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BODY METAPHORS. THE PRACTICE OF ERICKSONIAN PSYCHOTHERAPY IN A RECONSTRUCTIVE SURGERY CLINIC

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Ericksonian psychotherapy
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Summary

The article presents a description of the techniques of Ericksonian therapy, with particular focus on the use of metaphors, during the treatment of patients of the Oncologic and Reconstructive Surgery Clinic. This therapy is based on the assumptions of Milton H. Erickson – focusing on resources, on the future, introducing changes in small steps, using everything that the patient brings, and most importantly, individualized method of work. This approach is effective in the department setting, where patients confront many unknowns during treatment and where flexibility and openness to change are especially valuable. Surgery that changes appearance, transforms body image and consequently, the sense of identity. Losing one's current self-image carries long-term consequences. Using psychotherapy from the beginning of these changes gives a chance to reduce the painful consequences of the loss. The presented descriptions of working with anxiety, pain or resignation are examples of a holistic approach to treatment. Patients receiving relief from psychological suffering are more determined to remain in long-term treatment and are more motivated to recover. They also benefit from support and information about what they need to take care of in order to fully recover.

Introduction

Ericksonian psychotherapy [1] is based on trust of the unconscious and the intuitive wisdom of the person. This wisdom consists of all life experience (including unnamed, emotional or forgotten) and experience passed on from generation to generation. During therapy, communication takes place on two levels. The unconscious level is built on the patient's and psychotherapist's intuition, the phenomena of transference and countertransference, and reactions to nonverbal messages. Whereas at the conscious level, aspects are named and verbalized, the therapist, in keeping with their knowledge, directs the patient's attention towards expected solutions. This can be done directly or by symbols [2]. The non-direct communication tools used in Ericksonian therapy include metaphors and therapeutic stories, to seed the ability for change. These can be implemented by patients at their own pace, and in their own individual way [3]. Using metaphors, the patient's

problems and possible solutions can be presented in a symbolic way. The non-directive and imagery presentation of the patient's situation, enriches the perception of the content conveyed. It enables the patient to find their own meanings within the story which is being told, and draw conclusions beyond the storytellers intended meaning. Self-discovery of the meaning of the symbol engages the patient in the treatment and strengthens their sense of self-initiative [4].

Another important therapeutic tool is hypnosis. When hypnosis is used in a specific way, it enables the deepening of changes in which time plays a vital role. It also increases the effectiveness of the psychotherapy process [5]. Hypnosis has been used since the beginnings of medicine, to improve the functioning of patients. This was initially mainly for anesthesia [6], however it is still widely used to treat other symptoms occurring during hospital treatment. Numerous studies demonstrate the effectiveness of hypnosis to treat pain of various etiologies [7-9], post-traumatic stress disorder, [10] to reduce the stress effects of patients who are preparing for and undergoing surgery [11]. Furthermore, it is also used in the treatment of both depression [12] and anxiety disorders [13, 14], which coexist in patients undergoing surgical treatment. The use of hypnosis has proven to show high therapeutic efficacy.

Ericksonian hypnosis is one type of clinical hypnosis, which can be used for medical purposes by people specifically trained to do so. As Erickson [15] discussed, patients experiencing shock from painful experiences, are willing to cooperate in a hypnotic trance, as this facilitates their confrontation with any past suffering without secondary traumatization. A person in a hypnotic trance is relaxed, they are concentrating on their own experiences, and their attention is focused. In this state they respond unconsciously to hypnotic suggestions. Upon returning to the state before the trance, there is a feeling of change, often bringing the person closer to the solution they need.

Psychotherapy on the surgery ward

The Oncological and Reconstructive Surgery Clinic treats patients whose appearance will be transformed as a result of their treatment, to restore their health (and often to save their lives) [16]. Sometimes this change is meant to return them to the 'pre-illness state', as in the case of breast reconstruction after a mastectomy. However, sometimes it involves a transformation of image e.g., as in the case of facial reconstruction and transplantation [17]. The presence of a psychotherapist in the therapeutic team is not obvious due to the difficult to predict and relatively short stay of patients within the surgical ward. The activity of a psychologist in this case comprises diagnosis, crisis intervention or psychological assistance, whereas psychotherapy seems to belong to other places and conditions. In these settings, not every form of psychotherapy is possible to conduct yet, as experience has shown, Ericksonian psychotherapy can be applied here. Milton H. Erickson's idea that psychotherapy should be individually adapted to the needs of the patient, to their abilities and to external possibilities [18], seems to be especially applicable in this situation. Just as surgeons very precisely reconstruct the body destroyed by illness, by deciding which tissues to remove and which to use in their place, psychotherapy is constructed in the same

way. It helps patients accept loss and adapt to change. The first goal of therapy is always the same and comes from the specifics of the situation, to survive and live as well as possible.

