The Art of Therapeutic Communication

The Collected Works of Kay F. Thompson

Edited by
Saralee Kane MSW
and Karen Olness MD

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Introduction

Kay Thompson is acknowledged as one of the great hypnotherapists of the 20th century. She was renowned for her linguistic brilliance, as an international teacher of hypnosis, and as one of the most gifted students of the legendary psychotherapist, Milton Erickson. She lectured widely on the therapeutic use of language, the importance of motivation, pain management and pain control, the effect of language on physiology, and the use of hypnosis in dentistry, including the psychological importance of the oral cavity. Through her unique and extraordinary abilities with language, she entranced listeners throughout the world.

Her original contribution in articulating the importance of motivation is seminal in the field of psychotherapy and she played a significant role in the creation of the dual induction, one of the most innovative additions to the field of hypnosis. As importantly, she expanded the ways in which words and language, and thus metaphor, could be used in clinical hypnosis and psychotherapy. She was a genuine artist, capable of crafting complex, poetic and effective multilevel therapeutic messages, which inspired students and colleagues wherever she taught.

> "My words are the chisels, the brushes used to attempt to reach the inner block of material, the canvas of the individual, modifying the story as the cues demand, and waiting for the message that change is ready, leaving the creation to be interpreted by the patient, the one who commissioned the vision in the beginning." (Chapter Twenty-six.)

Equally impressive were her determination and ability to motivate others to learn these skills and to systematically teach them the "what and how" of her therapeutic communications. Her teaching presence, as an authentic model of everything she taught, was especially inspiring. All of her contributions are among the underpinnings of contemporary clinical hypnosis and are important resources for modern psychotherapy.

She began her professional career as a dentist and she also had a profound impact on the field of dentistry. Through her recognition of the psychological importance of the oral cavity, her teaching, political activities and mentoring of young dentists, especially women dentists, she has been described as having "as much of an impact on dentistry in the United States as Amelia Earhardt had on aviation". (1998)

It is of central importance to an understanding of Thompson's work to know that her dental practice was the impetus for her interest in learning about hypnosis. Since childhood, she had wanted to become a dentist, because she was both fascinated by her father's dental practice and impressed by the help he offered his patients. With her father's encouragement and support she applied to dental school and was the youngest student and, at one time, the only female student in her dental school; after graduation in the early 1950s she became the first woman to practice dentistry in Pittsburgh. Overcoming gender barriers, especially in professional politics, became a lifelong process.

Local dentists sent her their difficult patients, thinking that a woman would be gentler and more understanding. In order to help meet the needs of these patients, she began to explore different therapeutic modalities, and in the course of that process attended a hypnosis seminar in 1953 with Milton Erickson MD. By that time, Erickson, a brilliant psychotherapist, had published numerous articles on clinical hypnosis and was considered by many to be one of the most important influences, if not the most important influence, on the resurgence of modern hypnotherapy. He was an independent, uncommonly creative, and nontraditional therapist; only many years later would his ideas and work be credited for significantly influencing the course of modern psychotherapy.

After Thompson's first hypnosis course, she did an emergency root canal without any anesthesia on a pregnant patient and was amazed by her patient's ability to use hypnosis for what was normally one of the most intensely painful dental surgeries. Her lifelong passion for learning hypnosis had begun. After attending numerous hypnosis seminars, she was selected by Erickson for more advanced study, eventually becoming one of his closest

friends and colleagues. Her father and Erickson were probably the most significant personal and professional mentors in her life.

In many ways, Kay Thompson was a pioneer, perhaps because she was willing to be really in the present, by truly seeing and listening, outside the many cultural trances and belief structures which usually organize our perceptions of reality. She observed, observed and observed. She "knew" from a deep experiential understanding, and wasn't afraid to teach what she saw and experienced and understood, but couldn't yet explain. When her clinical experience contradicted what she "thought she had known" she noticed, acknowledged with curiosity, and was open and willing to change her mind. Her approach was phenomenological and generative, not ideological.

