ERICKSONIAN HYPNOSIS
THE NEW HYPNOSIS

BY

Stephen Brooks

Milton H Erickson practiced and taught from the 1920's to his death in 1980 and his outstanding contribution to the field of indirect approaches to hypnosis and strategic therapy has made him one of the most important influences in contemporary psychotherapy. He was a practising psychologist and psychiatrist, professor and lecturer, founding resident of the American Society of Clinical Hypnosis and Life Fellow of the American Psychiatric Association. He was author of over one hundred books, articles and papers.

Erickson is best known for his contribution towards hypnotic language. Together with Rossi (1976) he outlined a set of unique language patterns known as Indirect Suggestion which could be used with or without formal hypnotic trance. It is this achievement that has perhaps brought Erickson's naturalistic hypnotic techniques to the attention of practitioners of other forms of therapy.

The history of Indirect Suggestion in fact goes back to the 1800's when they were called Mediate Suggestions. Bernheim later coined the phrase 'Ideo-dynamic components of suggestion', meaning the parts of a suggestion that appeal to the unconscious mind rather than the conscious. In this respect Bernheim was perhaps the grandfather of current Ericksonian Hypnosis.

In the 1920's when early researchers such as Hill and Hilgard tried to standardise hypnotic inductions to measure hypnotic suggestibility, the indirect forms of suggestion were lost.

The uniqueness of indirect suggestion lies in its application to the needs of the individual patient. It consists of a series of flexible linguistic skills that can be adapted to meet the goals of different therapies. They can be applied in the alternative therapies, general practice, social work, dentistry and many other fields not normally associated with hypnosis. As these forms of suggestion are so indirect they can be inserted into ordinary conversation and therefore offer practitioners additional valuable skills for helping patients overcome their problems.

The Ericksonian approach to psychotherapy has split into two distinct schools. One primarily concerned with family and couple

therapy and one focusing on the individual. Whilst both schools utilize indirect suggestion, they do so in different ways. The Interactional approach is more concerned with what is happening between individuals and the Intrapersonal approach is more concerned about what is happening within the individual. Although both approaches aim to bring about change at an unconscious level, the Interactional approach looks at the structure of relationships and attempts to alter the structure to effect change within individuals at an unconscious level, whilst the Intrapersonal approach works on evoking unconscious patterns of association in order to ufilize a patient's own healing resources.

The Interactional approach was developed by researchers Haley, Bateson and Weakland who visited Erickson in the early 1950's. Together with Watzlawick they formed the Palo Alto Group and developed a set of approaches to family therapy that included symptom prescription, reframing, encouraging and utilizing resistance, anecdotes, analogies, and stories; encouraging responses by frustrating them and encouraging relapses. This approach has become known as the Systems Theory.

The Intrapersonal approach on the other hand emphasised the importance of utilizing the patient's resources for problem solving. Exponents of this approach believe that patients are unable to resolve problems because of their limited conscious sets, and often unknowingly reinforce problems by trying to solve them consciously.

By utilizing the symptoms, resistances, and complex on-going behaviours of the individual patient (as with the Interaction approach) the Intrapersonal therapist encourages the patient to experience naturally occurring trance states (as in daydreaming etc.) and then utilizes these states to guide the patient on an inner search of the unconscious for the appropriate resources for problem solving.

The Intrapersonal approach was developed primarily by Rossi from Erickson's work in the 1970's. By this time Erickson was old and very ill. His therapeutic style had become more and more economical and minimalistic. Many of the young therapists who studied with Erickson at this time believed that this was the new way to do therapy. It is the most non-directive approach to psychotherapy ever developed, with every aspect of therapy orientated around (or inside) the patient. It teaches profound respect for the unconscious, now no longer viewed as a pit of repressed desires as in the Freudian view, but as a reservoir of available healing resources.

It is the non-directive Intrapersonal approach that seems to fit most comfortably into the field of Humanistic Psychology and the approach which I intend expanding upon now in the rest of this article.

