

# The Milton H. Erickson Foundation NEWSLETTER

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Summer 1996

## Foundation Office Flooded

The main office of the Milton H. Erickson Foundation was flooded over the Memorial Day Weekend.

A broken water line inside the building at 3606 N. 24th St., in Phoenix, caused the flood, which resulted in some \$30,000 in damage. The staff has been working in the other buildings owned by the Foundation, all located adjacent to the Foundation's main building.

"It has been a little challenging to continue working, but we are fortunate that our operations are in several buildings," said Executive Director Linda Carr McThrall. "The staff has been flexible, and clients have been understanding. We hope people are not too inconvenienced by this."

McThrall said everything is expected to be back to normal by mid-July. Repairs and reconstruction are under way now.

## Conference Promises State-of- the-Art Learning

The Brief Therapy Conference scheduled for Dec. 11-15, 1996, in San Francisco, Calif., will feature the leading figures in the field of Brief Therapy.

The faculty will offer cutting edge information through workshops, panels, clinical demonstrations and other educational means. The Milton H. Erickson Foundation has sponsored two previous Brief Therapy Conferences, and each has been well received. While most of the faculty will return for the third Brief Therapy meeting, new presenters also will be on hand to offer their techniques in the field.

A registration form is on Page 3 of this issue. For additional information, please call or write The Milton H. Erickson Foundation, 3606 N. 24th St., Phoenix, Arizona 85016-6500; telephone, (602) 956-6196; fax, (602) 956-0519.

## Sexuality & Intimacy

"Integrating Sexuality and Intimacy: The Challenge of Treating Couples in the '90s" was held May 17-19 in Dallas, Texas. The scope and tone of the meeting was reflected in three keynote presentations.

The opening speech by Harville Hendrix, Ph.D. expressed an enlightened perspective on "Marriage as Therapy." Hendrix overviewed the limitations of historical and traditional approaches to marital therapy and introduced a new paradigm: marriage as a connection with the greater collective experience of life. Hendrix described therapeutic process as facilitation of the emergence of marriage as a central connection of individual contact. The philosophical and spiritual dimension of marriage provides an opportunity for awareness and participation within the context of life, Hendrix said.

John Gottman, Ph.D., gave a precise and informative discussion on "What Predicts Divorce." Rigorous scientific studies and longitudinal investigations provide data for examination of factors associated with stable marriages and with divorce. Researchers have now developed tools that predict likelihood of divorce within four years with 95 percent accuracy. The factors associated with stable marriages provide new insight into therapeutic interventions and in understanding the interpretation of interaction patterns within couples. The correlation of relationship styles with longer term consequences brings scientific support of the need for modification in therapeutic approaches.

The final keynote by David Schnarch, Ph.D., "Tyranny of the

*Continued on page 9*

## I N T E R V I E W

### Dabney Ewin, M.D.

by Jane Parsons-Fein, C.S.W., D.A.H.B.

#### BACKGROUND:

Dabney Ewin, M.D., is a general surgeon affiliated with Touro Infirmary, East Jefferson General Hospital, Charity Hospital of Louisiana, and St. Jude Medical Center. In addition to his active practice he is a clinical professor of psychiatry at Louisiana State University, and a clinical professor of psychiatry and professor of surgery at Tulane Medical School. He has received numerous honors and awards from organizations including the American Society of Clinical Hypnosis and the Society for Clinical and Experimental Hypnosis. Author of 17 clinical and scientific papers and twice receiving an award for best paper published during the year, he has contributed material to eight professional books, and written the foreword for two oth-



ers. Ewin's dedication to the advancement of medical hypnosis has included years of volunteer work at the medical school and involvement in 72 teaching seminars and 68 scientific presentations.

Jane Parsons-Fein is a Clinical Social Worker and is one of the founding members and president emeritus of the New York Milton H. Erickson Society for Psychotherapy

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## COMMENTS FROM THE EDITOR



Dan Short

According to Zeno's paradox it is theoretically impossible for an arrow to travel from point A to point B because the physical distance can be divided in half, leaving a space that also can be divided in half, and on and on without limit. Therefore, for the arrow to travel from point A to point B, infinity must be crossed. This paradox came to mind when I decided to share my thoughts on the

Ericksonian approach to therapy. A task that requires capturing, in still print, a series of insights that continue to evolve. My favorite definition of Ericksonian therapy comes from Kristina Erickson, M.D., who described it as "using anything that works." Many times Erickson explained his work by saying that he would use whatever the client brought to the session. Erickson viewed each individual as unique, thus the potential variation in this approach is limitless.

Because contemporary thought still relies heavily on Aristotelian logic, (which teaches us to limit our perceptions to distinct categories with finite boundaries), many find it difficult to understand an approach inspired by a man who did not rely on diagnostic labels or standard treatment procedures. Erickson's flexibility and creativity give his work a nebulous quality making it difficult to confine to a single interpretation. While the absence of rigid instructions may be frustrating for those who

want to know how to do Ericksonian therapy," there is greater depth of opportunity in a perspective based on one's own lifetime of experiences. (We should remember that although a definitive theory can make perfect sense, it exists only in the universe of imagination and two-dimensional print.) Because every individual has unique skills derived from personal experiences, the Ericksonian approach necessarily changes so that each individual is "able" to perform. Therapy inspired by Erickson involves a search for what can be done with the experience at hand, more so than recollection of procedures from the past. Perhaps most essentially, Erickson emphasized the importance of self-discovery and the development of one's own special abilities. He modeled flexibility while he discouraged imitation of his personal style. The Ericksonian perspective is not historical; there is no limitation to the recorded words or actions of its originator. Therefore, when you write a case report for the Newsletter or document research in a scientific journal, you are potentially

an important contributor to the collective understanding of Ericksonian therapy.

The articles contained in this issue, as with all material published in the Newsletter, are intended to edify and challenge the readership. Consistent with the priorities of the Foundation, the Newsletter will continue to promote the proliferation of new ideas so that Erickson's legacy remains a living and vital force. After all, Zeno's problem is not so impossible when we realize that the arrow also is potentially infinite in length and therefore analogous to the potential progress of those who aim for inspiration.

### Editor:

Dan Short, M.S.

### Corrections and Clarifications

Vol 16 #1 p 19: Richard Fisch, M.D., was incorrectly identified. He is the Co-founder and Principal Investigator of the Brief Therapy Center of M.R.I.

Vol 16 #1 p 17: Nicholas Brink, Ph.D., is from Lewisburg, PA.

## Conference Announcements

The Seventh European Congress of Hypnosis is scheduled for Aug. 17-23, 1996, in Budapest, Hungary. For information call or write: Eurohypnosis '96, 7th European Congress of Hypnosis, Budapest 64. Pf. 4. Hungary H-1378; telephone/fax +36 1 322-7637; e-mail: hipnozis@izabell.elte.hu.

\*\*\*

A satellite symposium of the Eighth World Congress on Pain, "Hypnosis and Suggestion in the Treatment of Pain," is scheduled for Aug. 23, 1996, in Seattle, Wash. Among the presenters are Joseph Barber, Ph.D., Giuseppe de Benedittis, Sam LeBaron, Donald Price, Karen Syrjala and Lonnie Zeltzer. For information, contact CME, Inc., (800) 869-2633.

\*\*\*

The Family Therapy Conference held in Puebla, Mexico, in April was "a great success," according to organizers Jorge Chavez and Vicente Martinez of the Benemerita Universidad Autonoma de Puebla. The Milton H. Erickson Foundation was a co-organizer of the conference. Featured speakers were Stephen Lankton, M.S.W., Joseph LoPiccolo,

Ph.D., Cloé Madanes, Lic. Psych., Salvador Minuchin, M.D., Peggy Papp, A.C.S.W., Carlos Sluzki, M.D., Paul Watzlawick, Ph.D., and Jeffrey K. Zeig, Ph.D. About 650 professionals attended the meeting.

### Media of Note

The *Collected Papers of Milton H. Erickson*, Vol. I, is published in German. Alida Peter supervised the translation.

Carl-Auer-Systeme, Kussmaulstr. 10, 69120 Heidelberg, GERMANY, is the publisher. The publication is the first foreign translation of the book.

## BULLETIN

The Erickson Foundation has learned that David Cheek, M.D. died June 12, 1996, at his home in Santa Barbara, California. He was 83. Dr. Cheek was noted for his work in ideomotor signalling. Dr. Cheek was a noted gynecologist/obstetrician whose work in medical hypnosis earned him the distinction of being one of the key figures in 20th Century Hypnosis. He is survived by his wife

A more detailed tribute will appear in the next issue of the Newsletter.

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## Special Offer for Newsletter Subscribers

As a way of saying "Thank You" for subscribing to the Erickson Newsletter, we are offering a \$50 discount off the early registration fee. This offer is good through August 15, 1996

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\$445 U.S. (\$345 U.S. for graduate students\*) for registrations postmarked on or before November 15, 1996.  
\$545 U.S. (no student discount) for on-site registrations if space is available.

#### Other Foreign Registration Fees:

\$295 U.S. (\$195 U.S. for graduate students\*) for registrations postmarked on or before September 30, 1996.  
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\*Students must provide a certifying letter from their school or department on letterhead stationery indicating proof of full-time graduate student status as of December 1996.

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#### REGISTRATION FORM

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Are you physically challenged? \_\_\_ yes \_\_\_ no

If yes, in what way? \_\_\_\_\_

What special accommodations do you require? \_\_\_\_\_



# CASE REPORT

## Extending Life

by Joyce Ann Tepley, L.M.S.W.  
Dallas, TX

I had polio when I was nine years old which paralyzed my legs and back. I didn't need a respirator then, but I am now 52 years old, my scoliosis is worse and my lungs are being constricted. Forty-four years of the effects of polio have taken a toll on my body, bouts of extreme fatigue and frequent respiratory infections caused me to seek an evaluation in 1986. I was prescribed the use of a ventilator to help preserve my breathing muscles and prevent heart problems.

If the ventilator could be used for the whole night during sleep, I would be ensured of more energy during the day, and of lengthening my life. I started the journey of experimenting with a newly developed face mask that fit over my nose and mouth, held in place by a custom-fit bite wing. Molded by an orthodontist over a period of several weeks, the mask had to have an exact seal. Hoses connected the mask to a small suitcase size respirator, and gave me the ability to turn over in bed. I was not enthusiastic about having to use a ventilator for the rest of my life, but I was willing to try. An insurmountable problem was the mouthpiece, which caused me to produce too much saliva. Even now, just thinking about it makes my mouth water.

Several months went by with no success. My respiratory therapist called me back to the clinic to try another custom designed nose mask. This model was molded only to the nose, and made of a softer material than the other plastic face mask. The growing number of aging survivors of polio has generated new equipment designs and services to treat post-polio syndrome symptoms. Armed with my new nose mask held on by two simple elastic straps, I tried again. I struggled with it for six years on and off, taking it back several times for adjustments, having a chin strap made to keep my mouth closed, and using hypnosis tapes. The most I could tolerate wearing it was 30 minutes at a time. In 1993, I started having premature ventricular contractions, I was always congested, and my fatigue was worse.

