The Milton H. Erickson Foundation NEWSLETTER

Michael D. Yapko, Editor / P.O. Box 4268 / Leucadia, California 92024

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The Milton H. Erickson Foundation, Inc.
3606 North 24th Street
Phoenix, Arizona 85016
U.S.A.
Telephone: (602) 956-6196

Statistics 'Prove' Success of Evolution Conference

What many people hailed "the best conference they ever attended," the Evolution of Psychotherapy Conference has measured up statistically as well.

The Dec. 12-16, 1990, meeting in Anaheim, Calif., was organized by The Milton H. Erickson Foundation. Statistics were compiled by the Foundation staff and have given the organization positive feedback to be used in future planning.

Of a possible five, the meeting ranked 4.49 overall in interest of topics.

The format of the conference, practical value of the topics and the extent to which expectations were fulfilled all scored higher than 4.0 (4.10, 4.20 and 4.20, respectively).

Attendees gave high marks to the Erickson Foundation staff with a rating of 4.37 for registration procedures. The conference headquarters hotel, The Anaheim Hilton and Towers, also saw a positive ranking with a 4.16. An Evening at Disneyland Park proved popular with a 4.36.

The mean ratings for the programs are as follows: workshops, 4.39; conversation hours, 4.34; panels, 4.18; keynote addresses, 4.15; clinical presentations, 4.11; dialogues, 4.01; and supervision panels, 3.86.

Workshops were three-hour events conducted by the faculty. Conversation hours gave attendees an opportunity to hear speakers discuss his or her type of therapy. Panels were presentations featuring faculty members together on a forum to discuss a specific topic (i.e., Family Therapy, Ethics, Humor, etc.). Keynote addresses, a new feature of the 1990 conference, brought attendees together for plenary sessions on two separate occasions: Viktor Frankl's address was "From Concentration Camp to Existentialism," Thursday, Dec. 13. Betty Friedan's address "The Challenge of Evolving Women, Men and Families," was held Friday night, Dec. 14.

Clinical presentations were given by various faculty members and gave attendees an opportunity to watch their teachers demonstrate their therapy methods.

Dialogues featured faculty members discussing a variety of topics. Supervision panels enabled the faculty to discuss specific cases and give advice to attendees.

"We use these statistics in a number of ways," said Jeffrey K. Zeig, Ph.D., Director of the Foundation. "The results help us see strengths and weaknesses in the program design. We also use the information for continuing education purposes. The compilation of these statistics is part of the ongoing process to offer the highest quality educational events in the field of psychotherapy."

Needs Assessment Survey Results

A second set of statistics also was compiled after the Evolution of Psychotherapy Conference. A "Needs Assessment Survey" was distributed to all attendees. The questionnaire will help determine whether or not to hold another Evolution Conference, and if so, who would participate, when and where would the event be held and what format would be used.

Respondents indicated they have a high degree of interest in seeing a third Evolution of Psychotherapy Conference. Of 13 cities from which to choose, Anaheim, Calif. ranked highest as a possible location for the third meeting, followed by Phoenix, Ariz., and Las Vegas, Nev.

"Since the 1990 meeting was held in a California city, we think the results indicate a West Coast venue," Zeig said. "However, this survey was taken from Evolution attendees who were roughly from the West Coast. We will also survey a national sample to be sure we have an accurate reading."

Respondents said they prefer to have the

Continued next page

Advertising Criteria Outlined

Advertisements for *The Milton H. Erickson Foundation Newsletter* must contain information conforming to Foundation educational requirements.

Workshop ads must contain the following information:

- The name, address and telephone number of workshop sponsor.
- Degrees of presenters.
- Eligibility statement (i.e., participants must have a minimum of a master's degree in a mental health field from an accredited institution or be a full-time graduate student in an accredited mental health program.

If registration forms are part of an ad, information required by meeting sponsor must include degree, major and university from where degree was earned.

All ads placed in *The Erickson Foundation Newsletter* are subject to review and acceptance.

Interview

An Interview with Aaron T. Beck, M.D.

at

The Evolution of Psychotherapy Conference, Anaheim, California

By Michael D. Yapko, Ph.D.

Aaron Temkin "Tim" Beck, M.D., is widely hailed as the father of Cognitive Therapy. He is University Professor of Psychiatry at the University of Pennsylvania, and is the recipient of numerous awards of honor for his pioneering work in the psychotherapy of depression, anxiety, and more recently, personality disorders. He has been named the winner of the Distinguished Scientific Award for the Application of Psychology by the American Psychological Association — an unusual award for someone who is not a psychologist. His books on cognitive therapy become classics almost as soon as they are published, and anyone interested in therapy techniques likely will be greatly influenced by his work.

This interview is different from others previously published in the *Newsletter.* Michael Yapko has authored several books on Ericksonian approaches to the treatment of depression, and this meeting represented a good opportunity for Beck and Yapko to exchange ideas and perspectives. Thus, what follows is more a dialogue than a conventional interview. The meeting took place in Anaheim December 1990, on the occasion of the Evolution of Psychotherapy Conference.

B — I don't know if it will work into your idea (of an interview), but I am really very curious about the similarities between my approach and the Ericksonian approach.

Y — At points where we can exchange ideas, that would be wonderful. If you would, please, start with some brief biographical information.

B — I'm a product of New England. As a matter of fact, I did all my schooling in New England right up through World War II. I was graduated from Brown University, went to Yale Medical School and did my internship at Rhode Island Hospital. I was never really set on the career of psychiatry. I got into psychiatry quite by accident. I was doing a rotating internship and wanted to get a residency in neurology; I had something lined up

Continued on page 8

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ADDRESS CORRECTION REQUESTED

Michael Yapko

From The Editor

In this issue of *The Newsletter*, my interview features Aaron T. Beck, M.D. As you may know, I have more than a casual interest in the topic of clinical depression, and who better to talk to about it than Tim Beck? What emerged in our dialogue comparing and contrasting Ericksonian approaches with Cognitive Therapy Methods was a powerful awareness of how vital the assumptions one makes are in determining what happens in treatment.

Milton Erickson once said that". . . if you look over the lives of happy, well adjusted people, they haven't analyzed their relationship with their parents — and they're not going to!" I appreciate the emphasis of both Erickson and Beck on the positive resources of people that can surface when the right context is created collaboratively by the therapist and the client. I also appreciate their mutal emphasis on actively promoting change and their minimal preoccupation with the client's negative history. These are especially relevant factors in formulating effective interventions in treating depressed clients. I look forward to the continued growth of the body of literature supporting the notion that good therapy can be done briefly, deliberately and reliably. I also look forward to future opportunities to establish further links between Ericksonian approaches and other result-oriented methods.

