construct. The real problem of informed consent is what you inform the client and how do you do it. Do you say there a potential risk in danger in using clinical hypnosis? I hope not because I am not aware of experimental studies demonstrating that hypnosis in and of itself is dangerous. But I am aware of court cases where plaintiffs have alleged that their therapists have inappropriately and perhaps negligently practiced hypnosis, which resulted in some kind of damage. But courtroom evidence and scientific evidence are not the same thing. I believe we need to emphasize the importance of this distinction.

EV: Are you in favor of nurses, social workers and other non-PhDs or MDs using hypnosis, measuring hypnotizability and applying it in their professional area?

EF: *Within their area of expertise, not only am I in favor of it, I am wondering why weare restricting them from doing it or denying them the proper training so that they canbe better at what they do.*

EV: How should their training be tailored? Are social workers eligible for SCEH and ASCH? Should their training be the same?

EF: *I believe that there are basic practices about inducing hypnosis and using hypnosis for broad things that just about everyone does like relaxation, pain control (both emotional and physical), improved self-esteem, etc. which all healthcare professionals should be trained in 'with or without the use of hypnosis.' These are areas of application that all healthcare professionals, in my opinion, need to know. If hypnosis can help promote such things, then I feel we should give all healthcare professionals training about how to accomplish these general things with hypnosis. And do it as quickly as possible because if we don't do it, people are going to end up suffering needlessly because the healthcare practitioners that are taking care of them could effectively treat them. However, I am also aware of training boundary issues as well. For example, consider something like dental anxiety (i.e., people who are phobic for coming in for dental treatment). Should a dentist treat dental anxiety? And my response to that is – Who else should? Who else knows more about dental treatment than dentists? However, there are some of my psychologist colleagues who would say – 'No, no, that's a phobia which is a psychiatric problem and dentists should not be treating psychiatric problems because they are not allegedly within the area of dental specialization.' I disagree. However, s should dentists go out use their training based on their experience with dental anxiety/phobias to treat other types of anxiety disorders like agoraphobia? No, I don't think so. If it is specific to their area of specialization then I think we should teach healthcare professionals to be respectful of their boundaries of expertise. And if you step outside that boundary, a professional organization should step in and say "you shouldn't do that!' I don't think we should throw them out of our organizations. I think we should help them clarify their understanding of what their specialization is and is not. There are many people who simply by virtue of their training in hypnosis, unfortunately started thinking that they were psychotherapists and that is unfortunate and could lead to potential law suits/ ethical charges. But that doesn't mean we should deny the training healthcare professionals in the uses of hypnosis. Instead, I think it means we should encourage various professionals to practice in their own area of specialization. If we don't train them in the general uses of hypnosis, think of where else they might get such training.*

EV: That brings me to the fact that there are a lot of societies. Should professional societies offer training facilities? Are they the organizations per se that should devote their effort to provide training facilities for these and other specialists?

EF: *Where a healthcare professional goes and gets training in the general uses of clinical hypnosis? Not only are we uniquely positioned in that regard. I thought we ought to be expanding so that our members are actually teaching these courses at a graduate level, a post-graduate level, as part of their training during an internship, or as supplemental professional education. Then maybe we wouldn't have to fly to Milwaukee or Chicago or Amsterdam to get special hypnosis training because it would be available within our own geographical region. I am hoping that we will broaden our perspective instead of limiting it further. Let's get it into the universities, into the medical schools into the psycho-therapy training centers as quickly as possible because we have so much to offer.*

EV: Should that training also include EMDR? Some people are leaving the hypnosis field for EMDR – That's where they want to go. Is EMDR different to hypnosis? Does EMDR capture hypnosis?

EF: *Exactly what EMDR is has not been scientifically validated. I think Francine Shapiro, who is credited with the creation and development of EMDR, maintains that they are not the same thing. While others have argued that both hypnosis and EMDR are similar, I agree with Dr. Shapiro. This goes back to the same issue that Mesmer faced back in the 1780's. Some of Mesmer's techniques were found to be clinically effectively. EMDR, there is no doubt, has also been found to be clinically effective. Outcome studies have demonstrated this beyond a doubt. Why is it effective? No one knows. However, I don't think that the underlying process issue is a criticism unique to EMDR. What are the processes, the underlying mechanisms that make other proven psychotherapies effective? 'We don't know. We hypothesize.' The first thing is to do the outcome research, but the process research, what actually happened there, why did the client get better must be done at a later date. Simply because a patient got better, after being exposed to EMDR or any other proven psychotherapy, doesn't mean that the theory about the mechanisms underlying each of these different treatment interventions is scientifically valid. But, as clinicians, is it our duty to be scientifically valid or optimally effective?*

EV: I have an ethical question. Should professional hypnosis societies train lay-people or teach lay-people?

EF: *I think that would be wrong. I think it would be unethical in a sense that you are in some way either tacitly or maybe even explicitly endorsing their right to practice in a way that they weren't trained for. It's not that someone can't learn how to hypnotize someone over a weekend – you could learn that in a day – what do you do with people after they are hypnotized? That's what I believe distinguishes us as healthcare professionals from the lay hypnotists. Certainly you teach people in terms of what do you do with the and where you take them? Unless we are letting it just come down to 'Don'tdo this' or somehow you think the compulsion model of 'I hypnotize you and you will do whatever I tell you to do', such as 'You won't smoke, you won't worry' – I don't think that's very effective. But I'd like to say that some of the techniques that lay hypnotherapists use are more advanced than that. I am simply saying that they just don't*

have the other background of practicing within the healthcare specialization that we've received numerous years of training, supervised practice and have been evaluated to make sure that we have developed the necessary skills to do this. They don't get that. Does this mean I shouldn't lecture to a lay-group about what hypnosis is? No, I think we should educate lay-groups about what hypnosis is. Should we teach them skills for inducing trance? – No, I don't think we should do that nor should we be teaching them skills about once trance is induced what to do, because we haven't got the background safety checks of the other education and training that we ourselves had received – lay people don't have it, we as healthcare professionals do.

EV: I know that you couldn't go to New York last week because of the bombing of the World Trade Center. You were going to meet with Herb Spiegel – whom you admire greatly. What does he represent for you?

EF: *He represents the best that there is in being a human being, a scientist, and a practitioner and that's something I respect. I think that he is just the best. He may not always have been right but he always tried to be.*

EV: What were you impressed by?

EF: *I was impressed that he valued my contributions, treated me with dignity and if I had a better idea than he already had (which wasn't very often); he was willing to discard his opinion in favor of the better idea. And that to me has been the rarest of qualities. I have not found that in our field or in my life dealing with other human beings. I think he is an exceptional human being, scientist, and clinician. I/m going to get to New York City to see him no matter what happens.*

EV: Were you daunted by the fact that they cancelled your flight?

EF: *They cancelled my flight but not my plans.*

EV: Finally, let me ask you what's your theme in your work – you have to do this all for some purpose.

EF: *My main theme and I have mentioned this before – personally to you and in one of my editorials – why do I do all this? Right before my father died, I was telling him how much difficulties I had had – I felt like there was one political fight after another and him being an old union president he just smiled and said, "Son, why do you do it then?" And I said, "Dad, I believe I am making a difference" – and that's what I wanted to do – to make a difference. That's what my mission is here – to make a difference, while I am here. And I hope to do that.*

The original interview was even much longer than the version that is printed here. I wish I could publish the entire interview. We haven't even touched on the many anecdotes, e.g. the one I had the pleasure of witnessing: the limo ride he organized with Erika Fromm and Herb Spiegel together on the back seat of a stretch limo on the way to the Chicago Society of Hypnosis annual dinner. Many others, that only vent 'après une bonne diner.' I felt his heart was touched during dinner the first night. I have known Ed for some years, but this dinner conversation made a difference to me. I knew but also 'felt' Ed is fighting for respect, truth and justice. As flourishing as his career was in the first twenty years, in the last few

years – especially after the ending of the editorship of AJCH – he has had a hard time picking up the pace that he always had and found it tough to find a stimulating environment that could use his spirit and ideas. Law school, Academia, Chicago Board of Trade, or another term as Editor. These are all strong cards that he has not played out yet. All together it was Managed Care, the FMS, and the death of his father (we started the interview talking about this, and we ended it here as well – he asked me not to write much about this for privacy reasons); were all things he has had a hard time dealing with. The hypnosis community should be careful not to lose him. He is an excellent teacher, and true scientist; if you see him with students, he is tops. I was kind of surprised to see how sensitive and almost 'slow' he is with patients. He thinks as quick as he talks, very fast. His life is not different; he runs a busy life. You hardly get him on the phone. One starts to wonder what he is running away from, or in other words, wants to get so passionately. If you ever want to call him, be prepared for the voicemail greeting: *"Hello, you have reached 761 6625. I am unable to pick up the phone right now, but if you leave a detailed 30-second message with your name and number I will try to get back to you as quickly as possible. Thank you very much and have a nice day."* – This is 'Fast Eddie'.

