rossi’s ideodynamic accessing model of hypnosis meets the goal of facilitating the patient’s own resources toward mind-body healing. His method is based on the hypothesis that the arousal that leads to hypnotic problem solving will naturally be followed by a period of calm that facilitates ratification of the therapeutic work. Rossi’s hypothesis includes a comprehensive discussion of how this process works. He describes an intricate mapping of how body chemistry shifts, one substance following another, as information bearing molecules travel through four major mind-body systems: autonomic, endocrine, immune, and neuropeptide (Rossi, 1986, p. 99). This information exchange is modulated by the limbic-hypothalamic system, to the rhythm of ultradian cycles. The ultradian cycles are 90- to 120-minute rest-activity cycles that govern “a variety of biological processes as they occur during the day and in cycles of REM sleep during the night” (Rossi, 1986, p. 133).

Rossi’s comprehensive theory of psychobiology postulates that mind-body healing in hypnosis occurs through communication at the genetic and cellular level. In fact, Rossi has cited research that even offers tentative evidence for the hypothesis that hypnosis may even be shown to facilitate neurogenesis (Rossi, 2000). He speaks of therapeutic hypnosis as “processes of accessing and utilizing state-dependent memory, learning, and behavior systems that encode symptoms and problems and then reframe them for more integrated levels of adaptation and development” (Rossi, 1986, p. 204).

The particular ideodynamic accessing model discussed here, the “moving hands” induction, starts with a suggestion for the occurrence of ideodynamic movement. As the patient becomes entranced, indirect and naturalistic suggestions are made while observing the patient’s unique hypnotic movements or while commenting on the patient’s verbalizations.

Rossi speaks of the moving hands technique as encapsulating the three stages of any therapy: signaling readiness for inner work; reviewing the problem; and resolving the problem. The therapist uses the patient’s focus on ideodynamic movement to facilitate hypnotic phenomena. As the patient observes his/her own ability to generate an overt behavioral signal, the patient can become more aware of his/her own creative resources. The technique then lends itself to a very flexible protocol as the therapist observes and, with nondirective suggestion(s), encourages the patient’s movement through the therapeutic stages.
The standard format for this “moving hands accessing of creative resources” (Rossi & Cheek, 1988, p.39) is to ask the patient to place his hands facing each other at chest level, six to eight inches apart, and to focus on the sensation of magnetic energy that develops in the space between the hands. The patient is then instructed to ask the Inner Self whether or not it is all right to explore the problem at hand with the suggestion that the hands can pull together for a “yes” signal or push apart for a “no” signal. Once the hands begin to move together to indicate readiness to explore the stated issue, the therapist suggests that as the unconscious mind begins to review the sources and manifestations of the stated problem, one of the hands can begin to float down to indicate that the review is underway. The suggestion is given that this hand will come to rest as an indication that the review is complete. As the first hand comes to rest, the therapist suggests that the other hand can begin to float down to indicate that the patient’s unconscious resources are being accessed to resolve the problem. The therapist then recommends that the second hand’s coming to rest is a signal of a satisfactory resolution of the problem. The wording of the suggestions can vary depending on the shared knowledge between patient and therapist about the problem; the exact phrasing is also determined by the patient’s reactions to the experience. For instance, during the resolution stage of a conflict that is long-standing, I often say something to the effect of, “When that hand comes fully to rest, that will be an indication that the resolution of this problem has begun in such a powerful way that you will be able in some way to notice, and the process will continue in the hours and days ahead until the problem is fully resolved in a manner that is congruent for all the parts of the mind, the conscious and the unconscious.”