Thompson emphasized the crucial importance of motivation in clinical hypnosis, an idea that is relevant to all kinds of psychotherapy. Through highlighting the significance of the client's motivation in a therapeutic situation, and by encouraging therapists to accept responsibility for motivating their clients, she espoused a view that was and still is far ahead of accepted norms of therapy practice. It is interesting to note that intention, which is very similar to motivation as it was conceived in the late 1970s and early 1980s, when Thompson was initially emphasizing its crucial significance, has recently become a core issue in modern therapeutic practice.

Throughout her career, Thompson was vehement in her repeated emphasis on the profound difference between clinical and experimental trance."I refuse to restrict myself and the patient to their ability to learn based on some artificial criteria determined by somebody, when the individuals who established those criteria really didn't have any motivation to go into trance." (Chapter Fourteen.)

Drawing from her clinical experience, she lectured about the power of belief and its potential effect on physiology, and demonstrated her understanding in her pioneering work with pain control and mind-body communication, again far ahead of her time. In 1972 (Chapter Seventeen), she confronted the accepted views about pain by showing a film depicting her own surgery at a Society for

Experimental and Clinical Hypnosis meeting (SECH), to force the attention of the established order.

At that time, there was a controversy among hypnotherapists about whether people actually learned to turn off pain with hypnosis or somehow denied the pain they were experiencing. All agreed, however, that skin is sensitive and that procedures involving trauma to skin really do hurt. This film forced many of the prominent teachers in the field to admit that they couldn't explain how Thompson could have undergone that kind of surgery by merely denying pain.

Thompson used suggestion and motivation to direct her clients in therapy; if necessary she used quasi-logical explanations to convince her patients to do the "impossible" things she knew they could do with their bodies.

In the following clinical vignette, Thompson describes an unusual healing event.

Many years ago, when I was teaching a course in dental school, one student said his girlfriend had been a volunteer patient for one of his buddies, and his buddy had gotten an unintentional mechanical exposure of the nerve with the drill, and did I think anything could be done. And I went over [while she was in trance] and said she could deposit secondary dentin around the opening into that nerve and she could keep the nerve from being infected and I said, "I know you can do this!"

When we finished and she came out of trance, she said that when the other two (her boyfriend and his buddy) were talking to her, there was no conviction there. The difference was that I said, "I *know* you can do this!" and that she heard me, she believed me, and understood that it was something she could do. Fortunately, I have some follow-up on that, because six weeks later, we took an X-ray of that particular tooth, and the calcification had taken place over that exposed nerve. You can't do that, but you see she didn't know you couldn't do that, and she did it and they didn't need to have to do a root canal in that tooth (Chapter Six).

Thompson was passionate about the necessity for engaging clients' beliefs in their healing, years before many of the fascinating aspects

Chapter Nine
Whose Story is This, Anyway?
A History of His-Story

This is a story about an exceptional man and his impact on an extended, self-selected family. But it is also a story about all those people in that self-selected family who want to be like him. But the end, yet the beginning, of the story is about the people who will benefit from his teaching as it filters down and is filtered down through all the ones who follow him.

His story is like a cascading waterfall on a powerful river. There is the main torrent of water, which, after it falls, continues to flow on as the river. But there are also drops and little streams and fallout from the waterfall that spray/stray far away, while others fall close to the mainstream, and others dry up before they ever land. Then there are others that start their own stream instead of rejoining the existing river.

But this particular story can only be my story of how I perceived his-story. So it is a story of how I use what I think I learned from Erickson to help those who have special needs that must be met before they are able to learn trance. It will also speak to my two primary beliefs, those of motivation and the need for inexhaustible and unending practice of basic skills with hypnosis! I will address basic techniques in utilizing hypnosis and trance.