Statistics *continued*

meeting every five years and indicated that the second week of December would be their first choice for meeting dates; however, all three dates seem satisfactory. The other choices are the third week in June and the first week in December.

The survey also polled respondents about the exact composition of the faculty.

"We poll a variety of professionals and graduate students to determine the format of the meeting and who will serve on the faculty," he said. "The results of this needs assessment survey are the beginning of a lengthy process."

Notes from the Foundation

Foundation Gets Fax

The Milton H. Erickson Foundation recently installed a facsimile line. The line is open 24 hours a day. The new number is (602) 956-0519.

# # #

Foundation Undergoes Renovation

The Foundation also has undergone renovation. The administrative offices (3606 and 3610 N. 24th Street, Phoenix, Arizona) have been newly carpeted and painted. While there were times when daily operations were disrupted, the staff was able to perform activities fairly normally.

Visitors are invited to stop by the offices this summer to see the new look.

# # #

Lankton Named Diplomate

Stephen R. Lankton, M.S.W., recently passed the exam for Diplomate in Clinical Hypnosis from the American Board for Clinical Social Work at the last meeting in October.

Lankton, founding editor of *The Ericksonian Monographs*, was honored at the Evolution of Psychotherapy Conference as the recipient of a bola tie belonging to the late Dr. Erickson. The presentation was made by Dr. Erickson's widow, Elizabeth, and his daughter, Kristina K. Erickson, M.S., M.D.

It's a Boy!

Lynn D. and Carol Sue Johnson of Salt Lake City, Utah, announce the birth of their son, Stephen Michael Johnson, on November 11, 1990. The birth went very quickly and very well, and mother and son are fine. Stephen Michael weighed eight pounds at birth and is gaining rapidly. (He should pass his father soon.) Lynn is the eminently capable Utah psychologist who regularly contributes book and videotape reviews to the Foundation's Newsletter. Our heartiest congratulations to Lynn, Carol and Stephen!

Zeig to Teach in U.S.S.R.

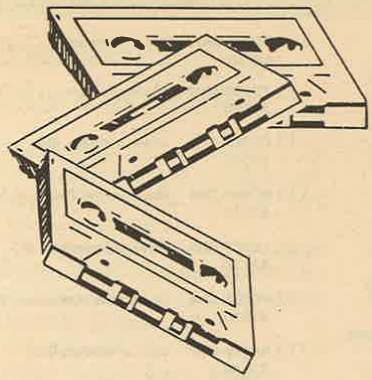
Jeffrey K. Zeig, Ph.D., will teach in Leningrad in the Soviet Union May 24-25, 1991, and in Moscow May 28-29, 1991.

He will conduct programs on Ericksonian psychotherapy. The programs are being organized by the Mainor Neva Project in Leningrad and the Association of Practical Psychologists in Moscow. For additional information on the program in Leningrad, contact Sergei Lebedev, Director, Mainor Neva Project, 4 Serpuchovskaya, Leningrad 198013, USSR, fax number (812) 315-1701.

For information about the program in Moscow, contact Julia Aloyshina, Department of Social Psychology MSU, Association of Practical Psychologists, Marx Avenue, 18, Building 5, 103009 Moscow, USSR.

Newsletter Business

The *Newsletter* is published three times per year. The closing dates are April 15, August 15, and December 15. This means all items to be included must be received by those dates. The *Newsletter* is posted approximately six to eight weeks later. As always, send all advertising directly to the Foundation in Phoenix. Training events, announcements and other information should be sent directly to me at the Leucadia, Calif. address on the front page.



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Conference Announcements

The International Conference on the Use of Stories and Metaphors as Tools in Communication will be held July 16-19, 1992, in Budapest, Hungary.

The Conference is being organized by the Hungarian Psychiatric Association. Plenary sessions, workshops, seminars and a poster section will be featured.

For additional information, write The Congress Bureau Motesz, Budapest, P.O. Box 32, H-1361, Hungary.

# # #

The first Scandinavian Conference on "Alternative States of Consciousness" will be held June 23-27, 1991. The Conference will be held in conjunction with the first World Congress on Mental Training at Orebro, Sweden.

For registration information, contact Pernilla Akesson, Scandinavian International University, P.O. Box 3085, S - 700 03, Orebro, Sweden; telephone, +46(0)19-33 22 33; fax, +46(0)19-33 22 35.

# # #

The Workshops and Scientific Programs of the First International Congress on Integrative and Eclectic Psychotherapy will be held in Mazatlan, Mexico, June 18-21, 1992.

The Congress is sponsored by the International Academy of Eclectic Psychotherapists and cosponsored by The World Psychiatric Association (Psychotherapeutic Section).

For further information, please write First International Congress, Administrative Office, Apartado Postal 51-042, 45080 Guadalajara, Jalisco, MEXICO.

12th Congress, Satellite Meeting Rescheduled

The International Society of Hypnosis has postponed the 12th International Congress of Hypnosis and Psychosomatic Medicine. The Ericksonian Joint Conference also has been rescheduled. The programs have been rescheduled to be held in Jerusalem, Israel. Tentative dates for the 12th International Congress of Hypnosis are July 19-21, 1992, (workshops), July 22-24, 1991, (scientific program), and July 26-31, 1992 (Satellite — now called the Joint Conference).

For information about the 12th Congress, contact Moris Kleinhauz, M.D., 12th International Congress of Hypnosis, P.O. Box 50006, Tel-Aviv 61500, Israel.

For information about the Joint Conference, contact Burkhard Peter, Dipl. Psych., c/o M.E.G., Konradstr. 16, 8000 Munich 40, Germany.

Upcoming Training

(Note: The Erickson Foundation lists workshops as a service to its *Newsletter* readers. We cannot attest to the quality of training provided in these workshops.) A $10 fee is required for each workshop submission.