A variation in the standard format

My own variation to this method has proved effective for rapidly engaging both children and adults. I introduce an element of fascination to the moving hands induction by first presenting an Energy Ball (Safari Limited) for the patient’s examination. The Energy Ball is a ping-pong ball that lights when held in the palm of the hand. It looks like an ordinary ping-pong ball except for the addition of two small strips of metal that conform to the surface of the ball. These metal strips are battery terminals. Inside, the ball is equipped with a small battery that powers light and sound effects. The version of the Energy Ball I am currently using begins to flash a red light and to emit a continuous high-pitched electronic sound that has a varying pitch when the terminals are connected. I ask the patient to make a cup of his or her hand. I place the ball in the cupped hand and, when the ball is lighted, ask the patient to tell me what is happening. The effect of this is that the patient becomes very focused and is usually entranced. In this state, even very logical professionals offer quite childlike explanations to my question of what is happening to activate the ball. One very cynical, 40-year-old man began to laugh and said, “My whole arm is tingling and it makes me feel happy.”

As the patient experiments with lighting the ball, I talk to him or her about the reality of autonomic or unconscious energy in the mind-body and how this energy is being transduced to light the ball. I explain that I am going to demonstrate a way to use this inner energy force for healing. It is at this time that I invite the person to place his hands according to the Rossi protocol and to focus on the energy in the hands, thereby introducing the “moving hands” technique.

Eye Movement Desensitization and Reprocessing

Francine Shapiro (1995), the originator of EMDR dates the inception of EMDR as a method to 1987. In teaching EMDR, Shapiro has said, “EMDR is a dance with the client in the lead. If you stay with it, poetry emerges regardless of educational background, a miracle unfolds” (Shapiro, 1995).
Allowing the poetry to emerge is one metaphor to describe the process of accessing the power within our patients. Despite the fact that the therapist is leading the eye movements, it is clear that the method is designed to follow the patient’s lead in accessing material. To emphasize the importance of following the patient, the EMDR trainee is taught to refrain from reflecting or re-stating the patient’s descriptions of his experience, and to simply encourage the patient to notice his experience and express the observation of that experience in his own words.

Shapiro (1995) views EMDR as a specific method within a general Accelerated Information Processing model. She describes the process accessed by EMDR in terms of connecting “neuro networks” (Shapiro, 1995, p.29.) Neuro networks is a term coined by Shapiro to avoid using the term, neural networks. Shapiro makes it clear that she is intentionally using a term without “a precise neurological referent...to underscore the point that the efficacy of EMDR is not based on the validity of the physiological model being offered” (Shapiro, 1995, p.29). Shapiro maintains that the concept of neuro networks is used as part of a working hypothesis to help explain how EMDR “can be used to gain access to and have an impact on material that is dysfunctionally stored in the brain” (Shapiro, 1995, p.28).

Shapiro (1995) likens the material that the patient needs to access to a train being stuck on a track or having no track. EMDR is viewed as the means for getting the train moving. She also uses the metaphor of a blocked channel that needs to be cleared so that information can move down the channel and toward adaptation. The process is considered to be a comprehensive way of resolving emotional problems. As the original channel is opened, content related to the originally targeted material often emerges. This part of the process is conceptualized as accessing feeder channels to allow the entire experience to be processed.

Shapiro recommends incorporating EMDR into therapy through the use of a clearly defined protocol with eleven standard steps (Shapiro, 1995, p. 217). After appropriate introduction to the method, the problem is targeted. Specifically, this entails the therapist helping the patient to determine the exact problem and to visualize an image that encapsulates either the whole problem or the worst part of the problem. This image becomes the representation of the problem and the starting point of the EMDR processing. Thinking of this target image, the patient is asked to state a Negative Cognition (NC), using the first person pronoun. The NC is a negative belief about the self that is expressed in the image; it is almost like a caption to the picture. For instance, in one of the clinical segments here the negative cognition (though not formally derived) was, “I really am different in some terrible way from everybody else.” Common negative cognitions include such beliefs as: “I am not lovable;” “I cannot protect myself;” and “I am inadequate.” The patient is then asked to create a Positive Cognition (PC), a belief he/she would rather have about the self, and to rate how believable the PC feels on a Validity of Cognition (VoC) scale of 1 to 7 (where 1 is completely false and 7 is completely true). The next step is to identify the emotions that are aroused when the image is brought to mind and to rate the distress level of these emotions on a Subjective Units of Disturbance Scale (SUDS; Wolpe, 1956) of 0 to 10 (where 0 is no disturbance and 10 is the highest amount of disturbance experienced). The patient is then asked to do a body scan to identify where in the body that disturbance is felt. When the patient has identified the image, the NC, the emotional disturbance, and the location of the sensation, he/she is asked to hold these aspects of the problem in mind. This is the target. At this point eye movements (EMs) are initiated by the therapist, who asks the patient, now focusing on the target, to follow, with his eyes only, her movements. She then moves her hand in a series of sweeps at an agreed distance in front of the patient’s eyes. There are variations of this standard procedure that include using left/right movement of light on a light bar, left/right
auditory stimulation, and left/right tactile stimulation as substitutions for the standard procedure of left/right visual stimulation.