Patients are informed of the possibility of psychotherapeutic support when they are admitted to the ward, and may also request it themselves. The need for consultation can also be reported to the therapist by the patient's family, doctor or other staff members, this could occur when they notice a worrying change in the patient's behavior. Below I will present descriptions of some of the psychotherapeutic work with patients of the Clinic. To protect their identity, some biographical details have been changed. The presented fragments of therapeutic work were always only a certain element of the psychotherapy process. In all cases, the therapy was based on creating a therapeutic relationship and alliance. Trance work using hypnosis, metaphor or therapeutic tales was to support, accelerate or deepen the changes occurring in the patient [19]. All therapies were conducted by the author of this text. Their length and intensity depended mainly upon external factors, and the time that could be devoted to each one.

Due to the specific nature of the work at the reconstructive surgery ward, the therapy contract had to be flexible. Sometimes therapy sessions were held daily (e.g., during the period of preparation for surgery, during the most difficult times for the patient or just after the operation), or once/twice per week (for longer stays in the ward). Some sessions lasted an hour, whereas some took several minutes of intensive work, this was due to time constraints as only that amount of time was available. Within this model of work, external factors determine the therapeutic contract more than in a psychotherapeutic office, where the time and intensity of therapy sessions depend only on common agreements. In the hospital environment, many limitations must be taken into account. It is a space for developing creativity, and the ability to make use of what is possible; both by the patient and by the psychotherapist. Although everyone realizes the importance of the patient's attitude toward treatment and therefore the state of their mental condition, surgical and medical procedures have priority in hospital procedures. The therapy which begins on the ward, is sometimes the start of a process that may continue after discharge from hospital, in the patient's place of living.

However, no matter the length of the therapeutic contact, each work with the patient follows sequential steps. At the beginning, a therapeutic alliance is formed. The patient's agreement to accompany them to treatment is then received. This is an important moment in which the patient not only opens up to the therapist but also to change that is to follow from the therapeutic relationship. The strengthening of the alliance and the therapeutic relationship deepens during the time of contact and is directly proportional to the time passing. The therapeutic contract defines the goal of therapy, such as what needs to change to improve the patient's functioning, then the diagnosis is established [20]. In order for the diagnosis to be used therapeutically, it is made up of a number of the following aspects: the areas of suffering are diagnosed, what needs to be changed for the patient to experience relief, the patient's resources are diagnosed, what the patient can use, what they can benefit from, what they can gain and the trance phenomena to which the patient is subjected are also diagnosed. (For a detailed description of the dimensions of trance phenomena, see the comprehensive publication by Edgette and Edgette [21].) Diagnosis of trance phenomena is required in constructing an effective therapeutic intervention. It is one that will help

the patient transition out of a stagnant state, and enables them to gain greater flexibility in the possibility of change. For example, if a patient has regressed within their life into a childlike state whereby, they feel helpless, trance enables them to progress into adulthood. Alternatively, it may be that the patient's attention is focused within themselves, however using trance allows them to direct their attention outward again. Due to time pressures and uncertainty about how many meetings can be held, the therapist sets the goal and the diagnosis at the first meeting. During this initial meeting the first therapeutic interventions usually take place.

The next stage is to create changes and consolidate them to improve patient's overall functioning [22]. At the end of each therapeutic contact a suggestion is made of the possibility of keeping what works for the patient, what can be developed in the future and further positive changes they still require.

"We are at a surgery clinic, expect the unexpected" – I tell patients. This is one of the features of psychotherapy that I provide, in essence the contract is as flexible as conditions which are beyond our control require. Due to unpredictability, we cannot contract on the number of sessions, their length, nor a regular meeting place (as sometimes the sessions take place in the Intensive Care Unit right after surgery, in the patient's room, or comfortably in the psychotherapist's office, depending upon the patient's condition), or on the duration of therapy. However, what can be contracted, is the goal in the here and now, and the possibility to explore the ability to influence one's condition in the future, to the fullest extent possible. Experiencing "today" something that may be helpful "in the future," is characteristic of Ericksonian therapy. It allows patients to become more realistic and empowered in their own sense of controlling the outcome of their situation. Furthermore, it seeds hope that there is some future.