I was familiar with the Ericksonian approach, having studied it as a clinical social worker. I consulted a

well known Ericksonian therapist for my first appointment in March 1994. She started by questioning me about any fears I might have in using the ventilator. We also talked about all of the little practical problems that got in my way. She suggested I simply sleep with the nose mask in bed next to me for the first week or so. The next visit was a formal trance session in which she talked with me about being on a journey, being followed by a Mack truck, and the truck passing me in a friendly way. In another session I vaguely remember her talking to me about growing from an infant, discovering what my hand could do, and continuing to learn in each stage of my life. Eight weeks later I used the respirator to take a 36 minute nap. That was the middle of May. The next time I used the respirator was the beginning of June. I concentrated on using it for naps in the late afternoon. By the middle of June, I was able to use the ventilator for more than an hour at a time.

Altogether I had 22 sessions over a seven month period. I kept accurate records of how much time I used the ventilator. I had a goal each month to increase my use by two hours. This January my goal was 46 hours. I averaged 30 hours a month, and was able to reach or exceed my goal eight months of last year. Six times I was able to use the ventilator for a full night's sleep, which is my overall goal. I hope someday, I will not have to think about it so meticulously.

Most of the time I spent with the therapist was spent talking about what I was able to do and what little adjustment I might use to push myself to the next level. She used many analogies with me to help reframe the difficulties that had previously kept me from trying. One helpful analogy was to think about how I used to sleep with hard plastic rollers in my hair when I was an adolescent. I was reminded of how I trained myself to tolerate the discomfort and still get a good night's sleep. Training myself to use the ventilator, the therapist said, was the opposite of quitting smoking. Every time I used it, I was adding time to my life. She is the kind of coach I need, unrelenting in confronting me when I deny how necessary the respirator is to keeping me healthy. She does not let me forget the reason I am putting myself through all this "trouble" to preserve my breathing muscles and add to my

quality and length of life.

I wish I could say that Ericksonian hypnosis has cured me and that I look forward to using my ventilator every night. However, I realize that this is a lifetime process on which I work one day at a time. I have been able to change my perception of the ventilator from something that would take over my life to simply a tool for better health. I am confident that I will continue making progress toward my goal. I have a means, a plan, and a good coach. What more do I need to succeed?

## DISCUSSION

by Leslie Hooker, M.S., L.M.F.T., R.N.  
Dallas, Texas

This case provides an example of how changes and advancements in medical technology give rise to new and challenging therapeutic issues. Poliomyelitis, a disease caused by three distinct enteroviruses affects individuals in a variety of ways. Following the acute illness, many of those who "recovered" are faced with lingering problems or new manifestations associated with the aftermath of the disease. Post-polio syndrome is a term used to describe a wide array of manifestations including fatigue, progressive weakness, joint pain and loss of functional abilities. One of the most life threatening concerns is progressive loss of respiratory function. This is primarily related to muscular weakness but also may be related to other musculoskeletal problems.

A ventilator is a mechanical device that assumes the workload of breathing. Traditionally, artificial ventilation delivered over a period of time is accomplished by means of a tracheostomy. The face mask described in this case is a technical advancement which allows support through less invasive means, however, it introduces new problems. A tracheostomy bypasses the protective anatomical structures whereas the face mask leaves the anatomical structures intact. The patient with a face mask has more to contend with in terms of adapting to the voluntary/involuntary balance in the process of breathing. Most ventilators used today are triggered in response to the patient's breath, cycling on inspiration. In the event that the patient does not breathe, the ventilator provides a set number of cycles per minute. A major advantage of using a ventilator with an individual like Joyce is that the volume of air provided by the

machine will fully inflate the lungs while simultaneously resting her own muscles. Despite the fact that the act of breathing while asleep is not a conscious activity, adaptation to a respiratory support device can be arduous.

Halstead, et al. (1985) have identified the following common characteristics of polio survivors: independence, perseverance, detachment, creativity and denial of limitations. The same characteristics that are helpful in overcoming limitations imposed by disease can contribute to resistance in dealing with limitations.

For six years, Joyce and her respiratory therapist struggled with resolution of physical and mechanical problems, never fully achieving the desired goal contained in the prescription to use the ventilator. Much of the adjustment inherent in the use of a face mask cannot be overcome with design modifications. Therefore, once that approach is maximized the user is left to internal resourcefulness to bridge the gap that remains.

The therapeutic approach facilitated progress by focusing on Joyce's personality strengths, her perseverance and denial of limitations. The first instruction was to sleep with the nose mask in the bed. This defined the mask as a familiar object and, metaphorically, as an inconvenience in the bed while she slept, rather than a part of the machine which had defeated her. Each succeeding accomplishment was meticulously charted giving Joyce a visible measure of her progress.

The hypnotic trances Joyce reports remembering dealt primarily with her own abilities to grow. The comparison of the discomfort of the ventilator with the discomfort caused by hair rollers which Joyce willingly tolerated enabled her to redefine the components necessary for a good night's sleep. The inescapable comparison and conclusion in that metaphor would present an irresistible challenge to a person like Joyce.

Ernest Rossi (1990) in his article "Psychobiological Psychotherapy" emphasizes the steps needed to integrate biological healing through psychological means. Overcoming her difficulties with the machine will not only help Joyce to maximize her own physical capacities but the process of dealing with her unique circumstances will create a more positive framework from which she can participate in life. Hypnosis can be used as a potent adjunct to accelerate

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## INTRODUCING THE INSTITUTES

### The Milton H. Erickson Institute of Chicago

by Hillel Zeitlin, LCSW-C  
The Maryland Institute for Erickson  
Hypnosis and Psychotherapy

The winds of change began to blow through the Windy City in 1984. Inspired by an Ericksonian hypnotherapy training with Steven Gilligan, a group of five Chicago clinicians decided to create a forum for further exploration of these innovative and effective approaches to psychotherapy. With the goal of meeting on a regular basis to discuss cases, brainstorm ideas and practice Erickson's teachings, the Milton H. Erickson Institute of Chicago was born.

The original founders knew that they were riding a wave of burgeoning interest in Ericksonian approaches, so President Philip Welches, Ph.D., held an open meeting for area professionals. Working together with the Milton H. Erickson Foundation, the Institute incorporated as a non-profit organization dedicated to the study and application of Ericksonian



Carol Sommer, M.S., L.C.P.C.

hypnosis and psychotherapy.

Incoming President-elect of the Institute Carol Sommer, M.S., LCPC, came to that open meeting. "My first Ericksonian experience had been in a workshop with Norma and Phil Barretta," she recalls. "I challenged Norma to make me believe I was hypnotized. At one point Norma turned to me and was playing with her pen. I didn't realize that I was doing the same thing. When she said 'Earlier, Carol you asked for something,' I went into a deep trance ... After that I was hooked."

The Board of the Institute created a membership structure, and determined that there was a particular

interest in a peer training program. In June 1986, some 27 clinicians from throughout the Midwest met. Coming from as far away as Milwaukee, St. Louis, Madison, and points in Indiana, the group agreed to conduct a monthly peer training. After assessing each other's special areas of interest and expertise, the participants worked together to explore such topics as indirect induction methods, Ericksonian client assessment, pacing and leading, and eliciting hypnotic phenomena.

The first year of peer training was such a success that a second, more advanced, program was conducted. By this time the Institute had expanded to such a point that the original Board of Directors recognized the need to allow new leadership to emerge. A new Board was formed that included both current outgoing President Thomas Goforth, M.Div., and Ms. Sommer.

As the Institute thrived, they formulated their own training philosophy stating: The training philosophy of the Institute emphasizes intensive experiential learning. Training includes presentation, demonstration, discussion, supervised practice, group trance work, and review of video presentations of Erickson's work. We give special attention to the practical application of concepts and tech-

niques in participants' own work setting.

The new Board brought new dimensions, one of which was hosting workshops with prominent Ericksonian faculty. "We all were particularly influenced by Rossi's minimalist approach, and Steve Lankton's multiple-embedded metaphor," Ms. Sommers remembers. The workshop also stimulated collaborative research efforts of Sommer and Ernest Rossi who joined to author the papers "Ultradian Rhythms and the Common Everyday Trance," and "Hypnotizability and the Menstrual Cycle."

The groups' training experiences and increasing expertise then formed the basis for a year long training program that the Institute offered to area professionals. Utilizing the foundation built from peer trainings, Institute trainers put together a comprehensive year-long training in Ericksonian therapy which spanned the gamut from the basics of fixating attention and building rapport, to complex treatment planning, paradox and mind-body communication.

In addition, the late 1980s saw the Institute found an audio/video library and a newsletter. The newsletter effort was headed by Alan Salmi, LCSW, the only original Board member still serving as an officer.

Continued on page 10



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Francine Shapiro, Ph.D., originator of EMDR, is a Senior Research Fellow at the Mental Research Institute, Palo Alto, California, and the recipient of the 1994 Distinguished Scientific Achievement in Psychology Award presented by the California Psychological Association. She has trained over 16,000 clinicians internationally and has been the invited speaker at and presenter at numerous national and international conferences. She is the author of *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures* (Guilford Publications, 1995), and many articles and book chapters on EMDR.

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- MH260-SOA2 **The Rise of Social Therapies**  
Lynn Hoffman, A.C.S.W.
- MH260-SOA3 **From Rehabilitation to Etiology: Progress  
and Pitfalls**, Margaret Singer, Ph.D.

#### INVITED ADDRESSES

- MH260-3 **The Evolution of a Cognitive-Behavior  
Therapist**, Donald Meichenbaum, Ph.D.;  
Discussant: William Glasser, M.D.
- MH260-5 **The Healing Word: Its Past, Present and Future**  
Thomas Szasz, M.D.;  
Discussant: Paul Watzlawick, Ph.D.
- MH260-6 **Shame: How to Bring a Sense of Right and  
Wrong into the Family**,  
Cloé Madanes, Lic. Psychol;  
Discussant: James F.T. Bugental, Ph.D.

- MH260-11** **Can Psychotherapy Be Brief, Focused, Solution-Oriented and Yet Comprehensive: An Evolutionary Perspective**, Arnold A. Lazarus, Ph.D.; Discussant: Donald Meichenbaum, Ph.D.
- MH260-17** **The Leap to Complexity: Supervision in Family Therapy**, Salvador Minuchin, M.D.; Discussant: Jeffrey K. Zeig, Ph.D.
- MH260-18** **Existential Therapy: Perspectives on the Therapeutic Relationship**, Irvin Yalom, M.D.; Discussant: Miriam Polster, Ph.D.
- MH260-20** **Case History – Evolution or Revelation?** James Hillman, Ph.D.; Discussant: Irvin Yalom, M.D.
- MH260-24** **The Self and Intimacy: A Developmental, Self and Object Relations Approach** James Masterson, M.D.; Discussant: Cloé Madanes, Lic. Psychol.
- MH260-25** **Coping with Loss During Older Years -- A Personal and Professional Perspective** Mary Goulding, M.S.W.; Discussant: Joseph Wolpe, M.D.