DATE 1991	TITLE/LOCATION/LEADER	CONTACT
5/24-25	Ericksonian Psychotherapy, Leningrad, USSR, Jeffrey K. Zeig	1
5/28-29	Ericksonian Psychotherapy; Moscow, USSR, Zeig	2
5/31-6/2	Ericksonian Psychotherapy (Advanced); Bern, SWITZERLAND, Zeig	3
6/4-9	Ericksonian Psychotherapy, Rottweil, GERMANY, Zeig, Bernhard Trenkle, Gunther Schmidt	4
6/7-9	Clinical Hypnosis; Anaheim, CA, David Cheek, Donald Schafer, Andre Weitzenhoffer	5
6/17-22	Phoenix Intensive Training (Basic), Phoenix, Ariz., Zeig, Brent Geary, Other Faculty	6
6/19-23	Residential Training in Clinical Hypnosis; Los Gatos, Calif., Deborah Ross	7
6/20-22	Trancework, Seattle, Wash., Michael Yapko	8
6/23-27	First World Congress on Mental Training, Orebro, SWEDEN, Faculty	9
6/24-29	Phoenix Intensive Training (Intermediate/Advanced), Geary, Yvonne Dolan	6
6/24-8/30	Cape Cod Summer Symposium, Cape Cod, Maine, Faculty	10
6/24-8/30	Cape Cod Institute, Cape Cod, Maine, Faculty	11
6/28-30	Ericksonian Psychotherapy (Intermediate/Advanced), Santa Clara, Calif., Zeig	12
7/12-14	Second Eastern Conference On Ericksonian Hypnosis and Psychotherapy: Co-Creative Contexts for Change; Philadelphia, Penn., Faculty	13
7/15-19	Cape Cod Institute, Cape Cod, Maine, Zeig	14
7/17-21	Psychotherapy as Empowerment, San Diego, Calif., Stephen G. Gilligan	15
7/26-28	Ericksonian Psychotherapy, Guadalajara, MEXICO, Zeig	16
7/24-28	Supervision, San Diego, Calif., Gilligan	15
7/24-8/30	Jersey Shore Summer Seminars, Absecon, N.J., Faculty	17
8/8-11	Advanced Supervision Training in Clinical Hypnosis, Los Gatos, Calif., Ross	7
8/12-16	Brief Strategic Therapy, MRI International Summer Symposium, Palo Alto, Calif., Faculty	18
9/2-4	Ericksonian Psychotherapy, Berlin, GERMANY, Zeig	19
9/3-6	Ericksonian Methods, Lodz, POLAND, Geary	20
9/6-8	Ericksonian Psychotherapy, Stockholm, SWEDEN, Zeig	21
9/7-8	Brief Therapy of Depression, Geneva, SWITZERLAND, Yapko	22
9/10-13	Ericksonian Psychotherapy, Rome, ITALY, Invited Faculty	23
9/11-15	Residential Training in Clinical Hypnosis, Los Gatos, Calif., Ross	7
9/13-15	Brief Therapy of Depression, Koln, GERMANY, Yapko	24
9/18-22	Trancework, Cedar Rapids, Iowa, Yapko	25
9/20-22	Guided Imagery for Clinicians, San Francisco, Calif., Martin Rossman, David Bresler	26
9/25-29	Hypnotherapy: An Ericksonian Approach, Pensacola Beach, Fla., Stephen Lankton, Carol Lankton	27
9/30-10/5	Phoenix Intensive Training (Basic), Phoenix, Ariz., Invited Faculty	6
9/30-10/2	Hypnotherapy: An Ericksonian Approach, Pensacola Beach, Fla., S. Lankton, C. Lankton	27
10/2-6	Trancework, San Diego, Calif., Yapko	28
10/4-5	Ericksonian Psychotherapy, Park City, Utah, Zeig	29
10/4-6	Guided Imagery for Clinicians, Portland, Ore., Rossman, Bresler	26
10/7-12	Phoenix Intensive Training (Intermediate/Advanced), Phoenix, Ariz., Invited Faculty	6
10/17	Ericksonian Psychotherapy, Little Rock, Ark., Zeig	30
10/17-20	Advanced Supervision Training in Clinical Hypnosis, Los Gatos, Calif., Ross	7
10/19-20	Ericksonian Psychotherapy, Mexico City, MEXICO, Zeig	31
10/31-11/13	American Association of Marriage Family Therapists Annual Meeting, Dallas, Tex., Faculty	32

Contact Information

1. USSR/CCCP, Leningrad 198013, 4 Serpuchovskaya, Mainor-Neva Ent., Sergei Lebedev, Dir.
2. Julia Aloyshina, Vice President of the Association of Practical Psychologists, Moscow 121355, Partizansky 25 - 56, U.S.S.R.
3. Susy Signer-Fischer, Lic. Psych., Weissenbuhlweg 29, 3007 Bern, SWITZERLAND.
4. Bernhard Trenkle, Dipl. Psych., Milton H. Erickson Institut Heidelberg/Rottweil, Bahnhofstrasse 4, 7210 Rottweil, GERMANY.
5. Richard Landis, Ph.D., OCSEPH. 2101 East 4th Street, Suite 111A, Santa Ana, CA 92705; (714) 547-8120. The Milton H. Erickson Foundation, 3606 N. 24th St., Phoenix, AZ 85016; (602) 956-6196; Fax (602) 956-0519.
7. Deborah Ross, Ph.D., Los Gatos Institute, 19845 Skyline Blvd., Los Gatos, CA 95030; (408) 354-7738.
8. Family Psychotherapy Practice, 2722 Eastlake Avenue East, Suite 300, Seattle, WA 98102; (206) 329-9101.
9. Pernilla Akesson, Scandinavian International University. P.O. Box 3085, S-700 03, Orebro, SWEDEN 46(0)19-33-22-33.
10. New England Educational Institute, 92 Elm Street, Suite F2, Pittsfield, MA 01201; (413) 499-1489.
11. M. Peters, Ph.D., Cape Cod Institute, 1330 ECHS, Bronx, NY 10461; (212) 430-2307.
12. Colleen O'Driscoll, University of California - Santa Cruz, 740 Front St., Suite 155, Santa Cruz, CA; (408) 427-6610.
13. Robert Schwarz, P.O Box 166, Ardmore, PA 19003; (215) 790-1414.
14. Gilbert Levin, Ph.D., Albert Einstein College of Medicine - Dept. of Psychiatry, 1303 Belfer, Bronx, NY 10461.
15. Omega Institute, 1504 Crest Drive, Encinitas, CA 92024.
16. Centro Mexicano de Programacion Neurolinguistica, Progreso 271, S.J., Guadalajara, Jalisco, MEXICO.
17. Mid-Atlantic Educational Institute, 309 North Franklin St., West Chester, PA 19380; (215) 692-6886.
18. MRI Symposium, 555 Middlefield Road, Palo Alto, CA 94301; (415) 321-3055.
19. Wolfgang Lenk, Ph.D., Milton H. Erickson Institut, Berlin, Wartburgstr. 17, 1000 Berlin 62, GERMANY.
20. Krzysztof Klajs, Felsztynskiego 23, 93-558 Lodz, POLAND.
21. Kjell Waara, M.Sc., Centrum for Hypnos & Psykotherapi, Sveavagen 76 nb og, S-113 59 Stockholm, SWEDEN.
22. Patrick Noyer, 73a Avenue Leopold-Robert, 2300 La Chaux-de-Fonds, SWITZERLAND. (039)23-08-18.
23. Camillo Loriedo, M.D., Centro di Studi e di Richerche per la Psicoterapia, Viale Regina Margherita, 37, 00198 Rome, ITALY.
24. Milton Erickson Institut e.V., Nassestr. 32, 5000 Koln, GERMANY.
25. Families, Inc., P.O. Box 130, West Branch, IA 52358; (319) 643-2532.
26. Academy for Guided Imagery, P.O. Box 2070, Mill Valley, CA 94942; 1-800-726-2070.
27. Carol H. Lankton, P.O. Box 958, Gulf Breeze, FL 32562.
28. Milton Erickson Institute of San Diego, 2525 Camino del Rio South, Suite 265, San Diego, CA 92108; (619) 295-1010.
29. Gary Totland, Director of Marketing, Benchmark Regional Hospital, 592 West 1350 South, Woods Cross, UT 84087-1665.
30. Arkansas Clinical Society of Hypnosis, HC73, Box 68, Jerusalem, AR 72080.
31. Teresa Robles Uribe, Ph.D., Instituto Milton H. Erickson de la Ciudad de Mexico, A.C., Nicolas San Juan 834, 20 Piso, Col. del Valle, Mexico D.F. 03200 MEXICO.
32. AAMFT, 1100 Seventeenth Street, the 10th Floor, Washington, D.C. 20036; (202) 452-0109.