THE DAY THAT CHANGED THE WORLD

Eric Vermetten, MD

Through the words of our President Éva Bányai, ISH expressed its deep sorrow at the plane hijackings and terrorist attacks on the United States, and its sympathy with the survivors and their families. At ISH we are concerned about all those who are affected by this tragedy, and about the potential of these violent events to lead to distress and psychological suffering in many, as well as prolonged or severe reactions in some individuals. We are also seeing the rise of terror-driven hate and fear. I requested two ISH members, Peter Bloom, MD and past president of ISH; and Richard Kluft, MD, who specializes in the treatment of trauma-induced psychiatric disorders, to comment on the events that happened on September 11 and to speak about their response to the atrocities that took place. Please read their careful and touching replies.

RESPONSE TO ÉVA BÁNYAI'S E-MAIL TO USA MEMBERS

Suzan Stafford

After the September 11 terrorist attack, our President Éva Bányai sent a letter of condolance to our USA members with e-mail addresses. One of the many replys she received was from Suzan Stafford, it reads as follows:

As a psychologist and member of ISCH in Washington, DC, I thank you for taking the time to express concern. The community here has mobilized well in responding to the attack on the Pentagon. I head the Disaster Response Network and am on the board of the Capital Area Crisis Response Team. We have been to the Pentagon, to local businesses and organizations, government offices, and are offering community "y'all comes" to help people in dealing with this disaster. We are very aware that there will be a need for ongoing interventions. If people in the area would like to help out in the months to come, they can contact me at suzanms@aol.com. I will do what I can to coordinate the response. Please include days and times you could be available and if you have a license (mental health, medical, etc.). Thank you again.

FIRST PANTS, THEN YOUR SHOES

Richard P. Kluft, MD

Saturday, September 8, 2001

At the fall Components Meeting of the American Psychiatric Association in Washington, DC, I spend the morning accompanying a colleague to advocate with a decision-making group for the transformation of our Task Force on Violence into a standing committee. Among our many arguments is that this committee could begin the preparation of our profession to address the psychological sequellae of a terrorist attack on the United States. We are told that our proposed committee is regarded as unnecessary and is unlikely to be established. As we leave, I tell the group that if we are unsuccessful now, we will be back. "We will be like a flashback," I say. "You'll see us again and again, whether you want to, or not."

That afternoon my wife and I visit the United States Holocaust Memorial Museum. Its impact is profound and disquieting. I emerge moved, and deeply shaken.

Sunday and Monday, September 9 and 10, 2001

I am haunted by my experiences on September 8. I never cease to be amazed and disconcerted both by man's inhumanity to man and man's capacity to deny, be unwilling to see, and to refuse to grapple with what is unwelcome, unpleasant, or outright intolerable.

Tuesday, September 11, 2001

I am in my office. On Tuesdays and Wednesdays, Catherine G. Fine, PhD, is in an office in the same suite. After a telephone session with a medically-ill patient, I open my door and find Catherine writing me a note. She says a patient just told her that an airplane has just crashed into the World Trade Center in New York. Terrorists on a suicide mission are suspected. I am shocked and stunned but not surprised. I have been convinced for years that terrorists would continue to mount attacks on the United States itself, rather than simply target Americans and American installations overseas. Catherine has her next session open, and my next patient is late. We sit glued to a small television screen. Within minutes we learn about the second airplane crashing into the second tower of the World Trade Center, and see that the Pentagon has been hit. We communicate more with apprehensive glances than with words. Catherine knows my sister works in New York. I know her mother works close to the Pentagon. Inwardly, I begin a worried inventory: Where are my family and my friends? Are they in danger? Are more attacks coming?

Within a few minutes my patient arrives. She is a charming and gracious woman who has former associates and friends both in the World Trade Center and the Pentagon. She has just seen the first tapes of the second plane crashing into the second tower. She feels as if she is floating outside of herself. Television images of what she witnessed are already recurring to her as intrusive flashbacks. Her composure disintegrates in a matter of moments. I encourage her to express herself. She weeps, sure she has lost people she values deeply. I empathize, and in a few minutes her depersonalization and flashbacks stop. Just before the session ends my caller identification indicates my daughter's telephone number. She has never called me at my office before. I excuse myself and take the call. My daughter had been trying to contact my sister, and finally got through. My sister is safe, but after the first crash she and went to an office window that looked toward the World Trade Center. There she witnessed the second plane plow into the second tower. She is badly shaken.

Between patients, Catherine and I return to the television. I tell her about my sister. She cannot reach her mother, and is concerned about her family. She decides to close her office to be available to her family. We talk a few minutes. Each of us finds a way to say it was comforting to have the supportive presence of a good friend in the midst of this horror.

My next patient has not heard the news, and is upset with me for talking to Catherine for a few minutes instead of starting her session on time. A former student radical, she had contemplated participating in terrorist acts and she lived in fear that she might be killed by terrorists. When I explain to her what has occurred, she refuses to believe me for over five minutes. She cannot accept what I am saying. When she comprehends that I am serious, she explodes in rage against the terrorists. It dawns on me that I have been so appalled by what I have seen, and so concerned about the victims and their families that I have not even begun to connect to my feelings about the terrorists.

As the day goes on, I notice that every other business in my building is dismissing its employees early. The street outside my building is jammed with cars. Traffic is not moving. Patients are calling to cancel their appointments. There is fear that Philadelphia, the birthplace of American independence, with the Liberty Bell and Independence Hall, will be attacked. The city has been shut down. Schools have been dismissed early. All major businesses have closed. The abrupt exodus of commuters from the city has created a gridlock downtown. A major highway I can see from my building is at a standstill. In my office, I am unable to tear my eyes from my little television. I watch the second airplane crash into the second tower dozens of times, and witness the towers collapsing over and over again. It becomes evident that I am now just about the last person left in the building, which has been locked shut by security personnel. The rest of my patients are unlikely to be able to reach me. I call them and cancel my remaining appointments.

When I get home, two wonderful gifts await me. Two messages. Catherine has called to say that her mother is safe. After three hours' efforts, she finally got through to her. She had been evacuated from her office building, but she is safe. My sister has called. She reassures me she is safe, and tells me that since all direct bridges and tunnels from New York City to New Jersey, where she lives, are closed, she and some friends are going to try to get home by a very long and circuitous route. I sit in front of the television, amazed to watch this awful history unfold. It is clear to me that there will be very few survivors.

I try to monitor my own reactions. I feel very little personal fear, but I am very worried about others – specific people, my country, Israel, humanity in general. Is this my professional self or some defensive ploy? Perhaps, but in the course of doing trauma work for three decades and in dozens of conversations with colleagues who have lived confronted with terrorism on a daily basis in their own countries, or who have endured disasters and their aftermath, I had come to grips with the world's violence long ago, and made an uneasy peace with the fact of its existence and potential imminence. Over the years I have picked the brains of friends and colleagues in Israel, Turkey, and the Netherlands to understand how they managed to live and function amidst terrorism and disasters.

I find it hard to relate on a personal level to news commentators who talk of how America has always seemed invulnerable and of how Americans are unable to imagine that what happens elsewhere could happen here. Of course I am aware that denial and dissociation are easy, comforting, and consoling on a societal as well as a personal level, so they are widely practiced in the United States, which has been largely spared in comparison to many other nations. My personal belief has been that ideologically-motivated terrorism is by its nature global, and that it was only a matter of time until it reached my own neighborhood. I have been feeling vulnerable for a long time, and, even now, anxiety over that vulnerability is more background than foreground in my mind.

I feel bursts of rage, and moments of patriotic fervor, but overall I feel a profound and intense sorrow for those who were hurt or killed, for those whose loved ones were destroyed or injured, and for the rescue workers. I try to work my way into the rescuers' hearts and minds, and this exercise in empathy is heartbreaking. I admire these men and women. They are going into harm's way. Hundreds of their comrades lie dead or dying in the rubble at ground zero. I am struck by how demoralizing the next few days are likely to be, because I am afraid they will work long and hard and find so few to save or help.

From somewhere in my mind I feel the urge to say the Mourners' Kaddish, the Jewish

prayer for the dead. I stand, and recite it.

When my wife comes home, our conversation is somber and restrained. We discuss the day's events, feeling glad that our own loved ones are safe, and feeling uncomfortably guilty for our gladness at a time when so many have lost so much.

As more information comes in about the hijackers, I find myself unable to focus on anything else. Later that evening I touch bases with Catherine, who has finally succeeded in contacting the rest of her family. We talk about the attack, and each of us has picked up somewhat different accounts. We must be watching different stations. "I am watching NBC," I tell her. "I'm watching CNN," she replies. "Why not watch the station the terrorists watch?" I have my first and only laugh of the day.

Sleep does not come easily. When I awaken, I realize that my television, tuned to CNN, has been on all night.

Wednesday, September 12, 2001.