**WORKSHOPS**

- MH260-W4AB** **Getting the Most Out of Technical Eclecticism** (2 Tapes) Arnold A. Lazarus, Ph.D., Clifford Lazarus, Ph.D.
- MH260-W8AB** **Redecision: Using the Past in the Present** (2 Tapes) Mary Goulding, M.S.W.
- MH260-W9AB** **Disorders of the Self: Differential Diagnosis and Treatment Strategies**, James Masterson, M.D.
- MH260-W12** **Cognitive-Behavioral Treatment of Post-Traumatic Stress Disorder** (1 Tape) Donald Meichenbaum, Ph.D.
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- MH260-CP3** **Supervision of a Psychodynamic Psychotherapy**, Otto Kernberg, M.D. (Also Available on Videotape)
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- MH260-P9** **PTSD and Abuse**, Cloé Madanes, Lic. Psychol., Donald Meichenbaum, Ph.D., Francine Shapiro, Ph.D., Lenore Walker, Ed.D.; Moderator: Brent Geary, Ph.D.
- MH260-P12** **Children and Adolescents**, Claudia Black, Ph.D., Stella Chess, M.D., Cloé Madanes, Lic. Psychol., Donald Meichenbaum, Ph.D.; Moderator: Brent Geary, Ph.D.
- MH260-P13** **Homework Assignments**, Claudia Black, Ph.D., Jay Haley, M.A., Arnold Lazarus, Ph.D., Joseph LoPiccolo, Ph.D.; Moderator: Bernhard Trenkle, Dipl. Psych.
- MH260-P17** **Sexuality**, Albert Ellis, Ph.D., Otto Kernberg, M.D., Joseph LoPiccolo, Ph.D., Judd Marmor, M.D.; Moderator: Betty Alice Erickson, M.S.

**SUPERVISION PANELS**

- MH260-SP5** **Supervision Panel**, Aaron Beck, M.D., Otto Kernberg, M.D., Jeffrey K. Zeig, Ph.D.; Moderator: Elynn Bader, Ph.D.

**DIALOGUES**

- MH260-D3** **Growth and Development of the Therapist** Mary Goulding, M.S.W., James Hillman, Ph.D.; Moderator: William Matthews, Jr., Ph.D.
- MH260-D4** **Current Controversies in Psychodynamic Therapy** Otto Kernberg, M.D., James Masterson, M.D.; Moderator: Camillo Lorio, M.D.
- MH260-D7** **Essentials of Therapy** James F.T. Bugental, Ph.D., Irvin Yalom, M.D.; Moderator: Carol Kershaw, Ed.D.
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## FORUM REVIEW AUDIOTAPE

### *Shame: Bringing a Sense of Right and Wrong to the Family*

by Cloé Madanes, Lic. Psychol.  
From The 1995 Evolution of  
Psychotherapy Conference  
H260-6, \$9.50 – The Milton H. Erickson  
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**Comments by: Kay Cauthorn,  
M.S., NCAC II, Dallas, Texas**

The absence of a sense of right and wrong at every level of society as a theme in therapy is rarely explored. In "Shame," Cloé Madanes describes the many sides to shame and how a return to shame could be healing. *How to approach shame without appearing to be moralistic or less-than-courteous is described clearly. Shame is "the emotion that helps us to distinguish between right and wrong, that keeps us from harming one another and that makes it possible to live in a group." But shame and guilt have acquired a stigma in our "feel good" society. "... who wants to espouse the value of uncomfortable emotions? Yet is it right for us, as therapists to help people feel good when they do bad?"*

Madanés describes the backdrop against which therapists have been placed contextually. Guilt has been mislabeled as a disabling emotion because some people suffer from inappropriate feelings of guilt. This does not dismiss the need for conscience. Too much shame can destroy and the elimination of shame runs the "risk of creating monsters."

Shame followed by a "genuine apology admits responsibility and expresses sorrow." An apology is a statement that the "harmony of the group is more important than the victory of an individual."

Madanés recommends 20 steps for families where sexual or physical abuse has occurred. Some of these steps are that the whole family address what happened and why it was wrong, that the abuser understands that he has inflicted a deep spiritual pain on the victim, that the abuser be truly repentant, that the abuser apologize, publicly and on bended knee, to the victims, and that there be some sort of reparation. Reparation has the ability to restore

damaged relationships

Madanés calls on us to be "loyal to the truth" and not to a person or a cause. She has developed a procedure that potentially could heal thousands of families. This paradigm seems to include many aspects of the 12 Steps of Alcoholics Anonymous. Madanés first describes "shame" operationally and then moves immediately into solutions with families and society. She gently shows families how to move from shame into healing with great clarity. In "Bringing a Sense of Right and Wrong to the Family," Madanés again shows herself to be a truly healing therapist.

**Comments by: Rick Pipkin, Ph.D.,  
Dallas, Texas**

Throughout the years, I have been fascinated by the work of Cloé Madanés and found very little if anything to disagree with. However, in her presentation, "Shame: How to Bring a Sense of Right and Wrong to the Family," there are several suppositions with which I have significant problems. First, Madanés' general application of the term "shame" becomes a confusing concept. Dr. Bugental, the discussant of this paper seemed to have the same confusion.

Second, the concept of having the perpetrator feel the shame, become remorseful, and ask forgiveness is an excellent modality, but only in ideal situations. Having perpetrators fall to their knees and apologize to victims and their families seems only to serve offenders by relieving offenders' feelings of guilt and shame. There seems to be an implication, that when the apology is offered and deemed sincere by the family, there has to be forgiveness offered to the perpetrator. This leads to some other questions: What happens to the feelings of the victim? What if the victim or family does not want to accept the apology? What if the victim is too young to understand the underlying psychology of the apology? The courts and therapists' offices are filled with offenders who, at one time, offered a sincere apology only to return and offend again. Nothing is offered in this treatment modality to deal with the reason the offense occurred in the first place. The mere presence of a feeling of shame for an offense is not a cure for violence or abuse.

Unlike other treatment approaches that Madanés has introduced, the

use of the apology to bring about shame is overly simplistic. This is characterized by her statement that a sincere apology by Attorney General Janet Reno for the mistakes made by federal agents at the Branch Davidian compound in Waco, Texas, in 1993, could conceivably have prevented the bombing of the Federal Building in Oklahoma City in 1995.

Again the implication is made that the apology would have led to forgiveness, which would have eliminated retaliation, if in fact that is what happened in the bombing. I do agree with Madanés that America needs a very strong sense of right and wrong, but the answer is not to rely on the apology of a perpetrator to indicate his everlasting change of behavior.

**Comments by: Betty Alice  
Erickson, M.S., Dallas, Texas**

Madanés' "Shame: Bringing a Sense of Right and Wrong to the Family" describes perpetrators asking forgiveness from their victims as part of therapy. The statement of the reality of the offense, and avoidance of responsibility for offending behavior, validates the victim and personal power is restored by the process of forgiveness.

Madanés weaves healing into the process of deciding whether or not to forgive. Forgiveness is fostered while protecting victims from the pressure to accept the apology. She also uses the shame generating the apology as a tool for growth for the perpetrator.

In this technique, there are difficulties in determining whether or not the offender is genuine in the expression of shame. Also the granting of forgiveness is up to the family who was "fooled" in the first place. Their complex and perhaps not even conscious feelings of involvement, "I should have ..." "Why didn't I ...?" and even "Why didn't she ...?" are not addressed. Sorting out these feelings would consume a great deal of time, and would move the focus from healing the victim to the healing of the family unit. Healing the family may be an admirable goal but it implies that the victim "must" help in this process and it places responsibility back on the victim's shoulders. An outstanding therapist such as Madanés might be able to help the victims distinguish between what is best for personal healing, and what is wanted by others for their own personal agendas, and feel comfortable about their choices, but I use the words "outstanding," and "might" advisedly. A good technique is good

only if the user understands when to use it.

Attempting to manipulate behavior by shame is as old as mankind. Believing shame can overcome dysfunctional behavior is simplistic. Many, perhaps most, child abusers had shame and guilt about their behavior before being caught. This shame did not prevent them from offending. In fact, shame may play into feelings of inadequacy and worthlessness which can underlie offensive behaviors.

No one can dispute Madanés' claim for the necessity of a clearer moral sense of right and wrong. Perhaps our compelling want for this blurs our understanding of Madanés' presentation. Bugental, in his discussion, seemed to be struggling for clarity as to exactly what shame, if it could be defined definitively, would accomplish and then, what the next step would be.

Madanés is a lively and dynamic presenter and therapist. Psychotherapists owe much to her. However, she owes to them the further refining and careful consideration of all factors relevant in the world of abusers and their victims as presented in "Shame: Bringing a Sense of Right and Wrong to the Family."

### **Sexuality** *continued*

Lowest Common Denominator" challenged current approaches to therapy.

Disparate views represented at the meeting were reflected upon. The basic and fundamental professional differences provided a dynamic interchange and brought to the foreground questions about the foundation of therapeutic paradigms.

The presentations, discussions, and debates gave the audience of 350 a rich opportunity for professional self examination, insight, and inspiration to go forward to the advancement of study.

The Milton M. Erickson Foundation, Inc. is proud to organize this dynamic conference for the second time. A third meeting is planned for next year. The faculty at the Dallas meeting included Elyn Bader, Ph.D., Lonnie Barbach, Ph.D., John Gottman, Ph.D., Harville Hendrix, Ph.D., Les Kadis, M.D., Sandra Leiblum, Ph.D., Joseph LoPiccolo, Ph.D., Ruth McClendon, M.S.W., Jock McKeen, M.D., David Schnarch, Ph.D., Bennet Wong, M.D., Jeffrey Zeig, Ph.D., and Bernie Zilberfeld, Ph.D.



## Learning From Histories

by Jean A. Olson, MSN, RN, CS, LPCC  
Albuquerque, New Mexico

A teacher handed a student an onion. "Peel away each layer, study it, and tell me what you find." The student took the onion and gently peeled away the outermost layer of skin. "I found a light brown layer of onion." The student continued to peel away the subsequent layers, describing each to the teacher. This process continued for a long time. Eventually, the teacher asked the student what might be found at the very heart of the onion. The student, who was growing wiser, replied, "another layer of onion." Sometimes it seems that the more you peel away, the more you find.

A man decided it was time to teach his young son to hunt. He began by listing all of the important aspects: "Walk quietly and carefully, do not rustle the leaves or the grass; do not speak; watch your prey carefully and wait for just the right moment to make your strike..." As he spoke, the young boy fidgeted. Soon, he began to doze. The father was disheartened. He knew his son must learn these critical skills in order to survive. The father had an idea. "Son, become the cougar." The boy's eyes brightened. His posture changed. For hours, he practiced moving silently through the brush, lying quietly watching potential prey, poised for the correct moment to strike. He became the most skillful hunter of the tribe.