Full regard must be given to the human need to succeed and to the desire for recognition by the self and others of that success. [1952]

(In Erickson, 1980, Vol. I chap. 6, p. 51)

Stephen R. Lankton

The Monographs

Ericksonian Monograph Number 8 and a New Brochure are Published

by Stephen R. Lankton, M.S.W., AHB-CSW

The Ericksonian Monographs just released volume number 8, "Views on Ericksonian Brief Therapy, Process and Action." This issue was co-edited by Stephen Lankton, Stephen Gilligan and Jeffrey Zeig, and reflects the theme of The Fourth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, "Brief Therapy: Myths, Methods and Metaphors."

There are eight articles contained in the issue, each outstanding for its contribution.

One chapter was authored by two of Dr. Erickson's daughters, Betty Alice Erickson-Elliott, and Roxanna Erickson Klein. Their opinions have been shaped by academic training as well as by their work with their father. They witnessed his changing approach and experienced the results of that change as they were among those with whom he practiced and demonstrated his evolving work. These two writers had to be subjective while stepping back to be as unbiased as possible.

The articles in *Monograph* Number 8 include, "Well Begun is Half Done: Techniques of Evaluation and Modification of Client's Attitudes, Motivations and Expectations about Therapy," by Emanuele del Castello, Dipl. Psych. and Mariarosaria la Manna, Dipl. Psych.; "Strategies for a Japanese Child to Accept a Position as the Eldest Brother," by Keiichi Miyata, M.A.; "Crisis Intervention of Schizophrenic Patients" by Michael Vancura, Dipl. Psych.; "A Marriage of Ericksonian and Psychodynamic Therapy in the Treatment of Emotionally Disturbed Adolescents" by Janet Sasson Edgette, Psy.D., M.P.H.; "Myths in Action in Hypnosis" by Jean Godin, M.D., Ph.D.; "Oral Poetry: Towards an Integrative Framework for Erickson's Clinical Approaches" by Peter Brown, M.D., FRCP; "Ericksonian Hypnosis in the Treatment of Clients with Examination Panic," by Manfred Prior, Dipl. Psych.; and "Milton H. Erickson's Increasing Shift to Less Directive Hypnotic Techniques as Illustrated by Work with Family Members," by Betty Alice Erickson-Elliott, M.S., and Roxanna Erickson Klein, R.N., M.S.

New brochure

New and potential authors will be happy to learn that a brochure is now available for the *Monographs* which explains the goals and requirements for articles submitted for publication. This is an updated version of the "Advice to Authors" letter which now has taken a more attractive appearance and a shape that allows for mass distribution.

It is our hope that it will serve to increase the number of submitted articles and simplify the rewriting process by providing more conformity to the requirements from the first draft. The brochure is available by contacting the Milton H. Erickson Foundation, 3606 N. 24th Street, Phoenix, Ariz. 85016, phone (602) 956-6196, fax (602) 956-0519; or Stephen Lankton, P.O. Box 958, Gulf Breeze, Fla. 32562, phone (904) 932-6819, fax/modem (904) 932-3118.

Respectful awareness of the capacity of the patient's unconscious mind to perceive meaningfulness of the therapist's own unconscious behavior is a governing principle in psychotherapy. [1966]

(In Erickson, 1980, Vol. IV, chap. 28, p. 277)

Motivating Action Through Hypnosis

Stephen Lankton, 1988.
The Milton H. Erickson Foundation,
Phoenix, Arizona

Lankton demonstrates working with a woman who views herself as too self-effacing and who has been unable to become as assertive as she wants. She hints at a history of abuse, but when Steve pursues that, she declines to give details.

How do we motivate our clients to ACT? Steve offers many answers, beginning with the introductory remarks, in which he says the topic is broad enough that, "we can *grasp*" (said softly) "it." So we are to learn, presumably, to *softly embed* action words into our talk.

Steve is an acknowledged master of metaphor and indirection and this tape is rich in examples of those skills. He additionally emphasizes paradoxical restraint from change more here than I have seen him do in the past. He is quite tentative and gentle with the client, possibly pacing her style, and so his paradox is also tentative and gentle, but there nevertheless.

I especially appreciated his gentle humor in paradox. At one point he asks the client to look at the audience and try to feel badly, and when she reports she doesn't feel badly, he encourages her to feel badly about not being able to feel badly.

During the session he is able to elicit a resource state and then utilizes the audience to create a reciprocal inhibition of the self-effacing behavior. This is a pattern well worth studying, and one I have used quite successfully, mainly with anxiety disorders.

Steve's words are quite entrancing, but I will repeat an old theme of mine, namely that we don't know for sure whether the woman is in a classic trance (e.g., a state characterized by involuntary movements and experiences) or not. I would like to see the kind of classic hypnotic phenomena which Erickson seemed to always be able to elicit.

—Reviewed by Lynn Johnson, Ph.D.
Salt Lake City, Utah

Facilitating Creative Moments with Hypnosis

by Ernest Rossi, 1985.
The Milton H. Erickson Foundation,
Phoenix, Arizona

I don't know what dreams mean. I don't know what my client's dreams mean, and I don't know what my own mean. When I try to analyze them, I can create reasonable meanings, but it doesn't seem to do anything for my life to do that. I gave up analyzing my dreams because it didn't seem to do anything for me.

Rossi does know what they mean, and furthermore, he models here a wonderful way that clinicians can utilize dreams in clients without knowing about dreams. He asks people to volunteer for the demonstration if they have had a dream about the conference. He then does some charming and skillful hypnotic inductions with the volunteers, in which he asks them to create their own, sometimes effable, meaning, something which comes strictly from themselves.