Metaphors

"Sometimes I tell stories."

At times I prepare the patient I am working with for a story, to support them in experiencing a change in mood and how they feel (therefore preparing them for the trance experience). I may also simply weave a therapeutic intervention into the general conversation. This was the case when I was asked by the surgeon operating on patient M. to undertake a consultation. Patient M. was a gentleman who was staying on the ward for a long period of time. During the third week of his stay, (and after yet another operation for cancer which was at the floor of the mouth and further complications), his mood was gradually dropping and he was becoming more depressed. This 50-year-old man was a construction worker and the head of his family. In his eyes this was synonymous with power and adulthood, however, he complained of helplessness, insomnia, and in his words "childish" anxiety. This was the fear that he feared the most. He blamed himself for his lack of courage and weakness, of which he was ashamed. In a short interview I learned about his early childhood experiences (including climbing trees), and that he had handled his previous hospital stay (due to a complication of a broken leg) very well. I told him that I knew what the solution

was and instructed him to focus on his breath, progressively deepening the trance. I then said to him, "Sometimes I tell stories. If I were to tell you a story, it would be about a boy who knew no fear, and his curiosity led him to the tops of the tallest trees. When he grew up, he forgot about his skills, but he started working in construction, and sometimes he climbed on the roofs of tall houses. Then he remembered everything and knew he was brave again. Even after he fell and broke his leg, he never stopped doubting his courage. As he lay in bed waiting for his body to be healthy again, he had a strong connection with his courage. This made it easier for him to wait. Sometimes he was sad and brave, sometimes angry and brave, sometimes impatient and brave, sometimes powerless and brave, sometimes worried and brave...". I carried on with the story and this intervention helped the patient to await the results of his treatment in a more peaceful way, without anxiety, and in relaxation. A few more therapy meetings took place after this (eight in total), during which the patient revisited various experiences that he saw as his successes, recalling how often he had been courageous. He coped well with the rest of his hospitalization, his mood evened out, his drive increased, he had better appetite, and he slept better.

Understanding the process: The patient was experiencing general weakening, as a result of being tired from a long and difficult hospitalization, which he identified as a weakness of character. In his perception, weakness was something he could not afford. He associated it with a childish, helpless reaction and he was fearful of losing control (particularly losing touch with his adult, active side). Patient wanted to feel physically and mentally strong. The longer he was ill, and the longer he was pulled down by successive complications, the more he experienced his helplessness and therefore the more his mental state deteriorated. He saw himself as not very brave, and he needed courage not to give up and to cope with the difficulties of further treatment, as after his stay in the surgery ward, he still had to undergo a long treatment of radio-chemotherapy. What helped the patient, was to get in contact with his previous experiences, and to remind himself of his potential for curiosity, which was stronger than his fear (resource utilization). He also experienced flexibility in the dimension of trance phenomena (among other things, from catalepsy – being frozen by fear, to movement – noticing changes in his well-being, and from progression – stiffening expectations of being "grown up and brave" to regression – "so that things could be easy as a play"). When patient recalled that he already had periods of weakness (for example when he was in the hospital after breaking his leg) and then returned to his former strength, it was easier for him to wait for recovery without anxiety.

Necessary resection of a part of the tongue

Mrs. N., aged 51, was a university teacher, and a patient for whom the decision to cut off part of her tongue was difficult for many reasons. The patient was highly motivated to cooperate with psychotherapy. In addition to fearing for her life, her long-term illness and the pain she was experiencing, she feared that even after successful reconstruction her life would not be as satisfying as it had been before. Her fears were, of course, completely justified. Mrs. N's speech disorder prevented her from returning to her teaching profession. Furthermore her swallowing and breathing difficulties continued long after surgery. She

knew all this as she was preparing for another operation. The first one was a failure and had resulted in the removal of the operated flap.

The patient found out during admission that she had the possibility of receiving psychotherapy and therefore requested a meeting. She started by asking what she could do to make it work this time. She had a basic knowledge of psychoneuroimmunology and the role of the psyche in healing the body. She was ready to empower herself to heal and was interested in how to reduce her stress levels.