Using the standard EMs, Shapiro recommends that the therapist use an initial set of 24 complete back and forth sweeps as a test of how the patient responds, and then direct the patient’s EMs as seems appropriate, stopping periodically to check on what the patient is experiencing. As mentioned earlier, she stresses that the therapist should not comment or repeat the content of whatever the patient reports but should just say, “Start there” or “Focus on that”, and begin the next set of EMs.

The sets of EMs are considered to be the “desensitization phase”. Reprocessing occurs as the SUDs (distress) is reduced to 0 or 1 and a VOC of 6 or 7 is attained. When this is accomplished, the PC is linked, with additional eye movements, to the initial target. Final steps in this protocol are a body scan and closure.

Variations from the standard protocol

The use of EMDR to be described here differs from the standard protocol because, in practice, Shapiro’s procedure can be unnecessarily formal and time consuming. Some of the steps she includes may be appropriate for the patient new to EMDR, but become disruptive once a patient is familiar with the process. Additionally, some steps tend to occur organically in the desensitization phase, seeming to arise from within what the patient quoted earlier called that “pervasive part” of the self. Observation of the unique response of each patient can help determine when the therapist needs to probe further. For instance, in regard to using the PC as specified by the protocol, without the therapist’s probing for a PC or VoC scaling, the patient may spontaneously state a positive cognition linked to the initial target.

Such a spontaneous statement usually includes a new cognitive understanding of the targeted problem accompanied by powerful feelings of relief and resolution that give it high validity. For example, a patient targeted a picture of some neighbors who sometimes harassed him and his distress and paranoid feelings of being in danger from them. During the EMDR he shifted to focusing on his mother’s anger and volatility and how that affected him when he was a child. He then described his childhood feeling as a sense of having died. As he continued with the EMDR, he had a sense of returning to himself. In the discussion after the EMDR, he reported:

It feels like in my head something snapped together. It feels like the child that died did, at some level, reconnect. If I look at myself right now, I can see different stages of development. During the EMDR I could only see now and when I was 6 years old.

In this example, the initial target was as distressing as it was because it was connected with and triggered the patient’s childhood feelings of being in danger from his mother. While EMDR clearly accessed these dissociated feelings, deriving a PC about the neighbors in the beginning was not necessary and would have been less efficient.

In fact, Shapiro seems to recognize the possibility for the superiority of PCs that emerge during processing in the statement that “as the session progresses, the initial positive cognition identified by the client may be superseded by a better one” (1995, p.60).

While probing for a PC as a step in the protocol may serve to direct the patient’s attention toward a positive outcome, it is also time consuming and may result in a PC that can be artificial and much less powerful than the positive cognition that arises spontaneously. Rather
than strict adherence to the protocol for obtaining and checking the PC, the important therapeutic step seems to be rechecking the original target to determine how much of the problem surrounding that target has been cleared or resolved and what remains for containment and future work.