The following morning I begin to confront the impact of the attacks on my patients. That day alone I find one patient has lost six friends; another has lost her niece; another had just been transferred to Philadelphia by her company, but formerly had worked at its World Trade Center office. Over fifty people she knew are missing and presumed dead. A woman whose children are in a large Jewish school in one of thee target cities reports that on the previous day, some of the teachers panicked, fearing the school might be a target for terrorists, and their terror was deeply unsettling to the children, who now had no reliable adult buffering them against their own apprehension and uncertainty. It took her hours to calm her family.

A school counsellor calls to cancel her session with me. She is sure she will be dealing with overwhelmed children all day. She reminds me that her husband had once worked at the World Trade Center. A man who had lived in New Jersey in a building with a view of Manhattan reflects on the view of the World Trade Center he enjoyed for years. He chuckles. He had once worked there, but was fired. He reflects ironically that the biggest disappointment of his career may have saved his life. He wonders with a mixture of hostility and concern whether the man who fired him survived the attack.

I specialize in the treatment of posttraumatic and dissociative conditions. As a group my patients have had a great deal of exposure to trauma. They are mildly dazed, shocked and apprehensive. Moments of feeling dazed or 'spacey' are often punctuated with periods of hypervigilance. The intensity and the vividness of the media coverage has been amazing. Virtually every patient has spent hours watching the second hijacked plane crashing into the tower, and the collapse of the towers, over and over again. This intense and repetitive witnessing of mass destruction has given rise to a wide spectrum of acute stress disorder symptoms. Hypervigilance and mild anxious and dissociative symptomatology are universal. Many are panicking over further anticipated terrorist attacks. Those who are parents are preoccupied with how to protect their children psychologically. Some are frankly paranoid about Arabs.

Many of my patients with histories of childhood trauma are feeling not only an acute reaction to the events of September 11, but are also beginning to suffer an upsurge of symptoms and concerns associated with their personal traumata. This suffuses their reactions to the attacks and their aftermath, which by some are experienced as personal assaults, evoking the sense of helplessness, horror, betrayal, and total lack of safety they experienced while being abused as children. They have difficulty in drawing upon the

coping skills they developed subsequent to the trauma and in therapy. They suffer terror in the present and terrifying flashbacks from the past.

One woman whose dissociative identity disorder had been resolved short of complete integration for years had abruptly redissociated a part, an age-regressed version of herself fixated at a time she was left alone by her prostitute mother for protracted periods, and frequently molested by a series of mother's boyfriends while mother was away. In session, this part became co-present, and the patient felt compelled to try to run from the office. She saw me at one and the same time as myself (from the perspective of her usual identity) and as a man who had brutalized her. For the next two weeks she would often be unable to go to work, because the dissociated part had enough power to enforce her wish to hide in a closet to avoid being found and mistreated. Every time she heard an airplane or helicopter she panicked, and, whenever possible, ran into a closet or under a table.

Catherine is in the suite this day as well. We discuss the attacks, and hypothesize what other approaches the terrorist groups may take in the future. Our ingenuity in this exercise is alarming. In a free and open society, it does not take much thinking to conjure up potential targets and strategies. We realize that our conversation, usually humorous, is morbid and grim.

That evening I telephone my sister. She clearly is suffering from some acute stress symptoms. It took her over 12 hours to make her way from Manhattan to her home in New Jersey.

Thereafter.

Over the next few days I come to realize that humor, my usual first line of defense, is not as available to me as usual. Being funny has gotten harder. Often my wit doesn't come easily or flow well, and when it comes I often realize it is not really funny or, at least, it is not funny now. I come up with what I think is a clever play on words, substituting 'Taliban' for 'tally man' in a famous Harry Belafonte calypso. I make up a few verses and try it on my wife, who usually appreciates my humor. Now she simply fails to respond. Two weeks later, on Saturday Night Live, a television comedy show, a cast member will sing a verse of the same calypso song with virtually the same word play. He will get applause from the studio audience, and my wife will turn to me and say, "Now that was really funny." For a while, 'funny' just hadn't worked.

When I am not at work, I continue to watch CNN. I find that the music I usually listen to fails to please me. The plight of the passengers who tried to overpower the terrorist in the plane that crashed in Pennsylvania and the tremendous loss of life among the police and firefighters preoccupy me. I find myself responding strongly to displays of patriotism that I usually find corny and off-putting. I am surprised to find myself looking forward to New York Mayor Rudy Giuliani's appearances on television. A month before I had been making fun of his notorious and all-too public affair and marital woes. Now he stands before the nation, determined to raise morale and to promote the recovery of his city. A man I had no particular respect or affection for has become a heroic figure. He has risen to the occasion, the symbol of the nation's refusal to be driven to despair.

Back in the office, and in my personal life, I begin to notice in many people, including myself, a distressing lack of concentration and an uncharacteristic irritability.

I use a fountain pen whenever I can. I love these writing instruments and have a number of very good ones, which I care for meticulously. On a number of occasions I fail to put my favorite pen in my pocket when I prepare for work. I also leave some pens out when I

usually put them away very carefully. Fearful of losing a good pen, I use cheap ball-point pens for the first time in years. I forget to water some of my plants, also among my favorite things. For about a week I loose patients' trains of thoughts more often than ever, and find myself having difficulty concentrating on concerns that are very important to them, but keep getting pushed out of my mind by preoccupations that relate to the terrorist attack. I am so busy taking care of others that I have been unable to take time to process my own feelings. They intrude insistently into my therapeutic work.

Although I and others are making special efforts to be caring and considerate, I experience a low grade vague irritability and feel it radiating from many others. Many of my patients are being somewhat snappy. I find I have been harsh to a patient with whom I have always had an excellent relationship, and that she has done nothing to provoke it. As soon as I notice the irritability has gotten out of control, I am alerted and can contain its expression, but my concentration remains dismal for about a week. I also notice that for a period of days, many of my usually automatic behaviors, actions so ingrained that they are for all practical purposes dissociated with a life of their own, have ceased to be automatic. I find I have to give deliberate thought and effort to make them happen. I have tied my tie the same way since I was a teen-ager. I usually give it no thought. The Friday after the attack I find myself looking at the mirror actually having to try to remember how to do a task I have done well over seven thousand times. I consider myself fortunate when these symptoms leave me. One day, while reflecting on these experiences, I found that the daily cartoon on my 'Far Side' (a humorous cartoon series) calendar depicts from behind a man, presumably quite befuddled, sitting up in his bed. The sun is just rising above the horizon. Pinned to the wall in front of him is a large sign that reads: 'First Pants, Then Your Shoes.' This speaks to me. After such a shock, if we are fortunate, we recover our normal behaviors bit by bit.

From the day of the attack I have heard an outpouring of anti-Arab sentiment. Some Arabs, Pakistanis, and Sikhs have been attacked. Some patients are avoiding stores owned by Middle Eastern and Asian individuals, almost all upset and embarrassed by their own prejudices. One patient who flies to Philadelphia to see me has realized that she lived very close to where some of the terrorists had stayed. She is terrified that there are still more terrorists nearby, and begins to avoid anyone who looks even vaguely Middle Eastern. A few days after the attack I call to discuss a referral to a medical colleague whom I respect and value. We know one another fairly well professionally, but all our contacts have been over the telephone. We have never met face-to-face. I am shocked to learn that she is Muslim, and has been listening all day to her patients demeaning her co-religionists, making no distinction between Muslims and terrorists who are Muslims. She has begun to fear attack or professional difficulties if her Middle Eastern origins and her religion become known. She is terrified for her children's well-being, and for the safety of her husband, whose ethnicity is more obvious than her own.

As I stay in touch with my sister and some friends from New Jersey, my home state, I am glad to find that most of them are rapidly rebounding and getting on with their lives. However, there are some chilling vignettes almost every day. Of a group of four affluent women who play doubles tennis and lunch together frequently, all but one was married to financial wizards who worked in New York. Now three are widows. A friend in a town from which many people commute to New York tells me that since September 11, there have been over 30 cars in the parking lot of the local train station that have not been moved. Their

owners all worked in the World Trade Center. My sister tells me that she now knows of several dozen people from her own neighborhood who commuted to New York the morning of September 11 and never returned home after the terrorist attack. I learn of children left in day care or school the morning of September 11, who lost both parents in the attack. Within a week of the attack the first of my patients to loose her job because of attack-related cutbacks and layoffs is unemployed and desperate.

As most of my patients loose their new acute symptoms by the end of September, I am impressed that what remains for many is the sense of vulnerability and the reactivation of former symptoms and concerns. However, some retain their hypervigilance about airplanes, and cringe whenever an aircraft's sound is heard. Among those who had been traumatized before, most feel reconfirmed in their trauma-centered view of the world, endangering the gains of years of therapy. They say words like, "You see, I was right. There's no such thing as a safe place. There's no such thing as a person you can trust." At this point, I do not know how long these attitudes will persist. Several dissociative patients become very depressed. They have coped by dissociating what is unpleasant and traumatic, and they find themselves unable to use this defense as they had before. For some, this represents an improvement. They have progressed far enough to cope in other ways, and can and now must tolerate the pain of dealing directly with life. For a few, not only can they not dissociate the present trauma, they have suffered the cracking of their dissociative barriers against the pain of the past, and they are becoming flooded with traumatic, often previously unknown, material.