We began our therapeutic work and the patient prepared for every possibility. The failure she had experienced, she soon realized that she knew how to deal with it. She also had a readiness for success and change. She had already made some important life changes. One of the most difficult recent challenges for her, was deciding to cut off her relationship with her alcoholic and violent father, who had been a source of pain and frustration for her for many years. Despite multiple attempts to change their relationship, the only way she could feel comfortable was to cut off contact completely. After this decision, her family went through numerous changes, followed by the patient moving and she met a man with whom she decided to have a relationship. However, this did not work out and she decided to cut off another significant relationship. At the time of admission to the hospital, and in preparation for another surgery to reconstruct her body, the patient was in the process of trying to reconstruct her life with another man. The question of what to do to make it work this time, in the context of her overall story, was very metaphorical. During one of our first meetings, the patient had reflected that what had bothered her up to that point, was an excessive focus on the needs of others. Now she was learning to get in touch with herself, her needs, and her body. By consciously breathing, and enjoying positive, deep contact with herself during hypnosis, she was able to experience the state of relaxation that supports healing, recovery, and the healing of tissues. At the end of the first session, Mrs. N. experienced this state and we agreed that she could recall it whenever she wanted to take care of herself in this way, by following the rhythm of her breathing. The therapeutic contact consisted of several meetings during her stay in the hospital. We could not specify the exact number and the patient understood that there would be as many sessions as could be arranged in the conditions of the ward. She could take something from each of them that would strengthen her. There was no time or place to look at the internal process and the changes that were taking place in the psychic space. We focused on body work, metaphors, and stories. The patient had a garden and she liked to work in it. she used to find there time to relax and enjoy the fruits of her efforts. To use this experience, the stories I told took place in a garden, where dried branches need to be removed, so that new healthy ones had a better chance to grow and blossom. The patient had repeatedly experienced that old plant parts had to be removed to make place for new life. She reminded herself of this in her hypnotic state. By taking care of her "inner garden," she was finally taking care of herself. During the two-week stay, four sessions of psychotherapy took place, and in the remaining time the patient used new autosuggestions to arrange the garden.

It is known that at the level of the body, the intended goal of surgical treatment was achieved. The operation was successful, the transplant accepted, and the patient was discharged home in stable condition. At her follow-up visit, which took place four months after she was discharged, she came to tell me that she had been able to make the changes

she needed to enjoy her life. She had been able to remove whatever was keeping her from being relaxed and happy. Unfortunately, there was not enough space to develop this storyline, and the patient did not tell me the details of these changes. However, it seemed that they were meaningful enough, so that she wanted to come and share the news with me, that her life had become better.

Understanding of the process: Cutting off the sick part to save the whole body, happened both at the physical level of the body (tongue cancer), and at the level of family relationships (toxic father). Both processes were difficult, with internal conflict, and both needed to be reconstructed. Therefore, the tongue muscle was reconstructed to enable the patient to speak, and swallow freely. Whereas the relationship was reconstructed to build a sense of security, enabling a new relationship with a man to occur. Originally both reconstructions ended in failure. In the next try, the patient started with accepting facts, understanding limitations and being open to different solutions. Association with resources (for example from past experiences and strong body parts), was what the patient began to practice in response to naming her needs. The state of balance achieved through this, helped her prepare for what was to come, giving the patient a greater sense of influence over her life and greater comfort in it. Recalling in trance the experience of working in a changing garden, helped her improve contact with herself, accept inevitable losses, and to be open to what the future holds. For this patient, the greatest change in the dimension of trance phenomena, was the movement from dissociation to association, and from attention directed outside herself to attention directed inside herself.

Analgesic compresses

Mrs. A., aged 49, worked physically in a small manufacturing company before becoming ill. She had been treated for breast cancer at another hospital 7 years earlier. She was initially operated and later underwent radiotherapy, which caused serious side effects. The therapy burned the skin and tissues deep in the body. It has created an open wound in her chest which resulted in pain and suffering lasting over 5 years. To cope with the wound, she was taking the maximum dose of narcotic painkillers on a daily basis. When she was admitted to the Oncological and Reconstructive Surgery Clinic, she was preparing for a surgical procedure to cover the wound with her own tissue and skin, which would be taken from another area of her body.