The protocol differs even more when using EMDR in conjunction with hypnosis. When combining the two methods, EMDR is sometimes used to desensitize and reprocess some aspect of the patient’s experience that has emerged during the hypnotic exploration. In other words, an image, an NC, a sensation, or an intense feeling that can be scaled and located in the body and that has emerged in the course of the hypnosis and can be targeted with EMDR. It has not proven necessary, and can be disruptive in this instance, to probe for each of the other aspects of the protocol formally. In most cases, the necessary elements emerge spontaneously as the healing story is accessed. Again, it is best to allow the patient’s unique response to be a guide.

This section has described aspects of Rossi’s ideodynamic accessing model of hypnosis and aspects of EMDR that are relevant in using these therapeutic methods together to help patients access their own inner power. The following section will discuss relevant theoretical aspects of these methods.

**Comparison of theoretical Aspects of the EMDR and hypnosis relevant to accessing inner power**

Shapiro (1995) argues that, “EMDR is not hypnosis” and that “EMDR and hypnosis are very dissimilar in their clinical effects.” She does recommend using hypnotic inductions for helping the patient create a “safe place” prior to treatment, for calming during and between EMDR sessions, and for closure at session’s end. For instance, Shapiro states that the clinician “should utilize hypnosis or a guided visualization” to return a client to a comfortable state (Shapiro, 1995, p. 161). The inductions she recommends are primarily visualization procedures, such as visualizing a healing light. In advocating this use of hypnosis, Shapiro is, of course, in a sense combining hypnosis with EMDR. However, her statement about the different clinical effectiveness of EMDR and hypnosis suggests that she overlooks how useful hypnosis is for effectively accessing therapeutic change.

The discussion presented here argues that hypnosis and EMDR are often similar in their clinical effects, especially when both follow the patient’s lead to elicit unexpected and powerful responses.

Rossi and Shapiro’s views differ in the way in which each conceptualizes closure and resolution. According to Rossi, the arousal and tension that preclude therapeutic work in hypnosis will naturally be followed by a resting stage. There should be no need for direct suggestion for calming and containment. Shapiro’s protocol requires the therapist to “install” the therapeutic work and the ensuing relief by using EMs to link the PC with the initial target. The discussion in the section above has indicated that with both modalities there is often a natural progression to resolution and rest.

In some situations using either hypnosis or EMDR the natural resolution does not occur. This can be due to variables such as time constraints and the extent and/or difficulty of the material being accessed. In these situations, it is important to acknowledge with the patient the current state of processing and the therapeutic gains and to help the patient achieve safe closure before ending the session.

An important similarity between the thinking behind both EMDR and hypnosis is that both tools focus on the mind-body process and facilitate access to stored “state dependent” memory.
or information. One of the common strengths of EMDR and hypnosis with ideodynamic movement is their ability to access inner energy that has been stored in the mind-body system in a way that blocks healthy functioning.

Rossi and Shapiro differ in their understanding of the process underlying this information accessing. Shapiro conceptualizes the process in terms of change occurring in “neuro networks”; whereas, Rossi conceptualizes the process of change occurring at the genetic and cellular level throughout the mind-body system. To date there is no definitive process research with humans that conclusively demonstrates change accompanying these therapeutic techniques at either a neurological or a cellular level. Nonetheless, there is some suggestion that physiological changes do occur with both EMDR (van der Kolk, 1997) and hypnosis (Rossi & Cheek, 1988). The body of literature on hypnosis records many reports of physiological changes related to the healing of a variety of physical symptoms. In addition, in clinical practice, physiological changes are frequently observed and include trembling, body movement, and change in skin color. Changes in sensation are also reported by patients. For instance, in response to hypnosis, several of my patients have reported becoming quite dizzy, even having the sensation of spinning, in response to the processing occurring during the moving hands work. The spinning sensation was so intense for one patient that she had to hold on tightly to the arms of the chair. Common physiological changes observed during EMDR processing with my patients are a sudden burst of tears, a startle response, or a change in skin color as they react involuntarily to the emotions they are accessing. Indeed, clinical observation of responses to both hypnosis and EMDR suggests a potential metabolic process, as Fine (1991) suggests, and/or an information processing involving the mind-body, whether at the level of “neuro networks” or at the cellular level. Both hypnosis and EMDR can initiate therapeutic process in such a powerful way that significant progress toward problem resolution is often achieved within one session.