As the days pass by, the Jewish holidays are especially poignant for me. People we know slightly but have always liked, invite us to their home. We accept. It is a time for gathering.

I subscribe to a few groups on the net, and follow therapists' discussions of the impact of trying to help others deal with their fears when they themselves are afraid, and uncertain. I am struck by the differences across the different groups. Some seem profoundly aware of the enormity of what has occurred, and appreciate that it will take time to address its psychological consequences. Others are amazingly naïve, and advocate amazingly simplistic solutions to incredibly complex therapeutic dilemmas and countertransference responses. I try several times to draft a helpful remark to one of these groups, but I cannot find a tactful way to make a constructive contribution. I wonder what planet the people in that group live on.

With the passage of time, my patients' reactions became more unique and individualized, and more consistent with their unique personal dynamics. One isolated woman went from first acquaintance to marriage with an equally isolated man within two weeks of the attack, and hid this from me until it was a fait accompli. Both she and her partner felt compelled by a sense of urgency to connect, because any day might be their last. People made strenuous efforts to mend relationships or to begin to implement a long-delayed plan of action. One woman became convinced that she would be destroyed in an imminent war, and gave away much of her wardrobe, unwittingly reenacting her preparations for suicide after experiencing a terrible abuse in her teens. In each case, there was no discussion of these events in therapy until after they had occurred. They seemed to be trauma-instigated enactments and reenactments.

As the days went by, I search for ways to make a contribution. Right now with all the chaos I have in my practice, including the destabilization and return of some patients who had terminated apparently successful treatments, I cannot leave my own patients to volunteer in New York. At the meeting of my psychoanalytic society, I propose that, in anticipation of long-lasting sequellae from this terrorist attack, and the likelihood of additional atrocities, we form a group

to study this type of trauma with a view toward building bridges between contemporary trauma theory and psychoanalytic concepts of trauma. Within minutes I find myself the chair of a new task force and study group. Some of the most senior and prestigious members of the society volunteer to join me. I am deeply touched. Many had been my teachers and supervisors.

In another professional meeting I shared what I had observed in myself and others in terms of how the recent events had impacted my concentration and irritability. Many colleagues expressed their gratitude. They had had similar experiences, but thought that they must be the only ones suffering them.

A few remarks on hypnosis and hypnotizability. In view of the fact that I work primarily with highly traumatized and dissociative populations, I do not know whether any generalizations can be drawn from my observations. In the first few days after the attacks I did relatively little formal hypnotic work except for symptom control and anxiety relief. However, almost all of my communications with patients who were having posttraumatic and/or dissociative symptomatology were received as if the patients were in trance. I had to be extremely careful about my remarks and interventions lest I inadvertently make a counterproductive suggestion. Many patients seemed much more hypnotizable in the few days after the attack, but their enhanced hypnotizability occurred in the contexts of the intrusion of acute stress symptomatology, the eruption of materials and experiences from the past, and a diminished capacity to maintain a ribbon of attention. With disrupted concentration, they often veered away from the ostensible subject of the hypnotic work to have hypnotic engagement with inner stimuli or extraneous external stimuli. For example, patients in trance who usually failed to respond to noises audible in the office, or with whom such noises could be used in the service of the trance experience, often opened their eyes and/or had a startle response if an aircraft flew overhead or if there were some sharp noise. Attempts to bring about calm in the present often resulted in hypnotically intensified fantasies of danger or harm. I also found a few patients so reluctant to leave the comfort of their trances that it became rather difficult to dehypnotize them. After a series of such experiences I cut back my use of hypnosis for a while, except to intervene when my patients' autohypnotic or spontaneous trance experiences went astray. Three weeks after September 11, I was able to use hypnosis judiciously with most of my patients for whom it was indicated or potentially useful. Some had not yet restabilized.

Looking forward.

Next week my wife and I are going to Boston for a course, and to visit family and friends. We will fly into Logan Airport, the most poorly protected airport in America, the airport at which some of the September 11 terrorists bypassed security and began their fateful hijackings. We will check into our customary hotel. You may have seen it on the news. Several of the hijackers stayed there before the fateful day of September 11, 2001. Will we be apprehensive? I don't know. But, in any case, we will go. We do not choose to allow terrorists to dictate our actions and choices.

Is that brave behavior? I don't see it that way. When things get disorganized, it is important to set them right and reclaim your life. Just like the befuddled gentleman in the cartoon, sometimes our putting things back together begins with acts as simple as getting up in the morning, studying the note on the wall ("First pants, then your shoes"), and behaving accordingly.

SEPTEMBER 11, 2001

Peter B. Bloom, MD

Our world changed on September 11, 2001. Now, nearly a month later, I am grateful that reason and restraint has prevailed while we absorb the impact of this event on our country and our world. However, as I write this on October 7, our planes have initiated our promised military response, and none of us know how this will all end. In this setting, I have been asked to comment.

I travelled to 'ground zero' last Saturday, two and one half weeks after the World Trade Center was destroyed. I was concerned about how I would feel looking at these ruins knowing victims remained within. I wondered if I would experience, as so many have and will, the awful shock of deep trauma that could haunt me personally for months to come. However, the trip had been planned to visit my brother and his wife in New York and to avoid it was not acceptable. So I went.

We walked three or four miles gradually approaching the site. Those few who shared our particular path merged with those on other paths until we found ourselves in a slow moving quiet mass of people. As we approached the two city-block limit surrounding the site, we saw the familiar sights shown repeatedly on televised reports: the mound of rubble with giant cranes at work, the ever present dust still being gently blown off and into our faces, and the enormous American flags hanging in silence from the remaining intact buildings nearby.

What did I feel? I was mostly surprised. While acknowledging the terrible loss of life, and the near misses by people like my own son who was scheduled to be in the World Trade Center the very next day, I was moved more by calmness and determination. Why on earth would I feel this quietness when, in the days before, I had been horrified, saddened and angered? I think it was the people around me – always the most important 'soul food' in my life. The crowd was hushed, moved slowly, and spoke quietly to one another. Americans from every possible origin and visitors from other countries were watching side by side thinking and feeling as one. Many of us spoke to each other and to the policemen, the firemen, and the national guardsmen. We told them how grateful we were for their presence. They thanked us and expressed their appreciation for our support during their own individual losses. The miracle of that gathering for me was the beginning of a transformation from my initial shock to feelings of pride, strength, and human kindness that were re-emerging even in that tragic place of destruction and loss. We had begun our recovery and now were slowly becoming free to face the future.

During my years in ISH, I have expanded my sense of American citizenship to world citizenship. I believe we are members of a world community. My friends around the world have taken my wife and me into their homes, as we have welcomed them into ours.

I am convinced that our worldwide relationships, as friends and as colleagues, are a very special and necessary foundation for us all during these difficult times. These relationships must be preserved and strengthened. We must travel, we must share our knowledge internationally at congresses and in journals, and we must share the special skills we use in caring for others during these times of stress. Even more though, we must care and nurture our relationships with each other in trust, honesty and love.

I believe that we must respond to this September act of terrorism with vigor and persistence. We must do our best to insure it does not happen again. But we must also discover the reasons behind the current profound level of misunderstanding and mistrust that motivated what has happened. It is the long-term solution that will be the hardest to achieve.

FLEMISH SOCIETY OF SCIENTIFIC HYPNOSIS – VHYP

Vlaamse Wetenschappelijke Hypnose Vereniging

This month we could start with a new training group in hypnosis; a lower number of attendants, compared with previous years, can be explained by the new formula, where participants are asked to commit themselves for the whole training program, instead of an A-course, with induction and deepening techniques, followed by a new commitment to take a B-training, with different applications of hypnosis. Not a single GP, in the training and only one dentist applying, who has been referred to a later training. On the other hand, we notice growing interests from the hospitals. Assistance has been asked a children's hospital, where also ideas are growing to do some training with the staff members.

In the meantime we are preparing the upcoming spring congress : ***'Learn young, learn fair'***, Hypnosis with Children and Youth. to be held in 2002, April 19th and 20th . We invited Laurence Sugarman MD and Howard Hall Ph. D. and expect also attendants from abroad.

Our Flemish journal in dutch 'TRANS', had an edition with reports from the ISH congress, in Munich, and another edition completely devoted to dermatological applications of hypnosis.