The surgery went well, however two days after the operation, the patient's pain perception increased and her mood deteriorated, she was depressed, scared and in pain. Her first therapeutic contact took place five days after surgery. The intervention was requested by her doctor. The patient thought she required more medication to manage her pain again. She stated, "I need these painkillers because I can't stand the pain. I don't want to feel!". However, the therapeutic hypothesis was that she didn't need the sensation cut off, just a change in body perception. I explained to her, "Thanks to the medication, you do not feel pain, among other things. But you can start to feel how your body stops suffering. You don't want to feel pain, so you can feel relief.... In order not to feel what you don't need, you can feel what makes you feel good." I seeded the idea that the solution is not

in anesthesia, but in finding the ability to experience feeling the body in another non-painful way.

The patient was very determined to stop suffering and she cooperated with the psychotherapist despite her doubts. During daily meetings, she began to learn self-hypnosis to feel her body without pain. On the ninth day after surgery (the fourth day of therapy), during hypnosis, the patient felt a significant change. She also mentioned about her difficulties outlining that, "I am trying to change this pain, but I don't feel good ... my pain is heavy, warm, embracing, holding, it makes it so difficult for me to catch my breath." Therefore, in my intervention, whilst deepening the trance state, I stated: "...and when you try to change that and it doesn't feel good at first, the change comes gradually... and that familiar feeling is heavy, warm, embracing, holding you down and making you difficult to catch your breath..., so you can feel it more.... and you can feel it clearly, in good deep contact with yourself... so you can forget what you don't need to remember and remember what makes you feel better... Because you know that feeling very well – heavy, warm, embracing, holding you down and making it difficult to catch your breath... and now you will remember it because you know it is good."

The patient felt comfortable in her body, recalling a pleasant experience from the past (which she had mentioned to me the day before, whilst answering a question regarding when she feels calm and relieved). She said with complete conviction: "Oh yes! Of course, I know that feeling! That's how I feel when my little grandson hugs me!"

The next day, despite the doctor's doubts, she asked to have her painkillers reduced.

She left the hospital 40 days after surgery, with a partial wound and no pain. There were eight therapy meetings in total during her stay. I spoke with her seven months after surgery. She was under regular surgical follow-up, waiting for another transplant. She told me, "I'm feeling good, taking care of myself, hugging my grandson tightly." A year and a half later, she underwent breast reconstruction. Now she looks and feels much better. She does not use painkillers.

Understanding of the process: The patient dissociated from her body to prevent herself from feeling pain. After surgery, when she wanted to start feeling her new body, her fear of pain would not allow her to do so. She was afraid of feeling, and afraid of not feeling the good changes that the surgery brought. She suffered from pain, lack of contact with herself, and anxiety. When the woman remembered how good the closeness of a loved one felt, and allowed herself to feel it during hypnosis, she associated her difficult feelings whit those feelings that served her and turned her own suffering into a pleasant burden. She used her previous experience to discontinue the use of painkillers. An individually designed hypnotherapeutic intervention based on the patient's previous positive experiences, resulted in the ability to change her body perception, therefore consistently reducing her chronic pain. The change in the dimensions of trance phenomena occurred in the areas of association-dissociation, amnesia-hypermnesia, and hypersensitivity-analgesia.

The new nose – the old self

Sometimes patients respond to therapy with their own metaphors. After intensive psychotherapy, metaphorical communication is a kind of new language understood only by the patient and the psychotherapist. Another story involved a patient with nasal cancer, a rapidly growing change that has distorted his appearance. Mr. K., a 60-year-old university educated man, had a flap of skin transplanted, after resection of the affected part of his face, which in further stages was to be transformed into a new nose. After the first operation, the patient's appearance was unacceptable to him. The patient was unable to look at his face without a bandage covering the operated area. He did not understand the enthusiasm of his doctor, who reported to him the successive stages of proper healing, the viability of the transplanted flap and the positive health parameters. It seemed that the surgery had been successful, the cancerous lesion had been completely removed. Luckily there was no metastasis, the transplant went well. Further surgeries were planned to create proper form to the transplanted flap and therefore give it the shape of a nose. The patient felt a loss of identity and experienced that he was not the same person after the surgery. He suffered from insomnia, and was constantly absorbed by thoughts of how he would be accepted in his society, and how he would accept himself. In conversations he used phrases like "this is not me", "before the surgery when I was me", "now that I am no longer me". He clearly divided his life into the time before and after surgery. The deterioration of his condition was reported by a nurse, who suggested that the patient should speak with a psychotherapist, to which he agreed. Therapeutic work with this patient was based around his insomnia, lowered mood, lack of drive, becoming withdrawn and his negative evaluations of reality. It focused upon finding relief from the depressive symptoms, on accepting his altered appearance and supporting his sense of identity. The patient looked to connect with himself through feeling his body, noticing constancy in many areas of his functioning. He spent three weeks on the ward, and during this time he had six therapy sessions. I directed his attention to finding everything that defined him as a person; a man, a father, a husband, a friend, a brother, a son, or a Christian. This had the expected effect, and he gradually began to change the rhetoric of his statements from "I was" to "I am."