Another teacher in another place wanted to describe the extent of the love of his God to a group of people who knew nothing of this God. He explained that the God's love was boundless, that it encompassed all people, even those who had made mistakes in the past. It was difficult for the people to accept these concepts. Ultimately, they rejected him. He moved on to another village. There he called the people to him and told them a story of a father whose selfish son abandoned the family in pursuit of a life of pleasure. The son squandered all his money. Eventually, with nothing left, he returned home planning to offer himself as a servant to his father in exchange for food and a place to live. When the father saw his son, he was overjoyed.

He called for a celebration and gave the son valuable gifts. The people were entranced by the story. They marveled at the boundless love, generosity, and forgiveness of the father. How wonderful it would be to know someone like that!

Wise teachers have used metaphors, anecdotes, parables, myths, and stories for centuries. Long before anyone knew anything about Kopp's (1971) three ways of knowing (rational, empirical, and metaphorical), parabolic theology (TeSelle, 1975), or the differences in the way the right and left hemispheres of the brain process information (Nebes, 1977; Ornstein, 1978; Rogers, TenHouten, Kaplan, & Gardner 1977), people told stories.

In essence, metaphors allow something unfamiliar to be described within a familiar context, making it more accessible to the learner. Although the idea is conveyed indirectly, it becomes more meaningful (Mills & Crowley, 1986).

A while back, there was a wise man who used metaphors not only to teach, but to help people make changes in their lives. He found that stories could be used in nonthreatening ways to establish rapport, make/illustrate a point, seed ideas and suggest possible solutions to problems while bypassing people's natural resistance to change (Zeig, 1980). His metaphors were described as being "two-level communication" that addressed both conscious and unconscious processes (Erickson & Rossi, 1976/1980). That man, of course, was Milton H. Erickson, M.D. Many of us continue to learn and change by listening to his stories.

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## Institutes *continued*

But Ericksonian life in Chicago is not all training and research. The Institute hosted an annual holiday party that features The Purple Santa Claus, played by Dr. Richard Cook.

Because another Erickson Institute opened nearby, causing some identity confusion in the professional community, the Chicago group decided to suspend their year long training and focus its efforts on offering "on-site" trainings or talks, maintaining both a referral service, and the audio/video tape library.

Still, President-elect Sommer is among those who would like to expand the Institute by sponsoring more workshops and reviving the annual training. She further would like to help the Institute have a separate office space, with more opportunity for participants to practice and share cases, and to carry one of America's earliest Erickson Institutes into the next millennium.

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## SPEAKING OF RESEARCH

### *Succeeding in the 21st Century: A Qualitative Analysis*

by Carlos P. Zalaquett, Ph.D. and  
Michael T. Turner  
Sam Houston State University

This study implements the use of grounded theory to analyze participant responses to the question "What are the skills and abilities undergraduate university and college students should acquire to succeed in the 21st Century?" A list of 55 experts was invited to participate in the study. A cover letter explaining the study was sent to prospective participants during the summer of 1995. A total of 28 responses (50.9% return rate) were completed.

Using grounded theory of qualitative analysis, the responses were

broken down into basic meaning units. The units included communication, multicultural awareness, multilingual skills, management skills, teamwork/cooperation, creativity, ability to adapt, empathy, stress management, work ethic, self discipline, responsibility, discriminative thinking, grammar skills, analytical reasoning, economics/business, mathematical skills, computer skills, and telecommunications.

Using constant comparisons, the units were organized according to their similarities, giving rise to four supracategories including: Interpersonal (characteristics that facilitate relations between the individual and other people), Intrapersonal (qualities which are intrinsic to the individual), Fundamental (an understanding of the basic academic fields), and Technological (specific and/or practical knowledge of advanced mechanical

or scientific processes) skills. Subsequently, these categories were combined to form two core categories: Attributional (relating to characteristics closely associated with the individual) and Educational (relating to the formal teaching process within schools of learning) skills, each "grounded" in the categories that subsumed it.

It was assumed that the responses would vary greatly and, if any consensus was present, the most likely response would have technology as its base; however, there was a high level of consensus on many of the responses, most emphasizing effective communication skills. The capacity to understand computer technology, the ability to think critically and multicultural awareness rounded off the top four responses.

Interestingly, more emphasis was placed on interpersonal characteristics of the individual and, unfortunately, these are the skills taught less

often at the college level. As psychologists, counselors, and educators, we need up-to-date information to provide the best guidance to our college students. With the information provided by studies such as this, we can help determine educational priorities and interventions to prepare college and university students for a world characterized by structural changes at the domestic and international levels, as well as changes in professional demands.

We are nearing the end of a century and of a millennium, and the authors hope their study will help stimulate more research on this topic and motivate psychotherapists, psychologists and counselors to get more involved in the process of helping students to empower themselves to succeed in the future. Dr. Zalaquett currently is developing a study about the skills and abilities psychotherapists will need to develop or acquire to succeed in the 21st Century.

## HISTORICAL TIMES

### *The Marquis Armand de Puysegur (1751-1825)*

#### *Belief & Will - an Erickson Precursor*

by Patrick Bellet, M.D., Institut Milton H. Erickson d'Avignon-Provence, France

The Marquis Armand de Puysegur was among the most fervent followers of Mesmer. Descended from a family of soldiers, grandson of the Marshal of France for Louis XIV, he became a colonel at the age of 27. This talented therapist was a multifaceted man. Author of several books, he and his brother, Maxime Chastenet de Puysegur, who also was an avid follower of Mesmer, were known as humanitarians. His brother formed the "Société de l'Harmonie du Cap-Français" in Haiti in 1784, which had among its goals the abolition of slavery, and Puysegur himself was responsible for the creation of many "Sociétés de l'Harmonie."

The most important of Puysegur's writings were the first two *Mémoires*, books in which he described the discovery of "Artificial Somnambulism." The discovery of this was a fortuitous circumstance.

On May 4, 1784, when he treated a 23-year old man named Victor, Puysegur produced a calm and deep "sleep" while retaining Victor's ability to speak and move. Later when Victor woke, he experienced amnesia for that session. Puysegur wrote about this and his other work with what is now known as hypnotic phenomena.

Early in his career, Puysegur utilized the techniques of Mesmer. But, little by little, he modified those techniques. He treated people outdoors and he once "magnetized" a tree for the treatment of a hundred persons. He stopped using a "baquet" (small tub) filled with water which was common in that time. His work provoked an evolution in Mesmer's system of animal magnetism. Mesmer probably knew of the existence of "Artificial Somnambulism" but had never spoken precisely about it.

Puysegur attributed many abilities to the somnambulists. For example, he thought they could see and describe illness in themselves and in others and that they could become clairvoyant.

As Puysegur developed his own framework, he made significant contributions to psychotherapy. He discovered and wrote about the importance of the "will" of the "magnetist" in the procedure of "magnetism." What then became important was the

concept of "Exclusif Rapport" or the relationship between the therapist and the patient. His notion of the power of will in altering physical processes determined a new way of treating patients. It was the birth of the psychological approach of therapy and remains an important concept in therapeutic work today.

The issue of the power of the therapist's will on the subject's mind raised many questions. Indeed, the risk of patient abuse appeared. This issue is debated even today.

Like Mesmer, Puysegur was a musician and sometimes played a harp during sessions of producing "magnetism." He also often asked his patients to sing with the music and, in this way, had them take an active part in the treatment.

He also discovered it was useful to develop the ideas of the patients which were favorable to the treatment. He utilized the patient's values as Erickson did later. He felt the solution belonged to the patient; the magnetist merely amplified those resources. Puysegur explained, "I nourished these ideas in him (the patient)."

Puysegur's careful custodianship kept magnetism alive during the disturbed period of the French Revolution. His development of Mesmer's work led to concepts in psychotherapy which are in use

today.

Although Deleuze became the most famous reference to ethics in the first part of the 19th century, ethical issues in hypnosis began with Puysegur and his belief in and study about the effects of the therapist on the patient.

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*Keynote by*  
**Jay Haley**



## Mesmer and Animal Magnetism

by Frank A. Pattie  
Hamilton, New York:  
Edmonston Publishing Co., 1994,  
xiii + 303 pp, \$39.95  
(315) 824-1965

The subtitle of this book "A Chapter in the History of Medicine" is an accurate description of the distinct information contained within. The life and work of Franz Anton Mesmer (1734-1815) provides a focal point for this in-depth descriptive monograph which provides an explicit account of the social and professional atmosphere from which current practices have sprung.

Frank A. Pattie, Ph.D., is Professor Emeritus of the University of Kentucky, with a long personal history of contributions to the professional advancement of hypnosis. He was an Associate Editor of the *American Journal of Clinical Hypnosis* and perhaps its most important supporter during the journal's formative years. He also was *President of the American Society of Clinical Hypnosis* from 1959-61. The book's foreword by Ernest Hilgard, Ph.D., reinforces the recognition of Pattie as a qualified scholar whose contributions have spanned half a century.

Other works also have chronicled the public and professional life and work of Mesmer. Laurence and Perry (1988) do a commendable job of detailing the professional reverberations of this influential figure within the social and historical contexts. Though not as detailed about Mesmer as this account, Laurence and Perry concur with Pattie's appreciation for the broad and latent consequences of the work of this man.

What is exceptional about this particular account is Pattie's full commitment to the employment of primary reference materials. I wrote Pattie to express admiration for his diligence. The book surpasses any volume I have seen in the use of source material. Pattie answered and stated that in order to properly research the topic, he found it necessary to amass his own library of 255 old books.

To follow suit, I quote Pattie (1994):

"I left no stone unturned." I fol-

lowed every lead. When Mesmer mentioned Mead in his dissertation, I looked up Mead's book and immediately saw that it was the source of Mesmer's dissertation.

"I picked up the *Revue de Paris* in 1956 and found an article by Dr. Rist, which is cited on p. 12 of the book and is a valuable part of the book."

Pattie also credits his knowledge of Latin, French and German which made writing the book possible.

Pattie's documentary details information about the personal life, the professional activities of Mesmer and the reactions of the public and professional community to his work and ideas. The writing style is succinct and factual, but the information portrayed is so detailed and vivid that the individuals involved brim with life.

Pattie presents the social and professional atmosphere within which Mesmer lived. His ideas and work are traced chronologically and annotated by reactions of the professional community to his work. The influence of this individual on the tenor of the time is punctuated with quotations from others. One of many choice references is from Mozart in the opera *Così fan tutte* written in 1790. Pattie's translation from Italian (p 33):

"(This is that piece/ Of magnet/ The stone of Mesmer/ Who originated/ In Germany/ And then became so famous/ in France.)

"The accompanying music is said to represent the flowing of magnetism into the bodies of these characters."

The book is replete with quotations from Mesmer's own writing. Pattie seeks the origin of Mesmer's ideas, and succeeded even beyond the exposés of Mesmer's contemporaries, who overlooked the plagiarism in his dissertation. In 1956, Pattie published an account of the degree to which Mesmer has borrowed ideas from Mead, and presented them as his own in his doctoral dissertation "On the Influence of Planets."

The book is appropriate for readers who are interested in history, in hypnosis, or in our cultural foundations of medicine. It reads easily, yet invites scrutiny, as nearly every point of information is documented. The relevance to current practitioners of hypnosis is fundamental.