Some general guidelines in using hypnosis and EMDR together, with illustrations of actual combinations

With the potential for combining hypnosis and EMDR comes the necessity for deciding where to begin the therapeutic work. A significant variable in any psychotherapy is patient expectation: What does the patient want that is within the frame of therapeutic appropriateness? If the patient states that he or she is choosing the therapist because he or she wants hypnosis, we consider beginning with hypnosis. If the patient is choosing the therapist based on the wish for EMDR, then EMDR is considered as the logical place to begin. In observing the patient at work, the therapist can assess whether the chosen method is working and whether another method might be more useful or whether to combine methods.

Once my patients have had experience with both hypnosis and EMDR, I often let the patient choose which of those two he or she prefers to begin with for addressing the problem at hand. Then in working with the patient, decisions can be made with regard to alternating these methods.

Although the focus of this presentation is on combining hypnosis and EMDR within a session, these modalities can also be combined over sequential sessions. An example can be seen in the following description of a brief therapy case. A 35-year-old teacher and coach, whom I had seen before with his wife for some conjoint therapy, came in because he was distressed and angry at his father. His father had just had another episode of binge drinking after being discharged from an inpatient rehabilitation center. He acknowledged his extreme sadness and expressed a desire to resolve this issue. In the next session, with EMDR, he was able to connect the feeling of sadness with feeling like “I’m just a scared little kid” and with childhood memories of needing to take care of his mother and of having
to go get his father out of bars. In the follow-up session, he reported being able to go to his parents’ home to visit them without feeling either anger or guilt. In that session, he established a new goal of being less selfish in relation to his wife. Since this was something the patient indicated that he wanted to explore, we used the moving hands induction to hypnosis, and he explored “how to be more thoughtful with” her. When he re-alerted, he reported that he felt he had “downloaded the program” and was confident that he could prioritize being more attentive to his wife. In a subsequent conversation with both of them, he reported that “his program” was 100% effective at first and had slackened off a little bit when he was stressed. His wife also reported that he was being more thoughtful to her. Therefore, alternating hypnosis and EMDR in sequential sessions, in this case, led to rapid resolution.

When deciding whether to begin with hypnosis or EMDR, one important consideration is how the patient is experiencing the problem. The case above illustrated some key factors concerning the patient’s experience. It showed that sometimes patients are wondering about some problem or want to explore an issue but have no clear idea of where to begin. While at other times, patients are acutely distressed and feeling stuck with some specific aspect of their experience that can be targeted. In either case, the patient’s energy in the therapeutic moment is already directed toward resolving the question or the distress.

As a general rule, hypnosis is my tool of choice when the need to explore is expressed, while EMDR is the tool of choice when the patient is feeling stuck or seems in acute distress.

Likewise, these factors help determine when hypnosis and EMDR can complement one another. If in the course of hypnotic exploration, the patient feels stuck, EMDR can facilitate therapeutic movement. If in the course of using EMDR, the patient seems to need to explore something more completely, hypnosis allows the patient to go more deeply into that exploration following the pace of his or her own mind-body processing. One patient commented that I seemed to be reading her mind when I introduced the idea of changing to hypnosis after beginning with EMDR.

It was weird, like you were reading my mind. I wanted to go back to the moving hands. I feel the discovery part is easier with the hands, there’s more comfort in the hands thing. It’s like stitching a quilt, the hands coming together like a zipper coming together. The EMDR is good when you’ve got something painful you need to get through.