Rossi does reasonably straightforward inductions, especially when the client doesn't follow minimal cues, so it is useful to watch him for the modeling that a student can do. His use of indirect suggestion is likewise something a beginning or intermediate student can profit from. The use of short hypnotic experiences is very useful. In my own work, I am much more likely to use several short trances in a one-hour sesion than one very long one; Rossi models an ideomotor-based approach to these short trances.

Rossi is delightful as playing a provocative, almost clown-like role to surprise and disorient clients. He seems to exaggerate his amazement, his breathing, and so on, and the clients go along with that. A student worried about appearing foolish can benefit from watching that aspect of his demonstration. Erickson himself often played a similar role, insisting on things one would think were ridiculous, but somehow getting his way after all. Rossi similarly insists people are in deep trance without any real evidence, and then the evidence (such as amnesia) shows up.

I can still kick a bit: Rossi suggests the "ah-ha" experience is central to psychotherapy, and I disagree with that. It is quite possible to have very good therapy results without any self-understandings, and given his close association with Erickson, I am surprised to hear him assert the central role of insight. But overall, this is a demonstration useful to a study group or teacher who wants to see several inductions and hypnotherapy demonstrations.

—Reviewed by Lynn Johnson, Ph.D.
Salt Lake City, Utah

In the course of living, from infancy on, you acquired knowledge, but you could not keep all that knowledge in the foreground of your mind. In the development of the human being learning in the unconscious became available in any time of need. When you need to feel comfort, you can feel comfort.

(Erickson, Rossi & Rossi, 1976, p. 155)

Interview *continued*

at the Massachusetts General Hospital. After my internship, it turned out that I'd have to wait for a year before that residency could start because of all the veterans coming back. As a result of that, I went to the Veterans Administration Hospital in Framingham, Mass., and started a residency in neurology there. I decided to stay there. At the end of the year, the chief of the department of neuropsychiatry found there was a shortage of psychiatric residents, so he made an ex-post-facto rule that neurology residents had to rotate through psychiatry. Much against my wishes, I did accede and started my residency and rotation into psychiatry. As I got into psychiatry, it really seemed very esoteric and strange. I found that psychiatry there was very much under the influence of the Boston Psychoanalytic Institute. Everything we would see in patients would be interpreted in terms of some deep, dark invisible forces. At first I thought it was very far-fetched, but when I talked to friends I really respected a great deal, they said, "You know the reason you can't really relate to this type of material is because you have your own resistances."

They would say, "At one time, we used to feel that way. Then, we got into analysis and we realized we were blocking out this kind of deep unconscious symbolism because of our own anxieties."

This intrigued me, and I thought, "There might be something to this after all." At the end of the first six months, I went on to an additional six months. At the end of that year, I was told that I had to go back to neurology. I thought, "Well, I've invested a whole year in this, and I still am not sure whether there really is anything in psychiatry." So, I fought to stay in the psychiatry residency. I stayed with psychiatry, and got very much involved with psychoanalytic approaches to psychopathology. I decided to do a fellowship at the Austin Riggs Center, a psychoanalytically-oriented sanitarium. The more I saw of psychoanalytic approaches, the more I was intrigued by them because they had unitary explanations for everything from incest taboos to war and peace. Consequently, after two years of fellowship training, I decided to go into psychoanalytic training. It just happened at the time the Korean War was going on, and I realized I would be called into service because of the doctors' draft. I had been on the reserves up to that time, so I volunteered for duty and was stationed at Valley Forge Army Hospital. After that, I hooked up with the Philadelphia Psychoanalytic Institute, went through my four years' training and was graduated in 1956. I embarked on an academic career at the University of Pennsylvania, where I did research, teaching, training and clinical practice.

Y — Let me back you up a little bit, Tim. You said when you started the residency you were not particularly impressed with the notion of the unconscious and the psychoanalytic view of things. You obviously were very pragmatic even then. Give me a bit of the developmental history of your emphasis on pragmatism.

B — I think my parents were both very practical people. My mother, whom I had the most contact with, had a lot of very good common sense. I think much of my approach to life is based on that — dealing with concrete details and building on them. I always felt I had to have an open mind, and when the various processes of psychoanalysis appeared to be counter-intuitive, I thought, "Well, it may be that this very pragmatism may be standing in the way of my seeing things that are not quite so obvious." So, I had to suspend disbelief, as it were, for a period of four or five years.

Y — Then, it re-emerged.

B — It re-emerged because I attempted to apply pragmatic approaches and rules to the data that a psychoanalyst would call the basic data of psychoanalytic research. It simply did not pan out. The psychoanalytic theses did not bear up under the harsh scrutiny of what you might call "academic analytic investigation."

Y — It was very important for you to have that kind of empirical approach?

B — Oh, it was, it really was. Otherwise, psychoanalysis could just be one other religion which has a tremendous spiritual impact and deals with the esoteric, but has no (empirical) basis in your world.

Y — Psychiatry is a broad field. Why your particular attraction to studying depression?

B — There were two practical reasons: One was that most of my patients were depressed, so it was an easy population to study. The second was that the psychoanalytic theories of depression had been so well spelled out and so concrete that they were eminently researchable, as opposed to any of the other psychodynamic formulations. Consequently, I was able to conceptualize the psychoanalytic formulations in a testable way.

Y — You say that most of your patients were depressed. Some of the recent epidemiological research shows that the rate of depression has increased dramatically. Why is there so much depression today?

B — Well, first of all, I don't trust the epidemiological studies. However, I don't see any great sociological reason for the prevalence of depression in society. I think if you look at any society throughout the world, depression will occupy

Continued on page 10

The general practitioner needs primarily to judge his patient's behavior in terms of what may reasonably be expected of that particular individual and in terms of what behavior is in keeping and harmony with the general established patterns of behavior of the specific person.

(Erickson, 1941a, p. 108)

Symptom Analysis: A Method of Brief Therapy

M. Gerald Edelstien, 1990.
W.W. Norton & Co., New York, $21.95.

Edelstien has produced an abreactive-insight model of brief treatment, using hypnotic interviews. This book explains the model and gives a variety of applications to a simple technique.

His theory is significant in that it is very simple and easy to apply. He says, "The patient experienced a traumatic incident (or a series of traumatic incidents) that caused some very painful feelings. In an effort to protect himself/herself from experiencing those painful feelings again, s/he adopted certain new behaviors, feelings, or attitudes. If those adaptive changes create problems, s/he is said to have symptoms."

Edelstien has a four-step treatment model which suggests the clinician (1) uncover the original trauma; (2) learn about the painful feelings; (3) understand how the symptoms protected the patient; and (4) help the patient understand the dangers no longer exist or there are better ways to protect oneself.

While Edelstien uses the notion of *insight* or understanding symptom dynamics, he allows that step four is really probably sufficient, and frames behavioral techniques as fitting into that step.