Baker (1990) notes that the relationship of mesmerism to hypnosis more closely resembles that of chemistry to alchemy or astronomy to astrology. After reading this in-depth account, I agree with that premise. Mesmerism is the historical foundation of contemporary hypnosis, and therefore provides a perspective of understanding unreachable by other means.

*Mesmer and Animal Magnetism* receives my highest commendations. It is an exemplary study of the power of engaging primary source materials.

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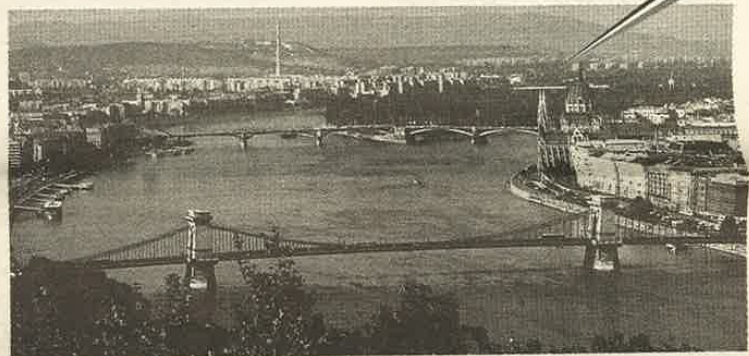
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### Reviewed by:

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## TOPIC REVIEW VIDEOTAPES

Videotapes by  
Mary Goulding, M.S.W.  
Distributed by  
The Milton H. Erickson Foundation  
3606 N. 24th St.  
Phoenix AZ 85016-6500  
(602) 956-6196, fax (602) 956-0519  
Reviewed by  
John Gladfelter, Ph.D., A.B.P.P.,  
F.A.G.P.A., Dallas, TX

### **"One-Session Group Therapy with Six Clients (Real) from the Audience"**

Tape #F280-V16  
(1993 Brief Therapy Conference)

In "One-Session Group Therapy," Mary Goulding, M.S.W., demonstrates Redecision Therapy with a group. Goulding is co-founder of the Western Institute of Marriage and Family Therapy in Watsonville, Calif., with her late husband, Robert Goulding, M.D. They trained therapists from around the world during a period of 20 years. The Gouldings were very experienced therapists and had trained with both Eric Berne and Fritz Perls. Redecision Therapy was created by them as a powerful group therapy tool that incorporated the theories of both Transactional Analysis and Gestalt therapy.

This tape displays many of the principles of Redecision Therapy with three individuals in a group of six people. (Due to time limitations, she was able to work with only three group members.) In her work with each of the group members, Goulding presents the format of Redecision Therapy through the development of the contract, the exploring of what the person wants to change and then the implementation of that change.

Humor was used throughout as an effective interpersonal style that enables each person to change as much as seemed right with them. Each person was able to achieve a degree of resolution of the presenting problem and experience a positive feeling about what was done.

Goulding's work exemplifies many principles in common with an Ericksonian approach. These include her special care in the use of language, the utilization of specific body

movements, the focus on choices and the attention paid to the existential time perspective. Her focus on the work and the clarity of the interchanges also are in keeping with how Milton Erickson did therapy.

The technical quality of the tape was professional in both sound and picture. This is a marvelous companion tape to one made later in the "Evolution of Psychotherapy" series by Mary Goulding. Good, high quality videotape of psychotherapy is of considerable value to both the private practicing therapist and to the teachers of psychotherapy. "One-Session Group Therapy" will be an important addition to a psychotherapy library in any professional setting.

### **"Brief Therapy- Redecision Model"**

Tape #H260-CPV14  
(1995 Evolution of Psychotherapy  
Conference)

"Brief Therapy-Redecision Model" is a live demonstration of Redecision Therapy by Mary Goulding, M.S.W., with three clients chosen from the audience. The purpose of the presentation was to demonstrate how a Redecision treatment approach can be used to do short-term therapy. After completing her work with the clients, Goulding answered questions from the audience and discussed some of the salient points of her work and its underlying theory.

Goulding's work with the clients demonstrated her effective use of a brief time frame, the specific attention paid to the language, the nonverbal communication and the treatment contract involved with each client.

The satisfactory conclusion of her work with each client demonstrated the support and safety that each person experienced and the closure which was enabled by the Redecision approach.

There are many similarities to Ericksonian therapy in a Redecision approach, especially in the use of a humanistic, phenomenological approach to each client and the respect and care exercised by the therapist. Goulding also used language with the same care typical of Milton Erickson and noted the body language of each client in a therapeutic fashion. She also kept the treatment carefully focused and used imagery with care.

This videotape is a fine demon-

stration of Mary Goulding's use of the Redecision approach to therapy. It is understandable and easy to follow. The beginning therapist may find questions about the techniques that can be answered only by a seasoned trainer in Redecision Therapy. The experienced therapist will enjoy the subtleties of the work and the adroit and careful techniques employed. For trainers in Redecision Therapy, "Brief Therapy" will be a valuable addition to training libraries and will be used regularly to display the finer points of this approach.

### **Case Report** *continued*

the process of healing; Waxman (1989) describes the value of this tool in working with patients with chronic illness or limitations. Both Rossi and Waxman cite the utility of hypnosis in integration of unconscious/conscious processes.

The conscious/unconscious qualities of respiration make it particularly challenging to adapt to mechanical assistance. Interestingly, Joyce found that short daytime intervals were the first area in which she was able to

master her use of the ventilator. Joyce learned the difficult step of releasing her conscious efforts and allowing the machine to deliver full breaths. By learning this step first, Joyce has demonstrated remarkable power and triumph over her struggle with the perception of the machine as a limiting factor in her life. The sequence of learning and paced progress demonstrates the very essence of adaptation in her use of the machine as an implement to strengthen and extend her physical capacities.

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## AUDIOTAPE REVIEW

### **"Searching for Reason and Finding Madness: A Hypnotic Experimental Paradigm"**

by: Philip Zimbardo, Ph.D.  
Tape MG 264-70; \$10.50

Available from the M. H. Erickson Foundation, 3606 N. 24th St., Phoenix, AZ 85016-6500; (602) 956-6196; fax (602) 956-0519

*Keynote Address: The 6th International Congress on Ericksonian Hypnosis & Psychotherapy*

The renowned social psychologist Philip Zimbardo is also known as a writer and popularizer of psychology. In this address he presents a fascinating discussion of the ways he uses hypnosis as a research tool. Zimbardo, who received his training in hypnosis at the Morton Prince Clinic and did research with Ernest Hilgard, M.D., has a superlative reputation as a researcher, teacher and textbook writer.

"Searching for Reason and Finding Madness" will appeal to those wanting information for research as well as those who want new ideas for diagnosis and treatment in clinical practice. Zimbardo's research is imaginative and well-conceived, but since this lecture reveals almost nothing of the methodology and replicability of the work, it is hard to comment on the research itself. Therefore, I will confine my remarks to this lecture.

Zimbardo begins with the explanation that instead of studying hypnosis itself, he uses it as a methodological tool, allowing him to create aspects of human behavior about which he wants to learn. In one experiment, he uses hypnosis as a medium to create psychopathology in "normal" human beings to demonstrate the psychodynamic processes by which an individual begins developing pathological symptoms. More information about the beginning stages of psychopathology could teach us to treat more effectively.

Zimbardo outlines five case studies. The first is that of an "almost perfect" student seeking help for physical symptoms; he had developed a system of self-handicapping symp-

toms to protect his self-image as a good student. He had the belief that these problems could be modified, but the true problem, poor academic ability, could not be changed.

In the next, an auto worker concealed embarrassing physical symptoms. His coworkers, who experienced similar symptoms, did the same until they discovered the cause was toxic brain damage. In the third case, "Old Joe" began to develop what appeared to be paranoia. Research supports that people, unaware of hearing loss, often develop paranoid symptoms as an adaptive response to their inability to hear other people clearly.

Fourth, he talked about a case upon which Freud based his theory of latent homosexuality leading to paranoia. Zimbardo said that the patient had been brutally physically and mentally abused by his father, but in the social climate of the day, the reality was ignored and Freud's fantasy theory was fueled to explain the illness.

The last case was Zimbardo's discussion of the accusations against the "Witches of Salem." To explain symptoms that could have been produced by ergot poisoning, which was unknown at that time, the physical symptoms of the accused women were attributed to bewitchment.

Zimbardo used these cases to illustrate that problems which appear to be psychological problems may be based on physical causes; the assumptions generated by ignorance about physical causalities are then false. He said these assumptions are based on a cognitive bias stemming from well-established ways of explaining significant discontinuities, especially when knowledge of true causes are limited by the state of current knowledge. There is, in other words, a cultural bias which drives explanations away from true causes which may be either unknown or socially unacceptable. Objective science, he said, lays out all conceivable causes, studies the evidence and eliminates that which is not explained by evidence.

Part of the work he has done is studying how people try to understand the discontinuities that affect their lives. He identified three ways in which people try to cope with personal discontinuities. First they try to find the cause and make the phenomenon rational and reasonable. A sec-

ond technique is avoidance and, third, people minimize the strangeness of an abnormal reaction by affiliating with other people in order to normalize their reactions.

Ideas like these are the grist Zimbardo turned into experiments in which he used hypnosis to induce pathological thinking in his subjects, who then began generating explanations that became disturbing, distressful and dysfunctional symptoms which were judged by clinicians to be pathological. These are what Zimbardo sees to be the end result of people searching for reason in discontinuities, rigidifying conclusions and becoming unwilling to switch to

alternative explanations.

The organization of Zimbardo's talk was confusing. It took so long to describe the five cases, I lost track of where the lecture was going. I then felt Zimbardo had to rush through some of his most significant insights. I was left wanting more explanation about the actual experiments and their significance for clinicians. However, I found "Searching for Reason and Finding Madness" enjoyable and interesting, and believe I gained a great deal of information from it.

**Reviewed by:**  
Francine Daner, Ph.D.  
Richardson, TX

## SPEAKING OF RESEARCH

### **Consultation for Insomnia: Hypnotherapy and Sleep Hygiene**

by Gary R. Elkins, Ph.D., ABPP, ABPH  
Temple, Tex.

This study reports the successful use of hypnosis within a brief multimodal intervention for insomnia. Because it is a symptom rather than a disease, insomnia can be related to depression, alcohol or drug abuse, medical disorders, or specific sleep disorders. Therefore differential diagnosis is essential for the effective management of this problem. Treatment for insomnia typically takes time and may be spaced over weeks or even several months. However, sleep clinicians are frequently asked for brief consultation either by other health care providers or by individuals suffering from insomnia. Therefore, research was conducted on a two session intervention utilizing hypnotherapy, behavioral recommendations, and education on sleep hygiene.

The subjects were eight consecutive patients referred for treatment of insomnia. Six of the patients received a diagnosis of psychophysiological insomnia and two of the patients received a diagnosis of insomnia associated with stress. Each patient met the criteria of insomnia which is more than thirty minutes of awake time during the night, or less than 6.5 hours of total sleep at night, for a duration of at least three months.