Rossi and Erickson identified a dozen or so more forms of indirect

hypnotic suggestion which initiate an inner search at an unconscious level as they cannot be answered consciously. For example a simple double bind question might be: 'Will you remember a memory from your recent or distant past?'. Embedded within this question is a presupposition that the patient will remember something: the therapist at this stage is not really interested whether it's recent or distant, and the question can only be answered by the patient waiting and experiencing whatever memory the unconscious offers.

By utilizing all of the patient's unconscious potential and communicating with the patient's unconscious via ideo-motor responses (involuntary finger movements and non-verbal signals) the therapist gets the unconscious to do all of the work.

There are three stages to this therapeutic process. First the therapist primes the patient with stories, metaphors and analogies about the relationship between the conscious and the unconscious. Second, by utilizing the patient's symptoms and life experiences, the therapist encourages the patient to enter naturally occurring trance states and make therapeutic changes (by 'trance' we do not mean the typical hypnotic trance of the passive hypnotic subject but an altered state of awareness during which the patient moves and talks). Third, the therapist uses the patient's experience of the session to ratify therapy.

Since these three stages overlap and often become confused, a brief clinical vignette may help clarify the approach.

A young Brazilian girl was brought to me as a demonstration subject during one of our training courses. She had a long-standing problem of acute asthmatic attacks which naturally terrified her and which she believed were hereditary. Two students on the course took notes and it is from this source that I have drawn this example.

To develop the first stages of rapport, I used humour and modelled the same posture, breathing and tonality of the patient. The use of humour is very characteristic of Erickson's approach. Humour often 'breaks the ice' and builds rapport through the sharing of a common experience - that of laughing, smiling and mutual understanding of a particular funny observation or topic. By matching the posture, breathing and tonality of the patient, the same outcome is achieved - an acceptance of the patient's physiology and therefore the patient's feelings at the time.

After talking to her about her symptoms, I decided to work on her strongly held belief that her asthma was 100% hereditary. She was a lively girl with an interest in mathematics, so I decided to utilize her interests and her fear of attacks to change her beliefs about the severity of the problem.

This approach to therapy, whereby the therapist utilizes the patient's beliefs and symptoms to actually change them, is quite common, as is the technique of utilizing the

patient's interests. By utilizing what the patient offers the therapist, you are not imposing a particular theory or methodology onto the patient. You are in fact utilizing what you are given and changing what you do as a therapist to meet the needs of the patient.

Fear, in the patient's terms, meant her fear of dying through being unable to breathe. Whilst eliciting information about her fear and identifying any resources the patient had available (times when the attacks did not happen, coping mechanisms, early learning experiences, etc.) I assisted her in entering a trance state. I did this by talking about naturally occurring trance states like day-dreaming and simultaneously slowing down my own breathing which was now firmly matched to the patient's. This slowing down allowed her unconsciously to do the same. I then let myself enter a light trance state which indirectly allowed her to recognise the physiological changes that happen when someone enters trance and then focus inwards and deepen her own trance state. I then asked her whether the fear of attacks made them worse. When she said 'yes' I quietly asked her what percentage of an attack was based on fear. When she answered '20%', she unconsciously reduced her previous belief by that amount. Throughout this process I had been inducing and receiving finger movements and unconscious and unconscious head nods from the patient as a way of indirectly communicating with her unconscious mind. I am always more interested in what the unconscious has to say than the conscious mind, because the conscious mind doesn't know how to help the patient; if it did, it wouldn't be sitting there asking for help. By communicating directly with the unconscious with finger movements and unconscious head nods, it not only ratifies the responses as being genuine unconscious communication, but also prevents conscious sabotage of the therapy by the patient's trying to help or solve the problem consciously with the previous ineffective pattern of behaviour.