The book is fairly short (173 pages), easy to read, and has a sufficient number of helpful ideas and suggestions about treatment to make it worthwhile. In addition, Edelstien comes across as a sort of cranky fellow, especially when he launches an attack on psychoanalysis and Freudian theory. There is a kind of ironic humor in his attacks that makes the medicine go down much more easily. He also attacks Ericksonian approaches at times, albeit somewhat more gently, and his attacks on indirection make thought-provoking points.

I disagree with him on his readiness to use medication in depression and anxiety and therefore assume that there are syndromes which only respond to medication. The actual evidence is much less clear than he would have us believe.

I also disagree with him about the role of "insight" in which he feels the symptom disappears when the patient understands how it came about. I suggest the essential feature is closer to what we call "reframing." The patient now feels differently about the symptoms because they mean something different.

All told, an interesting and useful book.

—Reviewed by Lynn Johnson, Ph.D.
Salt Lake City, Utah

How many of us really appreciate the childishness of the unconscious mind? Because the unconscious mind is decidedly simple, unaffected, straightforward and honest. It hasn't got all of this facade, this veneer of what we call adult culture. It's rather simple, rather childish.

(ASCH, 1980, Taped Lecture, 2/2/66)

Media of Note

The April issue of the American Journal of Clinical Hypnosis featured a lengthy, favorable review of Michael D. Yapko's hypnosis text *Trancework: An Introduction to the Practice of Clinical Hypnosis*. Peter Bloom, M.D., University of Pennsylvania was the reviewer. Bloom also wrote a guest editorial about Ericksonian versus traditional hypnosis, offering his opinions about perceived strengths and weaknesses of those he terms "Ericksonians."

* * *

The May/June issue of the *Family Therapy Networker* is a special issue on clinical depression. *Newsletter* editor Michael Yapko published a feature article entitled "Reframing Depression." It's a nice compliment to the dialogue between Yapko and Aaron Beck about depression and its treatment in this newsletter.

* * *

The first issue of a journal to provide a forum for "rank and file" therapists currently is being compiled.

The publishers of the new journal, *GrassRoutes*, hope to provide busy clinicians an opportunity to trade cases and to network. Contributors will be encouraged to be conversational rather than technical and be personal rather than formal.

Suzanne Hanna is editor of the publication. For additional information, persons may write the publisher, Judicial Advisory Services, Inc., P.O. Box 99704, Louisville, Ky. 40269.

* * *

Shirley Bliss and Roxanna Erickson Klein have coauthored an article, "M.H. Erickson's Interventions in an Adlerian Context: Treatment of Eating Disorders." The article appears in *Individual Psychology*, Vol. 46, No. 4, December 1990 by the University of Texas Press, P.O Box 7819, Austin, TX 78713.

Ms. Klein is the daughter of the late Milton H. Erickson, M.D., and his widow, Mrs. Elizabeth Erickson. Ms. Bliss is a longtime patron of the Erickson Foundation.

For reprints, contact Ms. Bliss, P.O. Box 50992, Denton, Texas 76206-0992.

Interview *continued*

about the same place in terms of the incidence of mental illness. So, I can't attribute depression to specific sociological factors.

Y — Do you attribute it to biological factors?

B — I think there are biological factors; there's a lot of evidence that certain types of depression have a very high overlay of biological determinism in them. My own theory is that people are wired in such a way that under certain circumstances a particular type of depression program could get activated. When these circumstances occur, the person will get depressed.

Y — You're talking about a biological predisposition to depression?

B — Yes. There is a biological predisposition to depression which varies from one person to another in terms of the individual's vulnerability. But we have a biological predisposition to everything; we all have a biological predisposition to thinking, feeling and behaving in particular, defined ways. The way thinking, feeling and behaving is expressed in some type of pattern is determined by the way the brain is wired. You see, everything's in the eye of the beholder in research. Some of the anthropologists I've talked to will take the opposite position and say that depression will express itself in different ways in different cultures.

Y — Do you agree with that?

B — Yes, I actually do. I have spoken to people from New Guinea, East Africa, Saudi Arabia and Ethiopia, and they say they see the same types of psychiatric conditions back home as they see in some place like Philadelphia. But, they are manifested in different ways. That's a scenario I don't really have any strong opinions on. I can only base whatever conclusions I have on what I personally have seen.

Y — If it is so different from culture to culture, then wouldn't it suggest that much of depression is, in fact, a learned phenomenon?

B — You see, just because I say there are biological factors doesn't mean that's the whole thing. We're wired in particular ways to acquire language, learn music, and so on. But, the type of language that we learn and the kind of melodies we respond to are determined by external factors.

Y — Well, that certainly would be consistent with your practice, because what you're doing is cognitive therapy. You're working at a psychological level rather than at an exclusively biological level. But, I'm really curious, then, how you respond to people like Martin Seligman who have written on the idea of attributional style being a learned phenomenon and attributional style being key components of depression. The sociocultural changes that lead people to be more helpless and hopeless has been a theme of the conference we're attending; there is this large learned element of depression that outweighs significantly the biological component. Do you agree with that?

B — I agree with that. In order to learn, though, you have to have neurons, and the neurons are set up in a particular way and patterned in a particular way to extract and read external information which may be adaptive to our current situation, or may have been adaptive under other situations. My thesis is that very possibly, at one time, the depressive reaction was adaptive at some point in the evolution of our species. Among primates that are separated from their parents at an early age, the infant goes into a state which is quite similar to what we see in depression — the loss of weight, and a kind of helplessness. This tends to then invoke a response in the other relatives — usually an uncle or an aunt — who adopt this little crying infant. So, the depressive response serves to elicit some type of positive constructive response from other figures. That's what I call a sociotropic depression, the affiliative depression that draws people toward the patient. The other type of depression you also find some kind of analogy to in primates is what I call the defeat depression. Goodall described in her observations of chimpanzees that when an alpha chimp in the hierarchy is defeated in some type of interaction with a lowel level male primate, the alpha primate will tend to withdraw from the group instead of getting into a death fight. Then, we see them reappear at a lower level in the hierarchy later. One of the hypotheses, then, is that this withdrawal is an adaptive mechanism for preventing both from becoming injured or killed. The defeated primate will live longer and then come back, but not be at the same level. So, a particular type of mechanism that could have been adaptive in the wild could be non-adaptive when circumstances change fairly rapidly. Our culture has evolved far more rapidly than some of these built-in (genetic) programs have. So, a program that *could* have been useful under more primitive circumstances becomes non-adaptive at the present time.

Y — You went though training in psychoanalytic approaches, and you're obviously fluent in your knowledge of the language of psychoanalytic thinking and its notions of the unconscious. Milton Erickson's concept of a resourceful unconscious is central to Ericksonian approaches to hypnosis and psychotherapy. You don't talk about the unconscious, but you're very comfortable talking about "automatic thoughts." How do you distinguish the two?