The essence of these stories is the distillate: the result of straining the original product repeatedly until it is reduced to a potent potion, a portion of which can be applied sparingly as we learn how to mix it with our own ingredients to produce a product that is particularly personal and pleasing. In this way, each of us takes the essence of what we saw in the substance of Erickson and each of us strains it through the sieve of our own perspective, thereby creating a new product. But in our insecure, needy, greedy way, we prefer for a while to interpret it as the original, and so the essence takes on many different extractions or configurations, none of which is the

original, each continuing a filtered distillate of the original, until we forget that it is not the same as the original.

I wonder what it is that is in the molecular distillate that I absorbed from Erickson. I reflected on how I use what I think I learned. I am sure that my view is influenced by my clinical utilization, which requires a reorientation of the patient's physiology, not just psychology. And I don't always have a lot of time to accomplish this change "within their heads" before I go in to change some physical thing in their heads.

The intensity of my physical intervention utilizing trance requires development of a belief in the physiological alterations that can be activated and achieved during the hypnotic trance. We physicians and dentists do not have much time to work through the bonding and transference that occur with the use of hypnosis directly, but they need to occur, indirectly, with the guidance of the doctor. About the time I get comfortable with just having to talk to people, I get a patient who is scheduled for surgery, and often I am also doing the surgery, so there is a different level of need and urgency and a deeper sense of commitment on my part.

There are a number of general opportunities I utilize to help this particular population with their special needs. Most of these patients have tried hypnosis before without success. I believe that the work I do with hypnosis is grounded in: (1) my learned focus on the foundation of motivation for change within the patient; (2) my learned willingness and perceived obligation to employ every means to enhance and restructure, reinforce, and build on that motivation; and (3) the conviction that there is the potential for change. In looking for commonalities in what takes place, I find a consistency in my acknowledgment and appreciation of individual differences. I cannot utilize others' predetermined approaches like frozen entrées, or even canned recipes, although I may start with the same cookbook. Nor must I rely on theories in those cookbooks. I must work with the ingredients on hand and I must have a taste for what is simmering with this one patient, different from any other I have seen, demanding a new adaptation of any recipe.

I find a constancy, in that all patients have within them the power to change, given the appropriate motivation and relearning. The

change must fit their belief systems. We, as therapists, cannot do it for them. Accepting the patients' potential and the multiple variations in that potential, makes it possible to work with those needs and motivations. The more the therapist can speak the true language of the patient, the better the patient is able to understand.

It is difficult to determine the "across-situations" incidence of consistency. It is the mixing and shifting back and forth from one approach to another, as required, that makes Ericksonian trance so difficult to analyze. He had the skill to be able to do the complex, simply.

But always, enhancement of motivation is the key I use to open the options the patient has locked out. Erickson understood and used these motivational differences. He was exceptionally smooth at slipping back and forth unnoticed, using his master keys on any locked door that presented itself. He would also combine and confuse what was behind the doors by using additional communicative tools. Neither the burglar nor the locksmith cares what combination of tools gets him into the valuables. I am not concerned about where that lock came from in the past. I am concerned only that the patient is ready to change the future.

Motivation can come from different motivating factors, and a motivating factor can have multiple origins. One door can be opened with many keys, and one key can open many doors. Since much of what occurs takes place in the unconscious, it is difficult to track. One constant is that trance is tracked by movement toward the future, as determined by the key motivation of the client.

Set One

How do I determine which key to use for the door that I am to help open? My first task is to determine the type of door and lock. The initial meeting is an inventory of the problem doors, so the patient is encouraged to talk, while I take scrupulous notes. Much can be learned without asking. I do ask what is being asked of me. The objective is to listen actively and observe carefully for the nonverbal

communication as well as for the words. Then it is time to make a judgment, based on the perceived motivation.

The first personal skill, then, is in deciding what approach the patient needs, so that you can affect the effect by a change in your behavior and an offering of trance. The offering must vary, so you must know how your key fits each door, and this requires practice.