Nicole Ruysschaert was invited at the Bulgarian congress of Hypnosis and Hypnotherapy, that took place in Sofia, 2001, September 21-23th; Milen Nikolov (Bulgaria), organized the congress and succeeded in bringing together different West European colleagues as Henri De Berk (Netherlands), Susanna Carolusson (Sweden), Consuela Casula and Tommaso Longobardi (Italy) Patrick Noyer (Switzerland) and East European colleagues. About 80 participants attended the congress, and were eager to experience and to learn hypnosis. Even the often necessary translation, sentence by sentence didn't interfere with trance experiences. For all presenters it was a fascinating experience, where we also could reframe ourselves, and come back with different perspectives on life, living, problem definition, and more insight in common and different life styles and meanings.

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BRITISH SOCIETY OF MEDICAL AND DENTAL HYPNOSIS – BSMDH

Rhona, our secretary for many years, has had to retire due to ill-health, we hope her health improves without the stress of us! Now the contact details for our office are:

Julia Say, 4 Kirkwood Ave.,Cookridge, Leeds, LS16 7JU. The tel/fax number remains the same: +44 07000 560309 and so does the e-mail: nat.office@bsmdh.org

After many years of guarding our accounts Martin Wall has moved on to greater things, he is now the President of the Section for Hypnosis and Psychosomatic Medicine at the Royal Society of Medicine. We welcome Geoff Ibbotson to the post of Treasurer and trust he will have a successful and enjoyable time in office. Those of you who know Geoff Graham will be glad to know he is making great progress since his recent CVA and is now keen to have contact with all his friends and colleagues.

Finally, I am sad to report the deaths of two of our well known members Dr Diana Cornick and Dr Barrie Millar, they will be sorely missed.

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GERMAN SOCIETY FOR DENTAL HYPNOSIS

Deutsche Gesellschaft für Zahnärztliche Hypnose

Dental hypnosis is continually growing in popularity. More and more patients and dentists in Germany send their requests to the Central office of our society asking for treatment or training. Our day of 'Gentle Dental Treatment' last year was a great success. More than 100 dental surgeries opened their doors for press and TV and there were even live broadcasts of hypnotic dental treatment.

As a result of all this, our society has grown to over 1000 (!) members this year and we are very proud of this growing interest and enthusiasm.

Our website http://www.dgzh.de presents an overview of our main events and topics. There you can also find a list of dentists trained in hypnosis.

International Congress on Gozo/Malta

Our International Congress on Gozo – held every year during the week before easter – was a great event this year. Among the lecturers were Victor Rausch from Canada – well known for his famous 'Rapid Induction Technique' – and Geoff Graham, the charismatic expert in hypnosis and NLP.

After seven days of workshops, trance and creative work the 150 participants left the island full of new ideas and highly motivated.

We are already looking forward to meeting again next year from March 20th to 27th. Preparations are already going on and there will be famous and internationally renowned trainers among the lecturers again.

Particular emphasis will be put on the interdisciplinary exchange among professions. All kinds of practitioners in hypnosis are welcome to join us.

7th Annual Congress of the DGZH e.V. in Berlin
September 14th – 16th 2001

Actually we are just returning from our 7. annual meeting at the 'Steigenberger Hotel' in Berlin. It was a very busy congress and about 350 people from all parts of Germany joined us for a weekend full of interesting topics. Workshops for experts and for beginners attracted the curious as well as the experienced. The programme particularly met the growing demands for information and training in hypnosis with children.

Regional groups and encounters

The foundation of new regional groups ('Regionalgruppen') all over the country demonstrates the success of our society. The meetings of practitioners on this level constitute the basis for the above mentioned interdisciplinary exchange among dentists, physicians and clinical psychologists. A first regional contact has often been the starting point of fruitful joint activities.

If you are interested in our society, our work, and our plans and projects, do not hesitate to contact us: Geschäftsstelle der DGZH e.V. (Central Office),
Esslinger Str. 40, D-70182 Stuttgart, Germany,
Tel.: +49711 2360618; Fax: +49 711 244032; E-mail: mail@dgzh.de

GERMAN SOCIETY OF MEDICAL HYPNOSIS AND AUTOGENIC TRAINING – DGAHAT

Deutsche Gesellschaft für Ärztliche Hypnose und Autogenes Training

On the general meeting of the 7. Conference the society in June 2001 reminded the chairperson, Mr. D. Clausen, on diverse activities of the society. A further education-calendar appears under other in the circular and in the internet with offers to the lectures of the society. Also the list oft the active therapists participates to get in the internet and also on the mail route of the offices. The society has looked after contact to European and international societies with national and international conventions.

A conference for the autogenic training under the direction of private-lecturer Dr. Stetter participates planned for the Spring 2002. Dr. K. Binder, long-time lecturer and regional-position-leader of the society, was given a farewell in worthy form. He took part in the preparation of the further education-guidline autogenic training of our society strongly. He has transferred also the book of his uncle, Mr. Helmut Binder, again. It participates a standard-work in the German language-area meanwhile: "Autogenes Training – Basispsycho-therapeutikum".

Mr. Prof. Lohmann handed over the scientific archive of the society for old-age-reasons. It now participates accessible in Blankenburg at the resin. It was fixed that in each case there, where the scientific archive, also the bust of our originator, Professor Dr. Dr. H. C. J. H. Schultz, its temporary location finds.

The next conference becomes in Blankenburg again, however already take place on the basis of the early beginning of the summer-vacation from the 7 – 9. June 2002. The topic is: 'Autogenic training and hypnosis with the psychic trauma'.

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MILTON ERICKSON SOCIETY FOR CLINICAL HYPNOSIS GERMANY – MEG

Milton Erickson Gesellschaft

In 2003 M.E.G. will celebrate its 25th birthday with a very special annual conference taking place in Göttingen (22.3.2003). The main topic centers around hypnoanalysis and

Ego-State-Therapy sensu John und Helen Watkins. We'd like to present lectures, discussions and workshops on different therapeutic models and concepts like Multiple Personality, Freud's tripartite model (Id-Ego-Superego), Schmidt's Inner Parlament etc.

Since this conference will simultaneously be running as the first world congress of Ego-State-Therapy, we intend to invite internationally renowned lecturers who have developed and advanced Ego-State-Therapy in its present state of the art. An excellent chance for beginners and advanced practitioners to learn from many masters.

M.E.G. provides further information as soon as possible.

Please note: The central office of M.E.G. is now located near to Nymphenburger Park:

(Central Office: M.E.G., Monika Kohl (executive officer), Waisenhausstr. 55;
Tel. 089 340 297 20; Fax 089 340 297 19; E-mail info@meg-hypnose.de).

Dr.Phil. Dipl.-Psych. Burkhard Peter and Dipl.-Psych. Wilhelm Gerl still reside at:
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ITALIAN MEDICAL ASSOCIATION FOR THE STUDY OF HYPNOSIS – AMISI

Associazione Medica Italiano Studio di Ipnosi

AMISI – 12 TH NATIONAL CONGRESS
ITALIAN MEDICAL ASSOCIATION FOR THE STUDY OF HYPNOSIS

TWENTY-FIRST CENTURY HYPNOSIS
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CARIPLO CONGRESS CENTRE,
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NOVEMBER 23 – 25, 2001

INVITED SPEAKERS: DR. ÉVA BÁNYAI, PHD
DR. BURKHARD PETER, PHD, D. PSYCH.

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JAPANESE SOCIETY OF HYPNOSIS – JSH

日本催眠医学心理学会

The 47th Annual Meeting of Japanese Society of Hypnosis was held successfully on August 3rd to 5th, 2001, at the Hokkaido University, which included a two-day well organized workshop (primary and intermediate courses) and a two-day scientific program.

In July new members of JSH-Board were elected. Dr. Toshimasa Saito was elected as the president for his 3rd terms until 2003. From October 1, new license systems for authorized hypnotists by our society has commenced. There are two kinds of license, Primary and Advanced ones.

Toshimas Saito, PhD President of JSH

ERICKSONIAN CENTRE OF MEXICO – CEM

Centro Ericksoniano de Mexico

Development of an ericksonian rating scale in México.

Francisco Robles Uribe MD. Felipe Vázquez Estupiñán MD

We reported in a previous issue on our intention of developing an Erickosnian rating scale. This is to follow on the progress. Ericksonian hypnotic phenomena are a set of skills and features potentially available to every human being. At the Centro Ericksoniano de México we are developing a scale to measure the frequency and intensity of such phenomena.

Through the development of an ericksonian rating scale it is possible to empirically demonstrate to what extent hypnotic phenomena are innate and how these experiences are learned in sequential trials or events in hypnotic sessions. Even more, we can establish correlations between the frequency and intensity of these events and the therapeutic progress.

Felipe Vázquez Estupiñán and Francisco Robles Uribe have divided the elements of the construct 'ericksonian phenomena' into the following components:

1. The ability to get into trance or 'letting go'.
2. The ability to develop distortions of body sensations like heaviness or lightness, changes in body temperature, sensations of levitation and paresthesia.
3. Time distortion.
4. Perceived empathy of the therapist.
5. Visual, auditory, tactile, olfactory and gustatory imagery.
6. Time progression and regression
7. Perceived ability to use inner resources

We selected this set of events with the idea that they are abilities used to develop trance and tools to create therapeutic experiences. For example, if we are able to identify that a person is prone to experience regression in time, we can perform techniques that capitalize this potential.