B — The whole notion of the unconscious goes back several centuries, preceding Freud by a great deal. Freud had a particular construction of the unconscious: His idea was that underneath the surface of one's thinking and feeling was a cauldron of taboo drives and wishes and motivational patterns. Then, there was a thick concrete wall of repression. The "unconscious," according to Freud, consisted of the compartment of the mind that is completely isolated from the conscious mind and kept in isolation through repression and defense mechanisms. So, when you use the word "unconscious," that's basically what people think of — the Freudian notion. Now, my own notion is that consciousness is on a continuum. Some things are more conscious than others, and some are less conscious than others. When you drive your car, you're not conscious of every single move you're making, but if you're focusing on it, then you do become aware of what you're doing. Automatic thoughts are brief signals at the periphery of consciousness. Only when people train themselves to concentrate on the periphery do they become aware of their automatic thoughts.

Y — And the goal of being aware of them?

B — They are the most significant messages going through the brain in terms of emotions and psychopathology. For example, if I'm talking before a group, I might have a thought that I'm not pacing myself well. This is the automatic peripheral thought: "You better speed up your presentation: you're talking overtime; or you're talking too slowly." These types of signals are going on all the time peripherally and regulate how you present the material. These internal signals are trying to keep you on track and get you to present the material in a particular way. Now, these thoughts can mess you up, can't they? They can say, "You're talking too fast. You're talking too slow. You look stupid. People are going to disagree with you." But these aren't the kinds of statements you are used to saying about yourself out loud to other people. Therefore, these little signals don't have to be at the forefront of your consciousness. However, it's interesting that when people get into a psychopathological state, this internal communication system becomes *dominant*, and the depressed person will then be thinking right at the forefront of his consciousness: "I'm dumb, I'm stupid. I'm making an idiot out of myself. I'm going to flunk this test. People are going to reject me," and so on. So, the peripheral communication system gets activated, dominates the unconscious thinking, and then produces all the unpleasant effects.

Y — Here's a contrast point with the Ericksonian approach. The application of hypnosis is a direct way of making the unconscious — whatever that is — more accessible in order to create automatic thoughts of a positive nature. So, instead of focusing on automatic thoughts for the purpose of making them conscious and then refuting, or clarifying, them or pushing them in a direction through conscious education, the idea is to use the hypnosis to make clearer thinking more of an automatic and effortless process. What you've been doing in cognitive therapy is amplifying consciousness. What would happen if you worked at amplifying clearer thinking at an unconscious level? Would you view that as an aid to the therapy process?

B — It could be. You see, one of the problems is that we're both serious investigators. And the question is, are we looking at the same phenomenon or are we looking at different phenomena? Are we looking at the same phenomenon with different colored glasses, and, therefore, conceptualizing it differently? Or, are we seeing two different things that happen to occur at this level of analysis? Now, it's hard for me to reframe what you said in the cognitive terms that I use. I am very much an avid [fan] of the cognitive model because it seems to fuse things — the advances made in psychology in general, particularly cognitive psychology, psychology of personality, social psychology, and wherever the emphasis is on information processing. The whole notion of information processing is that there is some type of apparatus that will reconcile external environmental events with past experiences, and then give the individual a particular picture of what is currently going on. Now, where we may be similar is my notion that the information processing in itself can be and usually is a very constructive part of the mind. But the negative thinking gunks up the normal workings of its apparatus. If you can readjust the thinking, then these kinds of positive elements you're talking about can come into play. It seems your approach is to get in and stimulate the constructive part. I think that may tamp down, but not extinguish, the negative. My idea is to go after the negative, and when that gets extinguished, then the positive will come up.

Continued next page

Interview *continued*

Y — Let me point out where we overlap, Tim. I think cognitive therapy is the treatment of choice in depression because it operates on a structural level: It focuses not so much on what they think, but on *how* they think. I'm interested in how those structural interventions take place on a variety of levels, including the cognitive one. So, the idea of applying hypnosis in conjunction with cognitive techniques is to facilitate the process of generalizing relevant learnings, solidifying them in the person's conscious and unconscious. In other words, if the person always has to consciously refute his own thoughts, he's having to work hard all the time.

Now, I suppose you might say, "Eventually it becomes automatic for them to think that way." There is the parallel in our goals: How quickly can you make that a more automatic process? I think hypnosis facilitates that process of making it automatic more quickly.

B — If pragmatically hypnosis helps, then all the better. If it makes people do better in the long run, then there's no question that hypnosis is a powerful tool. In fact, for many years I did use hypnosis, so it's not as though it's a strange, alien type thing to me.

Y — You *still* use hypnosis? I see you do hypnosis in your cognitive rehearsal techniques and imagery all the time!

B — Sure. So, there 's a continuum as to how hypnotic it is. However, one of the things that troubled me about hypnotherapy, in general, was the lack of collaboration between therapist and patient. This doesn't necessarily undermine hypnosis; I'm just talking about it philosophically. In the case of psychoanalysis, the therapist's own mission is that he knows everything, and the patient has to either go along and comply, or rebel...What I always try to teach my students is that you not only have to regard the patient as an equal, but also as a person who has to be apprised of some information that you have. Then, you work together toward a common goal.

Y — Cognitive therapy has an outstanding track record. In the National Institute of Mental Health collaborative study that compared cognitive therapy against interpersonal therapy and against drug therapy, cognitive therapy came out well.

B — Well, the collaborative study did not really compare cognitive therapy with these other conditions; they used therapists who *allegedly* were performing cognitive therapy. I think a different [better trained] group of cognitive therapists would come out with better results. But, cognitive therapy *does* have a good track record with the treatment of depression.

The medical culture has permeated the treatment of mental illness, and so the treatment of choice until proven otherwise, is always the magic potion. With cognitive therapy, with whatever track record it has established, it's done much better on follow-up in the collaborative study and in about 30 other studies [than other approaches]. Cognitive therapy is not going to gain as much acceptance among the psychiatric profession, though, because of the orientation toward the pill, the injection, or whatever.

Y — Even with demonstrable lower relapse rates?

B — In the collaborative study there *was* a demonstrably lower relapse rate — I didn't know you knew that. I'm still a little bit suspicious of the whole study. But, that's not going to mean anything. The degree of acceptance of research findings is going to depend on the sociological and cultural bias of the time. And cognitive therapy is not fitting into this bias as far as psychiatry is concerned.

Y — What would you say about those therapists who are still having their depressed patients pound pillows angrily and pound walls and only emphasize getting in touch with their feelings?