During the first visit, each patient was given recommendations for sleep hygiene such as: (a) Do not go to bed

until you are drowsy, (b) do not take naps during the day, (c) do not drink alcohol later than two hours prior to bed time. Patients also were given recommendations for sleep restriction therapy such as: (a) Do not use your bedroom for any activity other than sleep, (b) establish regular routines to signal bed time, (c) if you cannot fall asleep within a short time, go to another room and engage in a boring activity. The session concluded with a discussion of hypnosis and its use in facilitating sleep. The patient also was provided with a brochure describing the use of hypnosis and myths regarding hypnosis. The next session was scheduled within seven days.

During the second session sleep hygiene and stimulus control rules were briefly reviewed. Next, a hypnotic induction was followed with suggestions to focus on breathing and to experience relaxation. The relaxation was emphasized in terms of physical relaxation, mental relaxation, and emotional relaxation. Suggestions also were given for "restful sleep." Before leaving, each patient was given an audio cassette containing hypnotic suggestions consistent with those in the session.

After three months, post-treatment, patients were asked, "To what degree do you feel that your sleep has changed?" The average rating, on a 10 point scale, was 5.25 indicating a subjective sense of moderate improvement. Also, self-reports of time to sleep onset indicated improvement which ranged from 88 to 28 minutes, while average awakenings decreased from five to three per night. When asked which aspect of their consultation was most helpful,

*Continued on next page*



# CASE REPORT

## Reframing in a Case of Childhood Phobias

Henry T. Close, Th.M.  
The Milton H. Erickson Institute of  
Atlanta, Atlanta, Ga.

Thirteen-year-old Missie is afraid of everything, especially noises. Airplanes, thunder, creaks in the floor, wind, all carry an ominous threat that something is out to get her. During a recent rainstorm, she clutched frantically to Mom, sobbing and trembling, for what seemed to Mom like an eternity. She will change schools next year, and is terrified at the thought of new routines, new teachers, new friends, new demands. The family tries to be supportive, but she seems to exploit their concern. Sometimes Mom yells at her in exasperation, and strangely, that seems to calm her down. She tries reading the Bible, surrounding herself with stuffed animals, listening to loud music, etc., but she cannot escape the underlying foreboding of doom. The kids at school torment her about her phobias, which of course isolates her and terrifies her even more.

My first session was with her and Mom together. I referred to her phobias as "excess caution." I said that sometimes in families, there are people who have too little caution, and in some kind of unconscious way, somebody else may try to balance that by developing too much caution. That did not seem to be the case with them, with the possible exception of Dad's sometimes reckless driving.

I then asked Mom if she appreciated the value of Missie's caution. Most kids today suffer from too little caution, especially in relation to sex and drugs and thrills. Most of the families I see have kids with far too little caution, and it was refreshing to see someone who had too much. I said that in a world like this, people need to have a lot of caution. I asked if they had a burglar alarm in their home. Yes. Who makes sure it is armed at night? Missie. And who in the family sees to it that doors and windows are securely locked day and night. Missie! And who sees to it that the car doors are always locked? Missie! I encouraged her to continue being diligent about these things. I told her I had a daughter who was not cautious enough about these things,

and if she could figure out how to put some of her excess in a package, I would be delighted to pay her for it.

Missie has friends who are sometimes indifferent to danger. In fact, when she was younger, a friend goaded her into climbing a tree. When she fell, she was badly scraped and bruised. I encouraged her to keep as much excess caution as she needed in order not to be pressured like that.

She asked me if I had fears and phobias like hers when I was a kid. I answered honestly that I had not, but that I had been terribly shy and easily intimidated, and gave several examples. She seemed pleased to hear that. I then told her about some of the things of which I was afraid: heights, roller coasters, ladders, etc. She bragged about a roller coaster she had ridden, and I was duly impressed. I told her that nothing in the world could have gotten me on a thing like that, and that maybe I should be seeing her for therapy! I then told her about my memory of climbing to the top of a lighthouse, and clutching to the railing lest I jump off.

At the end of the first session, I asked her to be aware of anything that happened during the coming week that at one time in the past she would have been nervous about, but that now she was not. The next week, she mentioned an airplane that flew overhead without her being afraid it would crash on the house. I talked about how planes do crash sometimes, but that they are safer than driving. She also mentioned a storm that she weathered [pardon the pun] with equanimity. I talked about certain lunatics who do not take the power of a storm seriously — such as people who have hurricane parties — and sometimes die in them!

At the end of the second session, she felt she was ready to wait two weeks before we met again!

## DISCUSSION

by Jerry Weiss, Ph.D.  
Dallas, TX

What a charming case report! I am always heartened when a cure occurs in only one or two sessions. It must make the heart of Managed Health Care warm (if a heart actually exists) to read a study such as this.

We really don't know much of the background of Missie, the 13 year-old girl who is fearful of "every-

thing," except that Dad is sometimes a reckless driver and Mom calms her down by yelling at her in exasperation." I can only assume that Missie is of at least normal intelligence, is able to use her imagination consciously and easily, and is suggestible, at least, to Close. She also is clearly in distress at some of the consequences of her irrational fears.

Close's report is clearly written and a joy to read. He makes a friend of Missie, speaks to her at appropriate age level, reinterprets her fears as "caution," a reframing which presumably keeps her from being anxious about them, and strongly supports, to the mother, Missie's anxious "fears" or cautious behaviors as positive qualities.

By the end of the first session, it appears Missie is well on the way to being "cured." Close advances the therapy with an expectation that she will note something in the coming week about which, in the past, she would have been nervous and fearful. This requires Missie to turn her vigilance toward a wondering and reclassification of "fearful" events rather than that vigilance keeping her locked in the loop of "automatic" fearfulness. Erickson was fond of requiring patients to make one small change which then created new patterns. "Therapy is often a matter of tipping the first domino." (Rossi, 1973. p 14.)

At the second session, Close simply reinforces and reemphasizes the comments of the first session. Missie had done her homework. The airplane flying overhead had not caused a fear that it would crash into her house. She also talked about a storm which had not caused fear. Close treated both these reports with respectful sincerity and distinguished rational parts of anxiety from irrational fears about events such as these. Without directly addressing which of Missie's fears were rational and which were irrational, Close continued to support the rational fears which had been reframed in the first session as "caution." He also continued to follow dictates of Ericksonian psychotherapy. Rossi (1979) quotes Erickson, "She came to me with a problem and I tell her she is going to have to do some thinking. And then I demonstrate to her exactly that kind of thinking." (p 210)

I imagine Close feels this case was resolved by hypnosis. A question some of us may have is whether or not hypnosis was used. The modality appears to be more cognitive therapy than what is ordinarily thought of as hypnosis. But there are those who

would say that hypnotic phenomena occurs in all therapy; therefore, of course, hypnosis was used. I am of the later persuasion; it would be difficult to convince me that a conversational trance, at least, was not employed here.

I hope Close provides some follow-up information about Missie. Patients rarely call us months later to tell us how they are doing. However, if we are using single case studies to indicate behavioral changes, it behooves us to find out whether the behavior change is temporary or permanent. I would be interested to receive information of this youngster's behavior in three, six and twelve months after these sessions with Close. I am in no way questioning whether the described changes actually happened. I believe, though, their presentation would be greatly strengthened by some follow-up information.

### References:

- Erickson, M. H. & Rossi, E. L. *Hypnotherapy: an exploratory casebook*. 1979. Irvington Publishers. New York.  
Rossi, E. L. "Psychological shocks and creative moments in psychotherapy." *American Journal of Clinical Hypnosis*. 1973. Vol 16. pp 9-22.

### Research continued

each patient indicated it was the instruction in self-hypnosis and use of the tape recording.

With these results, the author believes that hypnosis may be a useful clinical technique in the treatment of psychophysiological insomnia, however, more research is needed. Future designs should compare subjects of high and low hypnotizability and include a control group. Also, the treatment components should be examined separately to determine which contributed most to the outcome. An important function of this pilot study is to stimulate controlled experimental outcome research with regard to the treatment of insomnia using brief interventions.

*Editor's Note: The full report of this research summary has been accepted and will appear in:*

Elkins, G.R., Consulting About Insomnia Hypnotherapy, Sleep Hygiene and Stimulus - Control Instructions. In Matthews, W. and Edgette, J., eds., *The Evolution of Brief Therapy: Annual Publication of the Milton H. Erickson Foundation*.



## VIDEOTAPE REVIEW

### *Humanization of Technique*

with Erv Polster, Ph.D.

H260-CPVII – The Milton H. Erickson Foundation, 3606 N. 24th St., Phoenix, AZ 85016-6500  
(602) 956-6196, fax (602) 956-0519

Watching the work of an accomplished psychotherapist is an important and interesting tool for the development of therapeutic skill and style. The majority of the content of *Humanization of Technique*, after some introductory comments, is a 40-minute demonstration session on stage at the 1995 Evolution of Psychotherapy Conference in Las Vegas, Nev. Polster fields questions from the audience after the demonstration. The technical quality of the tape is exceptional with great audio and very effective "split-screen" video that gives the sensation of being right on stage with them.

As I work and train from a Gestalt Therapy perspective, I find Polster's presentation of one of the theoretical and clinical hallmarks of Gestalt Therapy, i.e. the use of "self" in the context of a therapy relationship, an important contribution to therapeutic practice in other theoretical perspectives. The only significant weakness is the introduction that did not provide an adequate foundation to understand the work. The follow-up questions and answers helped clarify some points, but multiple viewings

proved the best way of understanding the qualities of the work. The tape may have a particular interest to training and practicing mental health professionals because Polster works with a therapist on the issue of using her humanity in her work with clients.

The demonstration is an excellent example of working in the interpersonal, "here and now" of the session. In his work, Polster skillfully uses his experience of the moment, observations, sensations, thoughts, hunches, and ideas as he attempts to discover the client's world of experience. As this "meeting" unfolds there are some wonderful moments of challenge, insight, humor, and movement. The session deals with pertinent issues such as using more of ourselves than just our professional persona, valuing the realities and experiences of our clients over our interpretations, how clients' issues often trigger our own fears and anxieties and how those assumptions can alter the therapeutic encounter.

Although I thought there were several instances Polster was overly pressing his agenda in a way that seemed inconsistent with his intended goal, he generally demonstrates using his humanity with skill and grace. The demonstration *Humanization of Technique* ends with an especially meaningful and enjoyable exchange.

#### Reviewed by:

Bruce A. Robertson, M.S., L.P.C., L.M.F.T., Denton, Texas

and still learn a great deal. But if you don't listen to the tapes you will miss "the entertainer," Dr Landis. He knows what he is talking about, he talks in a very enthusiastic way, and uses a lot of humor. He illustrates his method using demonstration subjects in a permissive, understanding and convincing way. It is obvious that he has worked extensively preparing this well-structured workshop.

His method of treatment for PTSD involves Ericksonian psychotherapy and hypnosis, NLP, cognitive therapy, imagery, dissociation,

## TOPIC REVIEW

Publications by  
D. Corydon Hammond, Ph.D.,  
A.B.P.H. (et al.)