The initial analysis of data on six hundred participants in our study has allowed us to classify ericksonian hypnotic phenomena into two broad categories: a) simple (the first three in the above list) and b) complex phenomena (fourth to seventh phenomena on the list). In the first category we put the most common and easy phenomena elicited by a trance experience. Apparently both phenomena increased their frequency with every subsequent trance experience, but the complex phenomena increased even more with subsequent sessions and seems to be essential in the therapeutic or change experiences involving and

array of symbolic and complex experiential processes.

The item content of the scale was recently modified and expanded from eleven to thirty three items, incorporating dissociation, separating the evaluation of different sensory channels and considering previous trance experiences.

We hope that this identification and measurement of trance phenomena could led us to enhance the tailoring of techniques to the individual and help to characterize the differencesof a variety of clinical conditions. The work currently developed at the Centro Ericksoniano de México includes the face, construct, content and concurrent validity of the instrument as well as its reliability. The confusing items were dropped and new ones were incorporated. We are approaching this instrument as a living creature thriving and evolving continuously. In future communications we are going to report the peculiarities of the reports of clinical and open samples, gender differences and responses obtained from samples of white and blue collar workers, among others.

We are working as well in the factorial analysis of the items to fully validate the factors that comprise the 'ericksonian experience'. Another basic issue that arises in the research horizon is the comparison of these hypnotic phenomena among different cultures; for this purpose we are linking to ericksonian societies throughout the world in order to make this aim possible.

Other News from Centro Ericksoniano de México

We have also signed another agreement with the Experimental Psychology Department at the Eotvos Loránd University in Hungary. This agreement was signed with Éva E. Bányai, who is the president of the ISH, and who currently heads this department. The purpose of this agreement is that by interchanges people from that University can come to our courses at the Centro Ericksoniano de México and that our students can go and study with them at their University. I, Maria Escalante Cortina DDS attended a course on Experimental Psychology in April and a student from that University will come to study with us in February 2002. We believe this will be an excellent opportunity both for Mexican and Hungarian students. In the year 2000 Katalin Varga who is both a teacher and Psychologist at the Eotvos Loránd University came to our Centre in México city and gave us a course while she was studying in our Centre.

We are very pleased to let you know that the ISH board of Directors finally voted in order to decide which Centre or Institute would organise the 17th Triennial Congress of the ISH on the year 2006.

The Board finally decided this Congress would be organised by our Centre, The Centro Ericksoniano de México and we are extremely happy to give you this news. We believe this will be an excellent opportunity for sharing with each other what we know, talk about results of researches and even why not, enjoying our country's wonderful historical places, landscapes, beaches, Mexican traditions and cuisine, during this event.

The Congress will be held in Querétaro, a state that is located only two hours away from México City by car. The City is well known due to its architecture, colonial places a beautiful auditorium named Josefa Ortiz de Domínguez where part of the Congress will take place and it is also near the traditional City of San Miguel de Allende.

So it is time to think about coming to México both for the Congress and for enjoying some vacations here. We will have activities for your spouses and children as well …See you in México!

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SWEDISH SOCIETY OF CLINICAL AND EXPERIMENTAL HYPNOSIS – SSCEH

Svenska Föreningen för Klinisk & Experimentell Hypnos

I will present some news about the office, the journal, the educations, ethical problems and an event in the interest of Building Bridges (a familiar concept in ESH and ISH).

The office: The SSCEH board has had a new president for two years now: Armando Liscano. Past president Stefan Fransson held the position during so many years and he is now the editor of the newsletter of hypnos, the part printed in Swedish. Stefan will celebrate his 50th anniversary in November. We also have a meticulous treasurer, Elisabeth Lindgren, who succeeded Torbjörn Hellenius, who held that office for many many years, and still is active with administration for SSCEH.

Education: Our 64 hrs hypnosis educations at a basic level is offered each year in at least two sites in Sweden simultaneously, and they are much asked for! Hypnosis for Pain management is offered regularly and Brian Roet, London, is an appreciated, humorous and easy-going guest lecturer in these seminars.

Our advanced postgraduate psychotherapy education, 80 university points/4 years, is in its phase of separation; the participants will have their degree as licensed psychotherapists this winter! We are quite proud of a qualitatively well developed education program, and according to the students' feedback we have attained the goals of integrating cognitive psychology and strategies with a stock of psychodynamic supervision, knowledge and hypnotic skills.

We have invited ass. Prof. Psychologist Hans-Christian Kossak from Bochum in Germany to demonstrate and teach about stage hypnosis. He will demonstrate for a closed group of students (my groups final seminar), with the purpose to explain the phenomena at stage, and also the risks of stage hypnosis.

I have invited the National Board of Health to participate as temporary students, because if anyone wants to perform stage hypnosis in Sweden, they will have to ask this Board to make an exception to the Swedish law. Unfortunately such permissions have been given recently. In order to avoid such scandals, SSCEH advanced education group is inviting responsible officials to gain more knowledge about the phenomena at work. Knowledge should equip them with the courage to refuse applicants. So far, their response indicates no interest to learn more. – Our correspondence will continue…

Building Bridges: For the ISH members it could be nice to know about the Bulgarian society! We were a group of European teachers, invited to the BUIB hypnosis conference in Sofia last September. BUIB is only two years old and they are eager to learn and eager to help their countrymen and clients. Among the invited European teachers were: Michail Guinsburg (Russia), Susanna Carolusson (Sweden), Henri deBerk (Netherlands), Consulo Casula (Italy), Tomasso Longobardi (Italy) and Patrick Noyer (Switzerland). Jerzy Siutas paper (Poland) was presented by a young, very talented researcher: Przemyslav Babel. From Rumania came Alexandru Tiba, also a promising student! – We were well received and taken care of by Milen Nikolov, the president of BUIB.

Susanna Carolusson, lic Psychologist & lic Psychotherapist
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THE INTERNATIONAL JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS – THE EDITOR'S UPDATE

Subscribers tell us that they have come to especially appreciate the SALIENT FINDINGS section of each IJCEH issue. This section summaries the very important and recent articles about hypnosis which have appeared in the general medical, general psychological, and broad scientific literatures. In this way our subscribers not only are apprised of other new developments in the field, but are cued to how hypnosis is faring in the broader scientific literatures. We are highly selective, using a criterion such that only articles which should be missed by no one in the hypnosis community, are summarized. Below is a sampling of recent SALIENT FINDINGS entries.

JOURNAL: Scientific American

Nash, M.R. (2001). The truth and hype of hypnosis. Scientific American, 285, 46-55.

The author of this July 2001 cover story article seeks to convey to an informed general readership what research has to say about the nature of hypnosis. This is a formidable task under the best of circumstances, and one which is made more challenging given the space constraints of a popular publication. The tact taken is to initially identify common misconceptions about hypnosis and directly confront those misconceptions with evidence. In doing so Nash (2001) first summarizes the methodological developments which enabled contemporary hypnosis research to mature. This helps the reader disengage from the old stereotypes surrounding popular notions of hypnosis, and to explore 'What hypnosis is' and 'What hypnosis isn't.' This is done in a user-friendly way by including a table with 15 common misconceptions about hypnosis alongside the actual facts in each case (e.g., The common misconception that 'People with certain types of personalities are likely to be hypnotizable' is countered with 'The reality is there are no substantial correlates with personality measures'). In further elaborating on the nature of hypnosis as revealed in the laboratory Nash (2001) cites and describes many classic studies which are familiar to the readership of the International Journal of Clinical and Experimental Hypnosis (IJCEH). This includes the seminal work of Weitzenhoffer and E. R. Hilgard (1959, 1962, 1967); the instructive cross-sectional and longitudinal studies of hypnotizability (Morgan, Johnson, & E. R. Hilgard, 1974; Piccione, E. R. Hilgard, & Zimbardo, 1989); the study of hypnotic analgesia and placebo response following experimental pain by McGlashin, Evans, & Orne (1969); the 'disappearing hypnotist' (Orne & Evans, 1966); active-alert hypnosis (Bányai & E. R. Hilgard, 1976), and others. Nash then proceeds to highlight more recent work using emerging technologies such as positron emission tomography (PET) in advancing our understanding of hypnosis (Rainville, Duncan, Price, Carrier, & Bushnell, 1997; Szechtman, Woody, Bowers, & Nahmias, 1998). Prior to addressing the question of clinical efficacy, Nash offers two cautionary paragraphs about the plasticity of memory and the perils of assuming that hypnosis enables individuals to relive the past in a literal manner. The section on clinical efficacy follows where Nash effectively describes the latest thinking on when, how, and for what problems hypnosis might be useful.