The patient in the example is a woman with a diagnosis of PTSD who has been in weekly therapy for about five years. She presented with a history of extensive sexual, physical, and emotional abuse. In the course of therapy, she has become less anxious and more functional. She not only resumed work on her doctoral dissertation, which she had avoided for years prior to therapy, but has actually finished it. She then secured a college teaching position to replace the secretarial job she had held at treatment onset. At this writing, she is still working diligently in therapy, is in line for tenure and another promotion, and has had a book accepted by a publisher. During our work together, she has responded well to hypnosis and to EMDR. I have used excerpts from her case in the following section to show combinations of EMDR followed by hypnosis and vice versa.

Sample combinations of hypnosis with EMDR within a session

Example of a session using EMDR then hypnosis

The session reported here followed a between-session phone call from the patient; she had a severe panic and a migraine brought on by an impending publishing deadline for her book. During the phone call, we agreed that a part of her seemed to be interfering with her
being successful and that it would be useful to hypnotically put that part to sleep. I then coached her in doing so, so that she could meet the deadline with her publisher. We contracted that in our next session we would extend help to the part that had been helped to sleep.

The face-to-face session began with the patient reporting that everything was ready for the publisher. We agreed to use EMDR to help that immobilized part of her that had been sleeping. She felt that her heightened “nervousness” signaled that the part of her that had been contained was ready to work. When she began to wonder about the connection between her feelings of being abnormal and her problem with her publication deadline, the switch from EMDR to hypnosis was made in order to facilitate exploration of that connection.

In reporting her work with EMDR, I have used “[EM]” to indicate a set of eye movements and have used “TH” for therapist and “PT” for patient. The patient had learned Rossi’s moving hands induction with the introduction of the lighted ball. In the hypnosis segment of this session, she was already focused and ready to use her hands. The patient’s commentary is verbatim except where changes are made to insure anonymity.

**EMDR Segment**

TH: Let me know when that part that was asleep is here.

PT: I’m pretty sure it’s here because I’m getting nervous. [EM]

PT: Think it’s Part that feels nobody can help me, so I might not make it if can’t get any help. [EM]

PT: Don’t know if this is going to work today. Pictures of home..my family...of going to church. Feel really dizzy, like something going on, but nothing is coming to mind. [EM]

PT: Whew. This feels major, but it’s not going to sound major. I’m thinking “I’m different from everyone else and that’s why no one can help me”, and it’s a whole systemic bad feeling, weird energy down my arms, upset stomach, nauseous, torso felt like sheets of metal cutting down through it. Glad you stopped. [EM]

PT: (Tears.) The question is, “What’s wrong with me that I’m so different from everybody else?” I don’t feel human. I was really glad I was hanging on to your hand because I was sort of able to feel a little human-ness there, like it’s possible for me to recognize human, so maybe I’m a little bit human. This is a life long question. I really am different. [EM]

PT: OK, it’s kind of differentiating itself. The answer is that people don’t understand me, and the pieces are there’s different kind of differences...don’t know why this is making me feel like crying...what I’m trying to say is that I am smart. I can’t help being smart. (Sobbing). I wish I was normal. The differentiation thing is the other stuff, the horrible life I had. But it’s trying to carry both inside the same body... because the part that doesn’t put off some people puts off other people. It’s really hard for me to find people to connect to. I used to try to act dumb and silly. I’m just trying to bring it back to last week and figure out what that was all about and why the thing with the publisher is so hard.

TH: Would you like to explore how this is connected to the publisher thing using the moving hands? (She nodded and held up her hands.)
**Hypnosis Segment**

TH: Would it be all right, right now, to explore the connection?

(She held up her hands and got a “yes” signal as her hands began to pull together.)

TH: As your unconscious reviews, one of those hands can begin to float down.

(Left begins to float down to indicate review.)

PT: I’m feeling like they think of me as a thing, too, and also about being caught. I’m remembering the times I feared being caught at school.

TH: Being caught?