Each of us must practice to acquire the skills and techniques to express the appropriate aspect of our personality for that person in the personal way it is needed. One of the things that always was impressed on me in Erickson his-story was to note his rigorous practice and self-discipline. He wrote out verbalizations and monitored his own behavior, ready to shift immediately as he observed minute changes in the patient. Because of his care and compassion for each person who came to him, he did all this to enrich his ability to reach the patient. He would listen intently for the tumbler to fall and act quickly when it did.

Practice, patience, creativity and commitment—and always to work hard—these provide the rosin that smoothes the key for teaching trance. After you master basic direct, indirect, permissive, authoritarian and confusion approaches—only then focus on storytelling and metaphor.

There are still those who say they just open their mouths and let their unconscious speak. It is okay to trust in and rely on the spontaneous unconscious, but only after there is an abundance of knowledge and experience in the spontaneous unconscious to rely on. If you are contemplating using a combination keyless lock, make sure you can remember the combination.

Set Two

Once you know the many master keys you have available, how do you decide which key to begin with? Formal, informal, direct, indirect?

Chapter Sixteen
Traumatic Situations

I can and will say almost anything about pain. Let me give you a very brief introduction about where I come from in terms of dealing with pain. I'm glad you are all here. I hope you are all here. I firmly believe pain is a danger or a warning signal. When anything that can be done and should be done, has been done, there is no longer any reason to have pain. Period. End of story. I said that first in print about 1960 and have not changed my mind about it. I have had people make valiant efforts to back me into a corner so I would have to back down. I have not backed out of my position that I can deal with any kind of back pain without going backward on that statement.

What it really says is when anything that can be done about the pain has been done, that means everything that is appropriate and you know what the pain is all about. It doesn't matter if it is physical, psychological or physiological or a combination of all three. The phrase, "when everything that can be done and should be done", refers to treatment. In no way does this say the patient is going to get well.

The pain and the dealing with the pain is the issue. This stands up to working with terminal patients, chronic pain, as well as working with acute pain and traumatic situations. Then there is no longer any reason to have pain. That aspect says that pain interferes and it interferes with the quality of the things that go on. That is the important point that we can achieve in discussing this with our patients whether we have two minutes or two hours. When you are dealing with traumatic acute kinds of pain, I deal in a more authoritative, interventional way. When it is someone with a chronic pain and they are told that they have to learn to live with it, I deal with that in my approach in a more time oriented way.

I feel I need to give my patients some understanding of what's involved in their pain. I walk in and I take charge!. That's what they want in that situation. I ask, "What kind of pain is it? When did it

start? Where is it worse?" That indicates that there are places where it's not so bad. If I ask, where doesn't it hurt, they can't deal with that. Where is it worse? They have to circumscribe it.

It's back to the Erickson philosophy of sometimes the way to teach people to lose weight is to teach them to gain weight. Because any gain can be a positive loss when you realize that you can only gain by losing. There are some people in here who listen very well to that statement. You take very practical realistic statements in terms of where the person is. You disrupt their conviction that any reality is fact by changing around any facts they thought could not be changed. You affect a paradigm shift. Put aside your assumption that you know the way the world works. Consider that it can work differently and then show them that it can.

If a client has pain in a traumatic situation where the pain has just been introduced, I want to say, "You don't want to hurt, because pain interferes with healing." If I don't get to them for three days, I say, "Boy, you are really lucky, pain really stimulates healing, you are well onto healing, let me tell you about it." They think, this has got to be crazy, but she's offered to talk about it so I'm willing to listen. There is an advantage to being able to be willing to have them think that I'm crazy. Because all the other people they are dealing with have been normal, rational, unconcerned people. I kind of wade in with both feet and say, "Let's do something about this, it's silly to hurt like that!" I *want* their attention. Once I get that, I will take my chances.