In sum, the article can be viewed as a primer of hypnosis, and it will not only serve as an excellent tutorial on hypnosis for the general readership of Scientific American, but it will also serve to inform future generations of serious students in the behavioral sciences and medicine about the nature of hypnosis. It has been over four decades since an article dealing with hypnosis has appeared in Scientific American, and the wait has been worth it. This cogent commentary by Nash (2001) is comprehensive, objective, and lucid. It will not only serve its intended purpose of informing those who are intellectually curious, but it will also have the added effect of making it easier for basic and applied researchers to do work in hypnosis and get proper credit for it.

William P. Morgan, Ed.D. – University of Wisconsin-Madison

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Pates, J., & Maynard, I. (2000). Effects of hypnosis on flow states and golf performance. Perceptual and Motor Skills, 91, 1057-1075.

Treggiari-Venzi, M. M., Suter, P. M., de Tonnac, N., & Romand, J. (2000). Successful hypnosis as an adjunctive therapy for weaning from mechanical ventilation. Anesthesiology, 92, 890-892.

When carried out properly, case studies can yield perfectly respectable scientific information about whether an intervention worked beyond mere chance, and some-

times even how it worked. The importance of case studies has been underscored by their inclusion in the APA methodological guidelines for defining an intervention as efficacious (Chambless and Hollon, 1998). In 2002 the International Journal of Clinical and Experimental Hypnosis will publish a special issue on when and how to design and carry-out valid case studies.

Four case studies have been published in the past few months which together highlight some of the reasons why the Journal has decided to devote a special issue to this matter. All four studies (three in medical journals and one in a psychology journal) also point to some interesting and innovative applications of hypnosis which, if the researchers had been tracked or analyzed them just a little more systematically, have yielded more definitive results. The first is a report by Ran Anbar (2001) on use of hypnosis with chronic dyspnea in children ages 8-18 (mean age 13.4). In this case the dyspnea (recurrent difficulty breathing or shortness of breath) was studied among 16 children who had normal pulmonary tests with no structural abnormalities. Self-hypnosis was taught to each patient in one or two 15-45 minute sessions. Thirteen of the 16 patients had improved at 20 month follow-up. Five reported resolution immediately post hypnosis; six others reported a gradual decline in symptoms with application of self-hypnosis The merit in this study is its innovative approach to what appears to be a not uncommon clinical problem. On the other hand, without a careful tracking of improvement over the 20-month period, it is difficult to determine whether hypnosis had anything to do with resolution. The fact that five patients reported immediate resolution is intriguing though.

A novel application of hypnosis was reported by Ran Anbar and David Hehir (2000) with an 11 year old boy suffering from respiratory distress episodes which sometimes resulted in loss of consciousness. There were repeated trips to the emergency room where inhalation resolved with oxygen and bronchodilators. From the age of 9 the boy was reported to have these episodes, typically interrupting sleep. He had a 4-year history of refractory asthma, and severe gastroesopageal reflux disease, and was under the care of a psychiatrist for anxiety. The question at issue was whether the boy suffered from vocal cord dysfunction (VCD), a condition of paradoxical adduction of the vocal cords during inspiration, and a problem which could explain the symptom features. Definitive diagnosis of VCD requires observation of the adduction via fiber-optic laryngoscopy during an attack. Provocation of an attack is sometimes achieved using methacholine, histamine, or exercise challenges. In this case hypnosis was used to successfully induce the symptoms during the laryngoscopy. An adduction of the vocal cords was indeed noted, and the proper treatment plan implemented (in this case speech therapy). Interestingly the boy reported spontaneous amnesia for the diagnostic procedure. The boy was reported to be a good hypnotic subject but apparently no attempt was made to measure hypnotizability. The author wisely notes that inducing such a respiratory episode with a patient must be done in an appropriate medical facility where emergency equipment and personnel are immediately available.

The third report describes the successful use of hypnosis as an adjunctive therapy for weaning a 46-year-old surgery patient from mechanical ventilation. The patient had a history of pulmonary tuberculosis, ischemic heart disease, gout, psoriasis, and alcohol abuse. He underwent right pneumonectomy for invasive aspergillosis. There were multiple problems with the healing process during the course of post-operative mechanical ventilation. Following infections and other complications the patient had a

tracheotomy performed on the 77th postoperative day. By this time the constant stress of ongoing uncertainty with multiple life-threatening episodes began to take its toll on the patient. He was demonstrating sleep disorder, severe anxiety, feelings of intense vulnerability, and a sense of impending death. At the point where medical weaning from mechanical ventilation was attempted, the patient was unable to tolerate more than 12 hours per day off the ventilator. At day 88 an hypnotic intervention was begun. Hypnosis was incorporated into a cognitive-behavioral approach which aimed at allaying anxiety and increasing time off the ventilator. Hypnosis sessions were 10 to 20 minutes in duration and appear to have been on a 2 to 3 times a week basis. After five such sessions self-hypnosis was taught. Sixteen days after onset of treatment with hypnosis the patient was off ventilation entirely. The authors present a clear figure which tracks the daily amount of time without mechanical ventilation, along with physiological indices of respiration. This is a splendid data set and might have been augmented with some current time-series statistical analyses. Still, this paper reports on an appropriate and interesting application of hypnosis in medicine which fits in quite nicely with the review of the literature on medicine and hypnosis by Pinnell and Covino (2000).

The final case study (Pates & Maynard, 2000) examined the effects of an hypnotic intervention on golf-chipping performance of three athletes using an ABA design where a baseline is established (Phase A), followed by a treatment phase where hypnosis is used (Phase B), followed by a third phase during which hypnosis is discontinued (Phase B). If the intervention is helpful, one might expect an increase in performance during Phase B relative to that during Phase A, and a return to baseline during Phase C. The hypnosis intervention involved relaxation, imagery, hypnotic induction, hypnotic poly-sensory suggestions, and trigger procedures over five weeks and seven sessions. The results appear to document the pattern of findings described above, with all three subjects performing best during Phase B (i.e., during the hypnosis intervention phase). However, no attempt was made to assess whether this pattern differs from chance, or whether demand characteristics might be at play. This notwithstanding, the ABA design is quite powerful in some cases and might be considered by clinicians who wish to systematically track the patient's symptom status before, during, and after treatment. In clinical contexts however an ABAB design is typically used where an extra phase is added where the treatment is reinstated.

References

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. Journal of Consulting and Clinical Psychology, 66, 7-18.

Pinnell, C. M., & Covino, N. A. (2000). Empirical findings on the use of hypnosis in medicine: A critical review. International Journal of Clinical and Experimental Hypnosis, 48, 170-194.

JOURNAL: Seizure

Goldstein, L. H., Drew, C., Mellers, J., Mitchell-O'Malley, S., & Oakley, D. A. (2000). Dissociation, hypnotizability, coping styles and health locus of control: characteristics of pseudoseizure. Seizure, 9, 314-322.

Research focusing on the causes and nature of psychogenic non-epileptic seizures are relatively rare. The authors of this study rightly note that pseudoseizures have been linked to stress, anxiety, and dissociative proclivities. Further, some theorists posit a link between

dissociativity and hypnotizability, especially in their clinical manifestations. This study sought to test the notion that pseudoseizure patients would exhibit higher levels of dissociation, a more emotion-focused coping style, and greater hypnotic susceptibility than the general population. Twenty pseudoseizure patients and 20 non-patient control subjects matched for age, gender, predicted IQ were administered the Dissociative Experiences Scale (DES), The Perceptual Alteration Scale (PAS), The Creative Imagination Scale (CIS), the Tellegen Absorption Scale (TAS), the Ways of Coping Questionnaire (WOC), the Hospital Anxiety and Depression Scale (HAD), the Multi-dimensional Health Locus of Control Questionnaire (MHLC), and the National Adult Reading Test (NART-2nd Edition). The inferences that can be drawn from such broad correlational sweeps across experimental and controls unmatched for clinical status are quite limited. Further, use of the CIS as a measure of hypnotizability is not advisable for such studies. Still, it is interesting to note that pseudoseizure patients scored significantly higher on the DES, and in their use of escape-avoidance strategies. The control group actually appeared more able to experience absorption (the TAS) than the pseudoseizure group. However, all of these findings might be explained by the more general fact that a clinical group was being compared to a non-clinical group. There were no significant findings associated with the CIS.

JOURNALS: Cancer and Vaccine

Jacobson, R. M., Swan, A., Adegbenro, A., Ludington, S. L., Wollan, P. C., Poland, G. A., Vaccine Research Group (2001). Making vaccines more acceptable-Methods to prevent and minimize pain and other common adverse events associated with vaccines. Vaccine, 19, 2418-2427.

Ernst, E. (2001). Complimentary therapies in palliative cancer care. Cancer, 91, 2181-2185.