The patient left the hospital in a stable condition, preparing for further treatments. During one of his follow-up visits, he came in to meet and talk about how he was feeling. He was peaceful, with no signs of depression, and full of enthusiasm for the various activities he had taken up since he decided to take a break from work. Among other things, he was busy with a major home renovation. He said, "I changed everything, rearranged the walls, changed the whole appearance of the house. "You mean to say you have a brand-new house!" – I said. The patient looked completely amazed and replied: "Oh, no! Not at all! This is my old, familiar home. Only it looks different now." We smiled at each other.

Understanding of the process: The patient, while suffering from his illness, pushed away his fear of death, focusing instead on his fear of disfigurement and loss of his sense of identity. These were the aspects he was able to work on during the therapeutic contact. Until he was ready to accept the new part of his face, he disassociated himself from it. Associating him in another aspect with his body and what defined him as a person was a therapeutic activity. This made him more easily adapt to the changes, focused on action,

the future, and gave him to ability to cope with his conscious and unconscious fears. The patient's use of the metaphor of a house that is still the same house after a complete renovation, was a message to the psychotherapist that the therapeutic change was effective. In this man, the change in trance phenomena occurred along the dimensions of association-dissociation and change in negative hallucinations (omitting parts of his identity).

Summary

The changes that patients experience at the Clinic are sudden and include a wide range of life aspects. Patients lose the sense of continuity of their lives. For many of them, life becomes divided into before and after surgery. By having to depend on others or external conditions, they lose their sense of control and fear the future, their life, health, family, or work. By changing their body image, which is fundamental to their sense of identity [23], they also often lose their previous self-image and self-esteem. All of the above stories describe therapy for individuals who were determined to heal, people for whom therapy was a support when a crisis occurred during hospitalization. Motivation for psychotherapy played an important role for the patients' willingness to engage in the process of change. How their treatment process would have gone without therapy is difficult to predict. The contact with the patients after the end of treatment clearly shows how well they used the time given to them for recovery and how the transformations started during their stay in the Clinic, fruitfully developed in the following weeks and months. Psychotherapeutic assistance in the surgical ward may seem difficult for patients to accept if evaluated by someone who has never been there. After all, patients do not go there to face their mental difficulties, but to undergo a surgery. Nevertheless, in my experience, they almost always welcome the opportunity to talk to a psychotherapist with pleasant surprise and openness. They are happy to have this opportunity and use it with curiosity (for many, this is their first personal contact with psychotherapy). It is clear to patients that recovery is about well-being and the whole person, not just the operated part of the body [24]. The use of the Ericksonian model of conversation, focuses on health, potential and possibilities, helps to have a free conversation that is not another therapeutic hardship for patients, but brings about a perceptible change. Patients sometimes call it out with accurate descriptions. One spoke of "therapy by the way", "You come into the room, we talk about seemingly trivial things, you'll tell a story, and then, as if by the way, I feel better and often look at problems from a different perspective". On the other hand, a man with lockjaw which increased during the course of his illness, was very moved by the hypnotic induction aimed at deepening relaxation for letting go of blockages and restrictions in the body. He said: "You told me nothing and you told me everything. It was very helpful. Thank you." This patient feedback is valuable information about the effectiveness of using metaphors in therapy, of course in addition to objective treatment outcomes (such as improved sleep quality, reduced anxiety, improved mood, reduced pain perception) [25].

Although the presence of a psychologist in the therapeutic team on a hospital ward is slowly becoming standard (in terms of diagnosis and psychological support), psychotherapy is still not associated with the health care received on surgical wards. In sessions

such as those presented here and based on the experience of my daily work in the Clinic, I see how applicable Ericksonian strategies are in facilitating the hardships of treatment and recovery. For this reason, enriching treatment teams with professionals who use these techniques may be the next step in developing even more effective, holistic treatment modalities. It is possible, just like in other therapies, to formulate a therapeutic contract in such a way, that despite difficult external conditions and lack of consistency, undertaking of therapy is a safe way of supporting and enhancing patients recovery.

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