B — Well, I think for a certain portion of patients it does good. Many years ago, before I used my current approaches, I used to have people do that because I was following my thesis that people who are depressed have a lot of built-in hostilities, and unless they could get them out, the hostilities would become like an abscess and poison their system. I used to draw them out and get them to express hostility to me; I [even] used to sometimes needle them in order to get out hostility! Some got better, and some got worse.

I then had to ask myself, "Why did these people get better from pounding pilows and throwing darts at the therapist? It seemed to me that the common denominator was the activity. Adolf Meyer used to treat depression by having patients run up and down stairs. To that degree, the expression of emotion may help, but for many patients it's going to have the opposite approach and make them feel guilty. They'll start beating on themselves more because they have expressed hostilities in that way. In any event, they don't learn anything from it. It may help in some cases to deactivate this depression, but it's not going to help them the next time the depression occurs.

If they continue to keep ventilating their feelings, it's going to create such a backlash from the environment that it probably will get them into another depression sooner. I have seen that in people who're going through a lot of the psychoanalytic stuff; they get into terrible problems with their families and their colleagues. When I was doing my residency with the psychiatric residents, these people were impossible to live with.

Y — Here's one of the ways I think the hypnotic framework is an extraordinarily useful one. It teaches us that anytime you amplify a portion of a person's experience, and do so out of context — the way pounding inoffensive pillows is anger out of context — it's unlikely to have a beneficial therapeutic response. Sending someone into a room to pound walls and yell and scream when that behavior is totally removed from any other aspect of his/her life is a nonsensical thing to do. Now there are scores of studies that suggest the same point; getting people in touch with their anger just makes them angrier. It doesn't make them any more competent. The overlap in our perspective is that learning is an important part of the process: active learning, directed by the clinician. The learnings have to be well-placed in the context of this person's life, including where, and where not to, apply these new learnings.

B — Let's see more of the overlap. I'm content to rest my case with depression, but that represents only a fraction of patients. Let's talk about personality disorders. I use a number of methods in personality disorders, and I wonder if these might be the same kinds of things you're using. Perhaps you just have a different name for them. For example, after a person is finished with depression, you may find that he or she has a personality disorder. The person may still be self-critical. What I had done with one case like this was take her back to an earlier period in her life...

Y — Is this called an age regression?

B — Yes. I had her recreate in imagery, while role playing, an episode of when her mother was highly critical toward her. She then experienced, for the first time since childhood, the full emotion of that time. My belief is that when people experience the total emotion, they're going to be far more susceptible to some type of modification. The molten iron [of personality] can be molded through the heat of the effect. In acute depression we don't have to take them back to childhood, because the effect is already there. They have plenty of effect, and so the cognitive data are modifiable. You take them back to where it all started and you get them to relive the experience and then bring to bear their more mature part. So, the question is, did I do age regression? I used to do hypnosis, but this was a far more systematic type of thing.

Y — That is because of the way you applied it, not because of the hypnosis itself.

B — That's right. I hadn't really thought of what I'm doing now as hypnosis, but I can see that you may be using the term broadly. So, how does that jibe with what you might do?

Y — Okay, here's a contrast point. The emphasis on history is marginal in the directive approaches. My emphasis is on therapy as a model of pattern interruption — looking at the patterns of how this person does what he does. An emphasis of the Ericksonian approach is to make use of context. What situations can I create, either through my relationship with my clients or through places that I send them in the world, where they will *have to* experience themselves differently? I can then take that new experience and amplify it, integrate it, and contextualize it for the person so it becomes his way of doing things. There is, in fact, a marked de-emphasis on history, a marked de-emphasis on going back to find original sensitizing events, and a recognition that those are not necessary conditions for therapeutic change. That's what I mean by pattern interruption: I simply want to change the sequence of how this person does what he normally does. When you're doing what

Continued next page

Interview *continued*

you call your cognitive probe, you have the opportunity to identify sequences in this person's behavior, sequences in this person's thinking, and sequences in the way this person relates to other people. The goal of the therapy, then, from my viewpoint, is to interrupt that sequence. Block that person from doing what he normally does, so he has to do something differently. That pattern interruption creates a receptivity, just through the ambiguity — the confusion — of thinking "I can't follow my normal sequence. What do I do?" One of the techniques that Erickson pioneered was his "confusion technique," where he would deliberately confuse people in order to build receptivity. By the time he'd introduce an idea with clarity, they'd jump on it.

B — That's what Socrates did. It's a socratic technique consisting of asking questions in such a way that the person becomes confused, because the answers to the questions are inconsistent. Then, out of confusion comes the truth.

Y — Erickson stated frequently that, "Out of confusion comes enlightenment." The idea, though, of identifying the sequences is one of the parallels, I think, between the cognitive world and the Ericksonian world. Your emphasis is also very much on the structure — the "how" of what the person does. In essence, when you're doing your interventions and you find out the way this person normally responds is to do "this," you're directive enough to say to them, in essence, "The next time you're in that situation, do this and let's see what happens." You make use of what you have come to call "experiments," where you'll send the person out into the world to experiment with new behaviors and new possibilities. Those are task assignments in the Ericksonian world. The time you first convince your patients that you can send them out into the world to do a new experiment, and they actually follow that, it's only because you promised them directly or indirectly "that this is going to make a difference." You've sold them on that expectation — that value is to be gained from following your prescription. There's a communication on your part that's very hypnotic, that suggests the future is going to be different from the past. The negative expectations, the hopelessness that you address is very hypnotic in its future orientation. You communicate to your patient that things are going to change.

B — You know, you're right. Lots of time people say the problem is purely semantic; it turns out often that it's not purely semantic.

Y — There's a structural difference?

B — No, but in this particular case, I think the problem *is* purely semantic. If you would ask me in a different context, "Is there an element of suggestion in what you do?" I would say, "Of course there is. There's always an element of suggestion. But you try to be aware of it and make sure it doesn't override." Now I think [you've identified] the areas that I would say, "Yes, suggestion is present;" [these are];" areas where you'd say [to me], "Yes, you're using a hypnotic type of technique." Does that sound right to you?

Y — Fair enough...

B — I might say to a person, "Do you think the future is hopeless? I haven't seen the evidence from what you've told me that things can't be better tomorrow, so why don't we do a little experiment to see what things can work out between today and tomorrow, and let's see how many of them turn out bad and how many of them turn out good." Well, the suggestion is that some things will turn out good; the patient must be thinking, "He's not an idiot, he's not going to tell me to do things that are going to go contrary to what he's trying to say." So, there is a suggestion that is implied in there and the message is: "Things can be good and if you look for it, you're going to find it."

Y — Absolutely...That's what always interested me about you; you have a way about you that's so non-threatening that when you say to your patients, "Do this, because I think it's going to help," there's a trust there.

B — Well, okay, thanks. I'm going to have to go now. We had a really nice talk!

Y — I greatly appreciate your willingness to do this interview. Thank you, Tim.

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