The one thing we talk about is teaching people to handle pain with dignity and die with dignity, to do all these things with control. We don't know how to give them that control without zonking them with medication. The alternative to that is hypnosis. When you are dealing with pain and you have those other factors involved, recognize the power that you have when you say to someone, "I can teach you to control …" You don't even have to finish the sentence after the word control, because it's all of the above. That control is something that they need to be given an understanding about because they are going to say, "But, this pain is real!" I'll say, "I know it, all pain is real. But the pain is interfering with your getting better. The pain is interfering with your enjoying your family." The pain is interfering with whatever I can come up with

that the pain is interfering with. The pain interferes with healing with the immediate traumatized patient.

I believe that the reason people who utilize hypnosis heal faster is not because they heal faster than normal, but because they heal at the normal rate, and that pain itself slows down healing. This is the premise I present to my patients. I had all these broken bones after an accident; I had a couple of broken legs. And I had this orthopedist who did not believe in hypnosis. When he took the first X- ray he couldn't see the break. He wouldn't let me see the X-ray, which I found absolutely fascinating I went and had my own taken. I tend to be ornery and am not threatened by all the physicians who don't know anything about hypnosis.. I didn't want to be off my legs for the 12 weeks he told me it was going to take. I was lecturing in Vermont in seven weeks, without a cane, without crutches.

I needed to focus all my energy on healing. My unconscious was selective. I only had my left leg in a cast. I was going from the hospital bed to the wheelchair. It was kind of curious that my unconscious made the decision to heal the left leg faster. I was able to demonstrate to my physician that I could get out of the cast and use that leg and at least use crutches. At that point I was able to focus on healing in my right leg. There was this absolute understanding because I was getting these hot flashes in my left leg. I finally realized I was sending the nutrients and energy to that area in order to speed up the healing and it wasn't happening in my right leg. And when he said I could use my left leg, then all of a sudden it got transferred to my right leg. I kind of scratched my head and said, apparently my unconscious knows what it is doing. Later, the only thing my physician said, is that, "You know she really does heal remarkably rapidly."

You can hear the conviction in my voice when I say this. So I can say to my patients, "If I can do this, you can do it too." So get busy. You can be as miserable as you need to be, but you don't have to be painful about it.

Question: What do I tell patients who are very inquisitive and want to know why pain interferes with the healing process?

"There is so much to be learned from this book, not only about how to do therapy, but, on a deeper level, about how to conduct one's life."

Sidney Rosen MD
Author of *My Voice Will Go With You: The Teaching Tales of Milton Erickson*

"This is an incredible book, one that contains material that is rich as well as inspiring. In fact, I know of no other book that covers the topic of hypnosis in such breadth and depth. Kay Thompson always wanted to write a book of her own. This marvelous volume, because of its multi-dimensionality and bolstered by the integrity of its contributors, will grant Kay her final wish."

Stanley Krippner PhD
Alan Watts Professor of Psychology, Saybrook Graduate School and Research Center, San Francisco, CA

"Kay Thompson's enduring and profound contributions to the field of hypnosis cannot be overstated. She contributed so much to so many through the sheer force of her personality, the strength of her beliefs, and her extraordinary ability to teach and share generously the brilliance and depth of what she knew. This wonderful volume captures both Kay's spirit and her wisdom, and can be slowly savored by anyone wanting to get a glimpse of greatness."

Michael D. Yapko PhD
Author of *Trancework: An Introduction to the Practice of Clinical Hypnosis*

"Kay Thompson's enormous contributions to all of hypnosis cannot be overstated. Her collected works offers readers the opportunity to learn more than they can even imagine from the multi-faceted talents of this superb teacher, therapist and human being."

Betty Alice Erickson MS
International teacher of Ericksonian psychotherapy and hypnosis

"Kay Thompson was, without doubt, a leading light in the world of clinical hypnosis and it is wonderful to have a comprehensive volume of her work."

Marlene Hunter MD
Past President of the American Society of Clinical Hypnosis and the Canadian Society of Clinical Hypnosis

"… contains many pearls of great price—Kay Thompson was a great teacher, wordsmith and therapist and this collection is a fitting memorial to her."

Dr Ann Williamson
Author

Hypnotherapy

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