Through appropriate questioning, using the various forms of indirect suggestion and ideo-motor responses, her unconscious told me that it wanted her to go deeper into the trance state to look for more resources. I asked her unconscious whethet it would allow her to communicate directly with her problem. Upon agreeing, the patient demonstrated physiological changes suggestive of a deep hypnotic state. This suggested to me that, in order for her to communicate directly with the problem, she had to enter a deeper trance state. Erickson often used both deep and light trance states: deep trance isn't always appropriate for therapeutic work. I usually, as with this patient, let the unconscious decide whether deep trance is necessary. Often it's not. I usually do most of my work with patients in a light state. After a while she opened her eyes, whilst remaining in a trance, and defocused, looking ahead into space. I told her a story about how I had learnt mathematics by adding and subtracting apples and oranges.

There then followed a long and laborious session of mathematics carefully timed to promote dramatic changes in her breathing (frightened shallow asthmtic breathing and relaxed deep breathing) during which time we added and subtracted apples from oranges and oranges from apples. By the end of the process, she had replaced all of the oranges with apples - metaphorically switching her 80% hereditary asthma with her 20% fear.

This meant that the belief in her 100% hereditary asthma hadnow been reduced by 80%. The adding and subtracting of apples and oranges served, not only to reduce her belief but to teach her how to handle the fear aspect of the problem with controlled breathing.

As this was learnt in a hypnotic state without her conscious awareness of it happening, the new breathing techniques would hopefully happen all by themselves whenever she felt an attack coming on in the future.

This metaphoric process was then followed by further verbal metaphors suggesting that she enter a relaxed state next time she felt an attack coming on and metaphors about breathing and going along with future asthmatic attacks rather than fighting them. She was then brought out of trance with suggestions that she could come out just as soon as her unconscious was willing to let her learn something of interest.

When questioned at the end of the session, she displayed amnesia for the experience and an unawareness of the passage of time. She stated that maybe she had got the percentages wrong at the beginning of the session and now felt that her asthma was really 80% fear and 20% hereditary. When asked how she would cope with the fear in the future, her muscles relaxed, she closed her eyes and she took a long deep breath. Suggestions were then given for her to come out of this second self-induced trance state just as soon as her unconscious knew she could control her problem.

After treatment she was able to control her attacks and felt much more confident about her future. Follow-ups later confirmed that therapy had been successful and that the attacks were no longer a problem.

This example demonstrates only one approach to treatment with Ericksonian Hypnosi. Ttruly there are as many approaches as there are patient's problems. These techniques have been used widely with many anxiety based complaints including phobias, habit control, psychosomatic problems, pain management, insomnia and many others. T he application of Ericksonian techniques is growing rapidly throughout the world and I foresee in the near future a dramatic shift in the medical profession towards consideration of the patient as a unique individual with his or her own needs. Having taught many hundreds of NHS practitioners as well as those from the alternative therapies, I know that these needs can easily be met with an understanding of the skills developed from the field of Ericksonian hypnosis and communication.

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THE ALCHEMY OF THE TWENTIETH CENTURY

A proposed special issue on the present day use of drugs.

There would seem to be five different purposes for using drugs:

1 Medical (for modifying or curing disease)
2 Celebratory (for pleasure and social occasions)
3 Shamanic (spiritual/magical/personal quest)
4 Enhancement (sustaining of work performance)
5 Escape (avoiding pain, boredom, fear)

Of these, some are legal, some are not. Some are socially acceptable; some are not; Some add to the fullness of life; some do not.

Contributions are invited from any standpoint, including controversy about drug use and its relationship to personal power, whether or not your views correspond with any of our five categories.

We would particularly welcome work on:

a Early 20th. century drug use with particular reference to the Vienna Circle, perhaps also the Order of the Golden Dawn who greatly influenced the intelligentsia of the time.

b The Doors of Perception: Huxley, Castandeda, Leary, Alpert re-examined in the light of 30 years' influence from their ideas.

c Current attitudes about use of drugs for sectioned patients in mental hospitals. A comparison with restraint techniques previously in use before the widespread prescription of strong sedatives would be helpful, together with the ethics of drugs treatment, iatrogenia etc and of course the success stories.

Please send articles and suggestions to Shan Jayran, 33 Oldridge Road London SW12. Tel: 01 673 6370.