Publications of the  
American Society of Clinical  
Hypnosis Press, 1994

American Society of Clinical Hypnosis  
2200 E. Devon Ave., Suite 291  
Des Plaines, IL 60018-4501  
(708) 297-3317

Reviewed by  
Timothy K. Baumgartner, Ph.D.  
Houston, Texas

### *Clinical Hypnosis and Memory: Guidelines for Clinicians and for Forensic Hypnosis*

This short book, created by the Hypnosis and Memory Committee of the American Society of Clinical Hypnosis is a concise, well documented guide to current issues regarding the relationship between hypnosis and memory. A compilation of research from the last several years, this guide provides the clinician with background, current debates, and legal implications of various viewpoints on the accuracy of memory as related to hypnosis and other nonhypnotic means of information solicitation, factors influencing distortion of memory, false memory, and ethical considerations for preparing clients for clinical and forensic hypnosis.

The committee presents a moderate position on the current debates of memory accuracy, encouraging the

clinician to operate within a client supportive framework, while being responsible to the potential consequences to the client and others of possible memory distortions. The book describes the current state of relevant research, illuminating experimental design problems which inhibit the validity of specific clinical conclusions, while offering helpful cautious generalizations.

This committee report, *Clinical Hypnosis and Memory*, likely will be experienced as supportive and refreshing to clinicians looking for practical and ethical guidance in their own work and professional development.

### *Medical & Psychological Hypnosis: How It Benefits Patients*

In this brochure, Dr. Hammond provides a brief review of research associated with various medical, dental, and psychological applications of hypnosis. The publication is not an instructional tool for the clinician, but rather may be considered as an informational resource for those seeking scientific documentation of the efficacy of hypnosis as treatment for numerous health concerns.

The clinician may find this useful when marketing to the medical community as well as when introducing clients to potential benefits of hypnosis. The brochure is brief, easily read, and includes a helpful position statement regarding the current issue of memory accuracy and hypnosis.

## AUDIOTAPE REVIEW

### *Beyond Survivor*

by Richard E. Landis, Ph.D.  
Distributed by Southern California Society for Ericksonian Psychotherapy and Hypnosis (714) 495-0323

*Beyond Survivor* is an eight audiotape album recorded live at a workshop held by Richard Landis, Ph.D., in the USA. Landis held a similar workshop in Stockholm, August 1995. The edited highlights that come with the tapes are comprehensive and thorough. You can read only the highlights, without listening to the tapes,

self-reparenting and "partwork," (see the review by George Gafner in the *Newsletter*, Vol. 15, 2).

Landis thinks the person afflicted by PTSD already has suffered enough and therefore should not relive the trauma and go through an abreaction. Instead he offers the patient self-empowerment and information integration, in order to learn new resources and new ways to see both the perpetrator and what happened in the traumatic situation. He uses several techniques for the cognitive/imaginal paradigms including second and third order dissociation, as well as

generative approaches to empowerment such as "the android" and "the shrinking parent."

Listening to the way Landis works with dissociated parts of the patients' personality gave me valuable ideas of how to use this method with different types of disorders. Therefore, I highly recommend "Beyond Survivor" to my fellow clinicians.

#### Reviewed by:

Göran Carlsson, Director  
The Milton H. Erickson Clinic of Mora, Sweden



## FORUM REVIEW AUDIOTAPE

### Cognitive Behavioral Therapy for Adults

Audiotaped Workshop  
by Donald Meichenbaum, Ph.D.

Recorded December 1995, at The  
Evolution of Psychotherapy Conference

H260-W35 A&B - The Milton H.  
Erickson Foundation, 3606 N. 24th St.,  
Phoenix, AZ 85016-6500  
(602) 956-6196, fax (602) 956-0519

#### Comments by: Lynn Smith, M.A.

According to Meichenbaum, Cognitive Behavior Modification can be applied to individuals, couples, and families. This approach is especially useful when treating affective disorders such as stress, anxiety, or depression. The essential definition of Cognitive Behavior Modification is "How do I respond in that critical moment of time?"

As clinicians, our jobs consist mainly of listening to people's stories which Meichenbaum says is the "stuff" of therapy. While we listen to patients' stories, we need to notice and help clients learn to notice their physiological responses, how they appraise the situation they describe, and the nature of their interpretations. Clinicians also should teach clients to look at their knowledge base and their expectations regarding critical situations.

Meichenbaum states that the art of questioning is the most important therapeutic tool. Through questions, therapists make people aware of their interpersonal cycles, automatic thoughts, and internal dialogues. By teaching clients to examine what they say to themselves, therapists can help clients "tell a different story."

Meichenbaum stresses that people don't get depressed or anxious, but unknowingly get caught up in cycles and begin to feel they are victims of their thoughts and feelings rather than looking closely at what they're saying to themselves to keep themselves feeling victimized.

The following is a "behavior repertoire" that gives clients a method to analyze situations in which they feel like victims: (a) discover automatic thoughts, (b) cognitive processes and schemas (i.e., Does the client bring other things to the occasion? Does this situation bring forth other mental representations?); and (c)

what does the event represent (i.e., What are the core beliefs and schemas that are affected by the event?). By teaching clients to perform situational analyses they begin to see that they have choices.

I enjoyed the tapes and have found them to be useful in my adolescent as well as geriatric groups. I highly recommend them for both beginning and seasoned therapists.

#### Comments by: Alan L. Fink, M.A., L.P.C.

The tape, "Cognitive Behavioral Therapy for Adults" gives us the opportunity to sit at home or in the office and listen to one of the leaders in the field of cognitive therapy. Moreover, it is both informative and entertaining. Meichenbaum uses humor and anecdotes, including personal ones, and therefore his points are a pleasure to listen to and learn from.

This tape primarily addresses the application of cognitive-behavioral techniques and principles in dealing with anxiety disorders and depression in adults. The quality of the recording is medium grade. The content is extremely sensible and contains information which every therapist in practice today should know. Interesting statistics and information about brief-intervention strategies are addressed throughout.

Meichenbaum stresses the importance of data and validity not only for measurement of effectiveness during therapy but also in consideration of the changing climate in this day and age of managed care.

Case histories are presented which contain examples of interventions used for both individuals and couples. Couples work is stressed because relationship is so central in people's lives. Components of cognitive therapy are described and analyzed in each case.

There is a relevant question and answer period. At the conclusion of the tape is a recording of a client describing the effectiveness of treatment. The woman had been raped as a child and was mute for two years.

"Cognitive Behavioral Therapy for Adults" is great for the practitioner, student, or anyone desiring a choice learning experience.

#### Interview continued

and Hypnosis. She has years of experience as a teacher and trainer and is a valued contributor to the Newsletter.

**Jane Parsons-Fein (JPF):** Who have been the most influential people in your life and what have you learned from them?

**Dabney Ewin (DE):** My father. He was known for his integrity as a construction engineer and people who knew him preferred a cost-plus contract to a bid. He taught me that if I ever had to choose between someone liking me or respecting me, I should choose the latter.

I was a junior in medical school when my father had diverticulitis with peritonitis and had a colostomy. He then had a kidney shut-down and lived for a week. During that time I became close to his surgeon, Dr. Champ Lyons. After graduating I took my surgical training under him at the University of Alabama where he was chief of surgery. Dr. Lyons taught me to read history. His maxim was "We do not have to repeat the errors of the past to relearn the same lessons." At minimum, I was expected to be familiar with the latest review article on my patient's problem, and to know the classic study in its history.

During the depression, I lived with an aunt who knew I would study Latin in school so she taught me Greek. I helped her prepare to teach her Sunday School class. She gave me a Webster's dictionary. On the flyleaf she inscribed the following quote from the Sanskrit, Laws of Manu, "All meanings, ideas, intentions, desires, emotions, items of knowledge are embodied in speech, are rooted in it and branch out of it. He who misappropriates, misapplies and mismanages speech, mismanages everything." In trance, we cure by suggestion, so the dictionary is the pharmacopoeia of the hypnotist. In hypnosis I have many mentors, but I probably owe most to my fellow surgeon, David Cheek.

**JPF:** I have heard you say that if you can give a suggestion in a few words, do not use many.

**DE:** It's the experience of the masters. Erickson's embedded suggestions were short. Coué's, "Every day, in every way, I'm getting better and better" is only ten words. Short suggestions and slogans require no conscious thought or effort, so their effect is on the subconscious mind.

Probably the most galvanizing waking suggestion in history was after the Second Punic War, when Cato closed every address to the Roman senate with "Carthage must be destroyed." Archaeologists still aren't sure they've found where that great city was before the Romans destroyed it.

**JPF:** How do you differentiate hypnosis and trance from suggestion and suggestibility?

**DE:** I like Coué's definition of suggestion as the unconscious, uncritical, acceptance of an idea. In terms of modern English, suggestion is simply presenting an idea to another person whether they accept it or not, and we must distinguish the traditional from the ordinary use of the word. Clearly, one can uncritically accept a new idea in the waking state as well as in trance, so waking suggestion is common. I think trance has occurred when one dissociates from the logical, verbal, left brain way of thinking into the instinctive, sensual, day-dreaming type of thinking associated with the right brain. Thus trance can occur with or without suggestion. When logical, critical, left brain type of thinking is diminished, one is obviously more prone to unconscious, uncritical, acceptance of a new idea (suggestion). I believe that hypnosis has occurred when trance and suggestion coexist. I look upon suggestibility as a measure of the capacity of the person to unconsciously, uncritically, accept ideas in either the waking or trance state.

**JPF:** I understand that you journeyed to Nancy (France) to study Emile Coué.

**DE:** All our "Laws" of hypnosis were enunciated by Coué. I think he has been disregarded in hypnotic history because he was a lay hypnotist (pharmacist). He learned the art from Liébeault and Bernheim at Nancy. He was the father of self-hypnosis. He said "all suggestion is self-suggestion," not the misquoted "all hypnosis is self-hypnosis." He maintained that he'd never cured anyone, only taught them a method to cure themselves. Baudoin's book about Coué reveals what an insightful thinker he was, how honest and humble and caring. He had a remarkable understanding of what he was observing in the people who came to him.

**JPF:** In what ways is your work similar to the work of Milton Erickson?

**DE:** I don't think I'm imaginative enough to invent an individual cure for each patient as he did, but by lis-

Continued on next page



## Interview *continued*

tening carefully to what the patient says I'm very much involved in his utilization technique. My therapy usually is short-term, and I tend to use hypnosis in a cathartic way more than Erickson did.

Also Br'er Rabbit stories are cultural in the South, so I use the quote, "Everybody's got a laughing place." If I meet resistance, I can ask the patient to just make a smile and scan back to, "some time when something made you genuinely feel like making this smile, and give me an ideomotor signal when you find it." This is a mini age regression. It's pleasant, and sometimes there is no scene, only an affect. However the statement, "Just go to your laughing place," will rapidly produce a dissociative trance in a burn patient.