PT: By them finding out how smart I was or what was going on at home. All kinds of prying people there. Afraid of what they might do to me.

TH: Who?

PT: The school. Always thought they’d be worse than my parents... always more scared at school because the kids made fun of me and were mean to me.

TH: And you were told by the family that others were dangerous.

PT: Yeah. And sometimes the teacher would yell at me. (Left hand at rest.)

TH: And as the right hand floats down, you will begin to resolve the problem, so that when that hand comes to rest, you’ll find that you can be comfortable dealing with the publisher and doing what you have to do. (Right hand gradually floating down with jerky movement.) Very nice. (Right hand at rest.)

PT: That was interesting. It was sort of an examination of the proposition that all outsiders are bad, a reality check. I was coming to the conclusion that not all outsiders are bad. As a matter of fact, they’re better than family. Actually, I’ve had pretty good luck with outsiders. I guess that the little piece of my childhood that gets hooked with my students is when they make fun of me. Guess I shouldn’t take it so personally. I still think they should behave themselves in the classroom.

TH: So let’s do an ecological check. Think about your publisher and getting the work done.

PT: It feels fine. They have an investment in me, want me to get the work done. They don’t even have to understand me. We just have our jobs to do. So I can keep my letter simple tomorrow.

I still can’t tell you what happened today, but it feels major. My arms and shoulders are sore. I feel OK. I don’t feel that kind of terrible different (sic), like there’s something wrong with me. That feels good. Feels kind of weird sitting here in my skin. Feels too confident, like I’m a queen or something.

TH: You are. You deserve it.

PT: Yeah because I’ve succeeded in a lot of ways.

**Example of a Session Using Hypnosis then EMDR**

The same patient came into another session with anxiety about a trip scheduled for the following day. Two friends were also going on the trip, and one of the friends was a close
friend and mentor. The patient said she was not sure what the trigger was, so we agreed to use hypnosis with the moving hands induction to explore the source of anxiety about the trip.

In this session we see EMDR being used to further reduce the anxiety that still remained after the patient has used hypnosis to access the underlying source of anxiety about a coming event and to begin to reduce that anxiety.

_Hypnosis Segment_

TH: Would it be all right to explore that fear right now? (Following the lighted ball induction, she positioned her hands and focused on the space between as they pulled together for the “yes” signal.) And as you review, one of those hands can begin gradually to float down. (Left hand floating down with some finger movements). Notice that movement, perhaps an indication of some information exchange taking place.

PT: Something around my sister.

TH: Your unconscious will decide how much you need to know.

PT: It’s definitely Market Street, main street in A-town (where she was having lunch the next day). It’s where I told my family I was going to marry John and all hell broke loose.

TH: When the left hand relaxes, that will be indication that your unconscious has thoroughly reviewed whatever is significant about the sources of the fear about the trips. (Left hand coming to rest.) And now that it has reviewed the problem, your unconscious can begin to resolve it. And as the process of resolution begins, your right hand can float down. Whatever you need to know, whatever your unconscious knows is safe for you to know can come into consciousness.

PT: It’s about them controlling my life. Going into the restaurant was a symbol of that control, being taken where I didn’t want to go. I can see the restaurant.

TH: Stay with it ...understanding fully the impact of this memory so that the fear can be resolved.

PT: There was so much I didn’t understand, compelling me into that restaurant, into that path. I was trying to fight it but I didn’t know how.

TH: It?

PT: Them, their values, plan for me.

TH: Marrying John didn’t fit their plan?

PT: No.

TH: So you’re saying you didn’t know how to fight it, but yet you did marry John.

PT: (Tears.) I won, but it wasn’t easy. (Sigh of relief.)

TH: Is there still some energy in that hand or is it coming to rest?