These papers are of special note because they are both comprehensive reviews of important clinical problems faced by physicians, and they both mention hypnosis as a viable alternative under some circumstances. In the Jacobson et al study (2001) the authors conduct a study which documents that approximately 90% of pediatric patients aged 15 to 18 months suffer from serious distress associated with vaccinations. More relevant to hypnosis, 45% of children ages 4 to 6 display serious and profound reactions which often interfere with treatment. Having established this, the authors comprehensively review pharmacological (e.g., refrigerant topical anesthetics, 'sucrose nipples'), procedural (e.g. applying pressure to the site, needle length, injection position), and cognitive interventions which have been proposed as possible solutions. Among the latter group is hypnosis which the author sites as quite promising in reducing anxiety and pain in controlled studies with children and adolescents.

The Ernst review (2001) paper addresses the broader topic of palliative cancer care. This review is less than comprehensive, but then again the scope of the problem is formidable. The author mentions nine specific types of complimentary medical interventions which have been studied. ranging from aromatherapy, to massage, spiritual healing, and of course hypnosis. Each of these areas receives a somewhat cursory review. Ernst concludes that hypnosis may be helpful for pain, anticipatory nausea, and anxiety, but cautions that more research is needed.

AWARD IN MEMORY OF PROFESSOR GRANONE

Professor Franco Granone, who died on October 21 2000, bequeathed €25.822,84 to the Centro Italiano di Ipnosi Clinico-Sperimentale, with the purpose of promoting studies and research on hypnosis in the international field.

The Executive Committee of C.I.I.C.S. has thus established an award to commemorate its Founder. The 'Franco Granone' Award will be granted every other year in conformity with the regulations to be painted in the coming months.

NOTE: THE ISH CENTRAL OFFICE E-MAIL ADDRESS!

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NEW BOOKS

Graham D Burrows, Robb O. Stanley & Peter B Bloom (Eds.) – ***International Handbook of Clinical Hypnosis.***
Wiley Chichester UK ISBN 0-471-97009-3
23 Chapters by International experts in aspects of hypnosis in clinical practice.

SOCIETY HOME PAGES

ISH – International Society of Hypnosis	www.ish.unimelb.edu.au
AFHYP – French Association of Hypnotherapy	www.afhyp.org
ASCH – American Society of Clinical Hypnosis	www.asch.net
ASH – Australian Society of Hypnosis	www.ozhypnosis.com.au
BSMDH – British Society of Medical and Dental Hypnosis	www.bsmdh.org
CEM – Ericksonian Centre of Mexico	www.hipnosis.com.mx
DGAHAT – German Society for Medical Hypnosis and Autogenic Training	www.dgaehat.de
DGH – German Society of Hypnosis	www.hypnose-dgh.de
DGZH – German Society for Dental Hypnosis	www.dgzh.de
IsSH – Israel Society of Hypnosis	www.israelsochypno.org.
MEG – Milton Erickson Society for Clinical Hypnosis	www.hypno.org

SOCIETY HOME PAGES *continued*

NvvH – Netherlands Society of Hypnosis	www.nvvh.com
SCEH – Society of Clinical and Experimental Hypnosis	http://sunsite.utk.edu/ijceh/scehframe.htm
ShypS – Swiss Society for Clinical Hypnosis	www.hypnos.ch
SMSH – Swiss Medical Society of Hypnosis	www.smsh.ch
SSCEH – Swedish Society of Clinical and Experimental Hypnosis	www.hypnos-se.org
TH-VH – Finland Society for Scientific Hypnosis	www.hypnoosi.net
VHYP – Flemish Society of Scientific Hypnosis	www.vhyp.be

MEETINGS AND CONGRESSES IN 2001

November 2 – 4: Milton Erickson Society Germany – MEG, Hypnotherapietage (Days of Hypnotherapy) 2001 & 100. Birthday of Milton Erickson: Psycho-Somatik: Trance – the missing link. Bad Orb.
Contact: M.E.G., Konradstr. 16, 80801 Munich, Germany.
Fax: +49(89) 3402 9719; E-mail: monika-kohl@t-online.de

November 7 – 11: Society for Clinical & Experimental Hypnosis – SCEH, 52nd Annual Workshops and Scientific Program; Plaza San Antonio, San Antonio, Texas.
Reservations: +1(210) 229-1000 Contact: Marianne Barabasz, Ed.D., SCEH Fellow, Interim Executive Director, SCEH Central Office, Washington State University, P.O. Box 642114, Pullman, WA 99164-2114.
Ph: +1(509) 332-7555; Fax: +1(509) 332-2097

November 8 – 10: Swiss Medical Society of Hypnosis – SMSH, 20th Annual Meeting.
Contact: Jane Wyler-Harper, MD; Ph/Fax: +4(61) 281 1988, E-mail: wyler@bluewin.ch; or
J. Philip Zindel, MD, President SMSH; Ph/Fax: +41(61) 261 7070; E-mail: j-philip-zindel@bluewin.ch

November 23 – 25: Italian Medical Association for the Study of Hypnosis – AMISI, XII. National Congress 'Ipnosi del 2000: Il pensiero di Milton Erickson e dei neo-ericksoniani' (Hypnosis in 2000: Milton Erickson and Neo-Ericksonian thought.
For information contact: MTP srl, Viale Monte Ceneri, 64 – 20155 Milano, Italy.
Ph: + 39(02) 3927 3293/4; Fax: +39(02) 3925 5168; E-mail: mtp.milano@tiscalinet.it

December 5 – 9: 8th International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy. Phoenix, Arizona,USA.
Contact: Milton H. Erickson Foundation, Ph: +1 602 956-6196 Fax: +1 602 956-0519; E-mail: mhreg@aol.com

MEETINGS AND CONGRESSES IN 2002

March 15 – 19: American Society of Clinical Hypnosi – ASCH, Annual Convention Theme: Integrating Brain and Behavior. Indianapolis, Indiana, USA.
Contact: ASCH Central Office, Ph:+1 630 980 4740; E-mail: info@asch.net

March 20 – 27: German Society for Dental Hypnosis – DGZH, International Congress on Gozo/Malta.
Contact: DGZH, Esslinger Str. 40, D-70182 Stuttgart, Germany.
Ph: +49 (711) 236 0618; Fax: +49(711) 244 032; E-mail: mail@dgzh.de

April 19– 20: Flemish Scientific Hypnosis Society – VHYP, Spring Congress 2002 : 'Learn Young, Learn Fair' Hypnosis with Children and Youth. **Venue:** University Hospital St. Jozef Leuvensesteenweg Kortenberg, Belgium.
More information on the congress is available at VHYP secretary's: Honingstraat 5 2220 Heist op den Berg, Belgium. Ph/Fax: 0032 (0)15 24 51 83; E-mail: VHYP@village.uunet.be

June 7– 9: Germany Society of Medical Hypnosis and Autogenic Training – DGAHAT, Conference: 'Autogenic training and hypnosis with the psychic trauma' Blackenburg. **Contact:** Dr. Med. W.-R. Krause, Chief doctor, Department psychiatry and psychotherapy with day-clinic, Secretary of DGAEHAT, Regional hospital Blankenburg, Thiestr. 7 - 10 38889 Blankenburg, Germany. Ph: 0049(0)3944/962186, Fax: 0049(0)3944/962350, E-Mail: psychiatrie@kh-blankenburg.de, Website: www.kh-blankenburg.de

MEETINGS AND CONGRESSES IN 2003

March 22: Milton Erickson Society for Clinical Hypnosis Germany – MEG: Annual Conference in Gottingen.
Contact: Central Office: M.E.G. Monika Kohl (Executive Officer), Waisenhausstr. 55, Germany.
Ph: 089 340 297 20; Fax 089 340 297 19; E-mail info@meg-hypnose.de); Website: www.MEG-Muenchen.de

August 2 – 8: 16th International Congress of Hypnosis in Singapore.
Contact: ISH Central Office, Level 3, Centaur Building, A & RMC, Repatriation Campus, Locked Bag 1, West Heidelberg, VIC 3081, Australia.
Fax: +61(3) 9496 4107; E-mail: ish-central.office@medicine.unimelb.edu.au

MEETINGS AND CONGRESSES IN 2005

10th European Society of Hypnosis – ESH, Jerusalem, Israel.
Contact: Shaul Livnay Ph/Fax: +972 2 567 2076; E-mail: livnshau@Netvision.net.il

MEETINGS AND CONGRESSES IN 2006

October 2006: 17th International Congress of Hypnosis in Queretaro, Mexico.
For further information e-mail: erickmex@hipnosis.com.mx

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9th Congress of the European Society of Hypnosis

September 25 – 29, 2002

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Hypnosis and the Other Therapeutic Modalities in the New Millennium

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Peter B. Bloom
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Karen Olness

Opening Lecture
Camillo Loriedo

Closing Lecture
Shaul Livnay

Invited Addresses
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Scientific Program: (September 26-28) consists of Keynote Addresses, Invited Lectures, Invited Addresses, Invited Seminars, Symposia, Dialogues, Panels and Papers. Specific Sessions will be dedicated to Training, Research and Ethics.
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