When I find that a patient is praying to a higher power, I want to be part of that team. I ask the patient to include me in his/her prayer, and specifically to ask the Almighty to give me the wisdom, determination, and understanding to be part of His plan for effecting a cure. The implanted suggestion, of course, is that there will be a cure. In return, I promise to pray for him or her. I believe my own religious faith makes it possible for me to say that with sincerity, because I do pray for them. A certain intimacy derives from this discourse, as though we have a special understanding to which others are not privy.

**JPF:** *In what specific way do you use hypnosis in your practice?*

**DE:** I do occupational medicine and surgery and my office is a mini emergency room. Acute trauma patients tend to be highly focused and quite suggestible. For such patients it has become part of my bedside manner to suggest positive outcomes using direct and indirect, permissive, and embedded comments, without formal induction ritual.

In any trauma situation, the patient is totally mobilizing for a "fight or flight." Once this patient is in the emergency room, I do not want him to either fight or flee from me. The patient has already done what he needed to do — flee to the emergency room. I want to turn that system off as soon as possible, because it consumes an enormous amount of energy that is better directed toward healing. Trauma patients normally go through shock and countershock over several days, and early reassuring hypnosis speeds the process of getting over shock.

At my pre-op visit I ask "How do you feel about this operation?" If the answer is "Okay, I guess," the volunteered conditional phrase "I guess" alerts me to induce a trance and do ideomotor investigation of what reservations were blocked at a verbal level. I want a patient to go to surgery confident and unafraid, not swimming in adrenaline. Once that preparation is complete, I do a progression to six weeks post-op so the patient may visualize herself healed, recovered, and back to normal activity. Post-op, the patients usually are remarkably comfortable.

If a patient experiences chronic, unexpected post-op pain, I help him regress through the procedure to explore for sounds heard while unconscious and under anesthesia. The law of Pessimistic (or Negative) Interpretation, enunciated many years ago by David Cheek, M.D., says that if a statement can be interpreted optimistically or pessimistically, a frightened person will interpret it pessimistically. Just imagine yourself, having surgery under local anesthesia, and hearing your surgeon say "Uh oh!" He may have simply dropped a hemostat, but you are most likely to fear that he has cut something unintentionally. Trance is beneficial in dispelling these types of fears.

A dislocated shoulder can be easily reduced by suggesting dissociation of the arm and muscle relaxation coupled with pain control. Chronic pain usually can be at least 50 percent ameliorated. I remain confident that the patient can do it [pain control] when necessary, but only to meet his own needs. It takes extra effort when it's for the ego of the hypnotist.

With warts, I suggest three choices: make it warm; make it cold; or make it tingle. Regardless of the choice, if the patient can fantasize a sensory change in the skin, most wart infections will clear. However, some warts fall into the psychosomatic category. For patients with psychosomatic disorders, I tend to use analytic techniques with a lot of ideomotor signaling, and age regression with reframing.

**JPF:** *How do you treat Constant Pain Syndrome with hypnosis?*

**DE:** To make that diagnosis, the patient's history includes an event in which he/she simultaneously experienced Ewin's triad of (a) mental disorientation, (b) fear of death, and (c) pain. Because the conscious mind is disoriented, the pain may be the only way the subconscious mind knows that death has not occurred, and the

pain gets invested with the primary characteristic of life itself — constancy. The therapist who approaches this patient with the avowed intent of eradication of the pain (i.e., life) is doomed to failure. I treat this by regression through the incident and reframing in hypnosis that "even though it seemed that you could die, the fact is that you now have all of your usual ways of knowing you're alive (got up, dressed, came to my office, etc.). Do you still need the pain to prove you are alive? It may require several regressions to get an ideomotor "No" to that question, after which I ask if it would be all right to be psychologically free of pain for one minute. With a "Yes," I suggest deepening of trance until freedom from pain is signalled, and count time for one minute before alerting. That night these patients routinely have an exacerbation of the pain, and I always see them the following day. I speculate that in dream sleep, the subconscious mind needs extra reassurance that death did not occur during the one minute interval of being pain free, and reacts with increased pain. They often express anger at feeling worse, to which I respond, "Isn't it wonderful that you have control of your pain! You can take it to zero, and can [also] make it worse than it was. Would you like, right now, to take it back to where it's been for several years?" It is very easy at this point to do a rapid induction and get an ideomotor signal that the pain has returned to its previous intensity. I then ask if it would be all right to cut that in half, repeating again the concept of self-control of the pain. Then I give Bertha Rodger's, M.D., post-hypnotic suggestion, "You will have all the comfort you need." I never make it an issue that all the pain will go, because some of these patients have other issues that cannot be resolved so simply. Self-preservation is the first law of nature, and it is up to the therapist to treat the person's fears with patience and respect.

**JPF:** *You have said that the severely burned patient needs psychiatric help from the time of injury to full recovery and that hypnosis is the psychiatric treatment of choice. Would you explain?*

**DE:** Our culture conditions people to dread burning. We have the history of Joan of Arc burning at the stake, stories of torture, Hell fire and damnation. The initial pain of a severe burn lives up to the horrible expectation. Unfortunately burn centers in general

are tertiary care centers, and rarely see the patient within the golden first two hours when hypnosis is most useful. However, the early use of hypnosis and reassurance not only produces pain control and physiological limitation of the "normal" progression (worsening) of the burn, but also a salubrious attitudinal response that enhances tolerance for the long course of treatment. This carries through tubing, dressing changes, immobilization for skin grafts, physical therapy, rehabilitation, and work on body image.

When I started using hypnosis with burn victims, I was convinced at first that the burns simply were not as severe as I had initially diagnosed, but shortly thereafter, I treated a patient whose leg had slipped into molten metal at an aluminum plant. Using hypnosis I had him "cool and comfortable" a half hour after his burn, and when he got out of the hospital in 18 days, without a skin graft and without narcotics, I became a true believer.

**JPF:** *You have presented evidence that negative attitudes can enhance and maintain inflammation, interfering with healing.*

**DE:** An inflamed area is hot, painful, red, and swollen. The best demonstration that this originates in the brain is on the BBC tape where Dr. Leon Chertok produces a blister on a hypnotized patient by suggesting that he is placing a hot coin on her forearm. There is no true heat stimulus, only a thought. By the same token, when there is a heat stimulus from a burn, early hallucination that the area is "cool and comfortable" prevents the mind from further aggravating the problem with an inflammatory response. Anyone who has had a sunburn knows that when you leave the sun you are not in as bad a trouble as ten hours later when the central nervous system has initiated an inflammatory response.

**JPF:** *You are well known for your work with hypnosis as an anaesthetist. Can you tell us about this work?*

**DE:** I should not have such a reputation because I have rarely used hypnosis as the sole anesthetic in the hospital setting, and then only when chemical anesthesia was inappropriate. I regularly use it as an adjunct to anaesthesia.

**JPF:** *How do you see the mind-body connection?*

**DE:** The only way to separate the

*Continued on next page*



## Interview *continued*

mind from the body is with a guillotine.

**JPF:** Tell us about ideomotor signaling.

**DE:** It's just a form of body language, but much easier to elicit in trance than a nod of the head. I find it very useful. David Cheek credits Leslie LeCron as the originator, but Erickson used it, also. I was greatly flattered when David asked me to write the foreword to his new book on ideomotor signaling. Cheek is to ideomotor signaling as Erickson is to indirect suggestion.

**JPF:** How do you think professionals can work to resolve the controversy surrounding retrieved memories?

**DE:** Most research is done to resolve controversy, so I feel sure that many researchers are busy devising experiments that they hope will enlighten us. I think the worst flaw in memory research is failure to distinguish between implicit and explicit memory, and reporting on one as though it were the other. How much of an early memory is absolute fact versus con-fabulation is worthy of serious study by those who make that their priority. I can only set priorities for myself. As a clinician, my priority is to improve my patient and do no harm, *primum non nocere*.

**JPF:** Please comment on the differences between clinical hypnosis and experimental hypnosis.

**DE:** Trauma (fear and pain) induces an animalistic sympathetic fight or flight trance quite different from the parasympathetic, calming trance we seek to induce with visualizations of

safe places. The information obtained in these two types of trance appear to be encoded differently in memory. Unfortunately, ethics prevents study of the sympathetic trance in the laboratory, and I think this accounts for much of the controversy about memory between the clinicians and experimentalists.

I like Ainslie Meares' Apologia for his book *The Management of the Anxious Patient* (1963). He says, "Some of my colleagues have been critical because I have presented material for which I have no scientific proof. I believe very firmly that it is the privilege of the clinician, perhaps even his duty, to express any ideas that appear to him to explain phenomena within the field of his clinical experience. It is then for those who work in the scientific branches of medicine to examine such ideas and subject them to a degree of critical scrutiny beyond the capacity of the clinician." In this manner these two disciplines can support and enhance each other's work.

**JPF:** What life experiences impacted you as turning points?

**DE:** The first clear turning point was the decision to study medicine. Now I start each day feeling like Christopher Columbus, knowing that I'll discover something new before the day is done.

Divorce impelled me into analysis and led me to pay more attention to my second marriage. During my analysis I discovered real empathy, both with myself and others, and realized that analyzing feelings was the key to my own psychosomatic symptom of paroxysmal atrial tachycardia. My heart rate would go to 260

per minute and I was rated on my life insurance. Twenty-eight years after my analysis it has never recurred. Self-analysis has been an ongoing thing. I never leave a remembered dream without attempting to interpret it. Ideomotor signals are very helpful in answering questions about a dream.

**JPF:** Please tell us about your personal use of self-hypnosis.

**DE:** After my by-pass I got Dean Ornish, M.D.'s book on reversing arteriosclerosis, *Reversing Heart Disease* (Ballentine Books, Random House, New York, 1990). I opted for self-hypnosis. I made myself a 15-minute tape with some children's music in the background, a progressive relaxation induction, Ainslie Meares' affirmations spaced 20 seconds apart followed by the recommended 20 repetitions of Coué's "Every day in every way I'm getting better and better," followed by an alerting suggestion for the morning or a sleep suggestion at night. I play it at night as I'm falling asleep and set my clock 15 minutes early to play it as the last 15 minutes of my sleep cycle in the morning. Coué noted that our bad ideas come without effort, and our good ones should come the same way. This is effortless. I don't know if it will have the same effect as Yoga, but it helps me with the slings and arrows of daily life. Heart attacks are more common in the morning than any other time of day, so I believe the morning session is the most beneficial. My prayers are separate. The only connection this has with my faith is that God helps those who help themselves. Defining the unconscious

would fill a book and still be vague.  
**JPF:** Once you talked about Helen Keller and something she said to you.

**DE:** I had the opportunity to meet her while in the Navy. I brought my copy of her autobiography and asked her to autograph it. She printed on the fly leaf, "For Dabney Ewin, who will find that obstacles are things to be overcome if we are to live strong and unafraid." I have it framed in front of my desk for ready reference when I catch myself thinking that life is tough.

**JPF:** How would you like to be remembered?

**DE:** For those who knew me to feel that they can see farther because they're standing on my shoulders.

## Donations

The Milton H. Erickson Foundation has received a total of \$460.94 in donations since the last issue of the Newsletter.

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