PT: Coming to rest. (Pause.) OK. That was interesting. Funny how you can’t do that on your own. I knew that whole thing but didn’t connect it with A-town. Still some pieces I blocked, the specifics of why my mother was upset, why my sister was upset. They were the women in my life and I thought I was going to get support. I was in my
twenties. It was a logical time to announce I was going to get married... think I was in graduate school. So I had finished my education, which was my mother’s thing. Her big thing was that she didn’t want me to go to college, wanted me to stay home and take care of her. My sister totally bowled me away. She was furious with me. I was hurt because I had planned on asking her to be in my wedding. She was nasty. Eventually it came out she was jealous. She wanted to be married too, and knew that wasn’t possible. It was little sister syndrome of wanting everything the big sister had at the same time. I was feeling a lot of pressure then to not marry him, felt I was going to lose the love of my family if I did. Trying to break out of that family was so hard!

TH: Let’s do an ecological check on the thing about your trip tomorrow.

PT: They’re not compelling me against my will. If they’re going into a restaurant I don’t want to go to, I’ll just say I’d meet them later. Oh, that’s a relief. Guess that’s what I was worrying about, the restaurant thing. I’m figuring even if I walk into a place and don’t like the looks of it, I can leave. In those days I would just eat even if I didn’t feel like it.

TH: Is there any anxiety left or can you just look forward to the trip tomorrow?

PT: Still a little nervousness about being taken that far from my house, even though I’m not being dragged. The other little piece is that I like Rebecca so much I’m always afraid if she gets to know me better she’s not going to like me...or afraid I’ll do something awful...or I’m not good enough. Funny she’s the first person to notice I feel that way and was distressed by that. Yet she seems the person I have the hardest time believing...that she could feel the same way, not find me disgusting.

TH: What’s the level of anxiety?

PT: It’s 40-60% of the original stress level.

TH: Would you like to address that anxiety with some EMDR?

PT: Yes.

EMDR segment

TH: What are you picturing?

PT: Getting into the car. [EM]

PT: Feels like being trapped, like in the scary movie I watched recently. [EM]

PT: Thinking about junk in bottom of Rebecca’s car. There won’t be rotten apples and garbage in her car (i.e., as in her family’s car). [EM]

PT: I am going somewhere partly familiar, not Alaska. [EM]

PT: I do have the option of speaking, saying what’s on my mind.

TH: Go back to the picture of getting in the car. Where’s distress level now?

PT: Twenty per cent. [EM]

PT: Actually I feel pretty good right now. Stress meter went down into the ground.

The object of these examples is to show how effective combining hypnosis and EMDR can be. In clinical practice, choices of when and how to combine modalities needs to be made in
the context of the clinician’s understanding of what the individual patient is experiencing as well as knowledge of the patient’s responsiveness to each method. In examining the above combinations of hypnosis and EMDR, it seems obvious that, though I have suggested guidelines, there are no hard and fast rules for when and how to combine hypnosis and EMDR. For instance, in the case illustrating using hypnosis then EMDR, I could have begun with EMDR, targeting the fear. Some of the same memories would probably have emerged. My choice was influenced by the history of therapeutic collaboration with this particular patient and the fact that it was her uncertainty that seemed most salient.

Conclusion

This article has discussed and demonstrated some possibilities for effectively using hypnosis and EMDR in combination. Each method was described and important similarities in the clinical effectiveness of Rossi’s ideodynamic accessing model of hypnosis and EMDR for accessing the patient’s own resources for healing were delineated. The unique features of each were also discussed. This comparison of similarities and differences was designed to explained why the two methods effectively complement each other. Case material then showed some examples of how hypnosis and EMDR can be used together to achieve the therapeutic objective more effectively than either used alone.

With practice in combining the two methods, a variety of possibilities for alternating hypnosis and EMDR will present themselves to the therapist. One example would be using small segments of one method in the middle of a session primarily devoted to using the other method. So that, combining hypnosis and EMDR can be a versatile option to add to the therapeutic toolbox.

References

Energy Ball, No. EB-400. Safari Limited, Box 630685, Miami, Florida, 33163.


