EXPERIENCING HYPNOSIS:

THERAPEUTIC APPROACHES TO ALTERED STATES

By Milton H. Erickson, M.D.
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Photograph by René Bergermaier

Dr. Milton Erickson and Dr. Ernest Rossi

We dedicate this volume to Elizabeth Erickson and Margaret Ryan, whose thoughtful editorial work has made it possible.

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INTRODUCTION

This book is a continuation of our earlier work in *Hypnotic Realities* (Erickson, Rossi, & Rossi, 1976) and *Hypnotherapy: An Exploratory Casebook* (Erickson & Rossi, 1979), whereby the senior author, Milton H. Erickson, trains the junior author, Ernest L. Rossi, in clinical hypnosis. Taken together, these three volumes present a deepening view of what hypnosis is and the ways in which a creative process of hypnotherapy can be achieved. The material in these volumes touches ultimately on the nature of human consciousness and suggests a variety of open-ended approaches to facilitate its exploration in hypnotherapy as well as in more formal research situations.

Indirect communication is the overall concept we use to cover what we have variously described as two-level communication, the naturalistic approach, and the utilization approach. The common denominator of all these approaches is that hypnotherapy involves something more than simple talk on a single, objective level. The readily apparent, overt content of a message is like the tip of an iceberg. The recipient of indirect communication is usually not aware of the extent to which his or her associative processes have been set in motion automatically in many directions. Hypnotic suggestion received in this manner results in the automatic evocation and utilization of the patient's own unique repertory of response potentials to achieve therapeutic goals that might have been otherwise beyond reach. In our previous volumes we outlined the operation of this process as the *microdynamics of trance induction and suggestion.* Although this is the essence of the senior author's original contribution to modern suggestion theory, we will review in this volume some of the many means and meanings that other authors have used as they struggled to reach an understanding of indirect communication in the long history of hypnosis.

The first section of this volume presents an historically important lecture on clinical hypnosis by the senior author wherein we witness his transition from the older authoritarian approach to hypnosis to the new permissive approaches, which he pioneered. Due to the unique nature of this presentation, an audio cassette of it accompanies this volume. We strongly recommend that our professional readers listen to this cassette and savor it a bit before dealing with the lecture as presented in the text.

The second and third sections of this volume focus on the phenomena of catalepsy and ideomotor signaling, two of the senior author's basic approaches to trance induction and hypnotherapy. The primary concern is the practical question of how to induce therapeutic trance and how to evoke the patient's repertory of life experiences and involuntary response systems that are utilized in hypnotherapy. As is characteristic of our previous work, the growing edge of our current understanding of the subjective experience of clinical trance and altered states is discussed throughout.

A film of Erickson made by Ernest Hilgard and Jay Haley at Stanford University is available from Irvington Publishers for study by serious students who wish to observe the nonverbal aspects of Erickson's I innovative work utilizing the reverse set in hypnotic induction presented in Section III. We believe that further research on and development of this reverse-set approach will greatly expand our understanding of the dynamics of trance and serve as the foundation for a new generation of more effective approaches in hypnotherapy.

The fourth section, dealing with the experiential learning of hypnosis, illustrates one of the senior author's favorite occupations in recent years: the training of professionals in the use of clinical hypnosis by allowing them to experience the process themselves. The two sessions presented in this section are illustrative of the problem faced by a modern, rational, scientifically trained mind in learning to experience hypnotic phenomena. Herein are illustrated many of the phenomena and paradoxes of modern consciousness as it seeks to understand more about itself by making an effort to transcend its current limitations.

Ernest Rossi *Malibu, California*

SECTION I

The Indirect Approach to Hypnosis

We begin here by illustrating the indirect approach to hypnotic communication through the transcription of a lecture given by the senior author before a group of his professional colleagues. We then outline our current understanding of this approach and its relevance for facilitating the processes of hypnotic induction and therapeutic trance.

A. HYPNOSIS IN PSYCHIATRY: THE OCEAN MONARCH LECTURE

This lecture is an unusually clear and succinct presentation of the senior author's approach to hypnotic induction and hypnotherapy. Given at the height of his teaching career, it represents an important shift away from the authoritarian methods of the past to his pioneering work with the more permissive and insightful approaches characteristic of our current era. In the actual words of this presentation we can witness how important concepts are in transition. While Erickson still uses the words *technique* and *control* a number of times—and even *manipulate* and *seduce* appear once each—it is evident from the broader context that they are outmoded in the traditional authoritarian sense in which they had been used.

A paradigmatic shift is taking place in this presentation: It is now recognized that the most significant person in the hypnotherapeutic interaction is the patient, not the therapist. The patient's potentials and proclivities account for most of the variance (what actually happens) in hypnotherapy, not the purported "powers" of the hypnotist. The therapist does not command the patient; rather, as the senior author says, "It is always a matter of offering them [patients] the opportunity of responding to an idea." It is now recognized that the hypnotherapist offers the patient many *approaches* to hypnotic experience rather than imposing hypnotic *techniques.* The concept of *technique* implies the mechanical and repetitious application of a particular procedure in the same way to every patient with the intent of producing a preconceived and predictable response. The concept of *approaches* implies the profferance of alternatives to help each patient bypass his or her own particular learned limitations so that the various hypnotic phenomena and hypnotherapeutic responses may be experienced.

Therapists do not "control" the patients; rather, they help the patients learn to "utilize" their own potentials and repertory of unconscious skills in new ways to facilitate the desired therapeutic outcome. This new orientation requires the development of many observational and performance skills by hypnotherapists. More than ever it is required that they learn to recognize and appreciate each patient as a unique individual. Every hypnotherapeutic interaction is essentially a creative endeavor; certain known principles are being applied, but the infinite possibilities within each patient require an essentially exploratory approach to achieve the therapeutic goals.

This lecture is highly characteristic of the senior author's style of presenting his approach to hypnotic induction and hypnotherapy. Listening to it on the cassette accompanying this volume in a relaxed mood may have important values for the reader that are not contained in the edited version presented in this volume. Before reading any further, then, the reader may best listen to the cassette labeled "Hypnosis in Psychiatry: The Ocean Monarch Lecture." Those readers who are familiar with our two previous books in this series will know why we recommend listening to the cassette first. Other readers will understand the reasons after reading the discussion of this tape that follows its edited version on these pages. Please listen now to the lecture.

A. HYPNOSIS IN PSYCHIATRY:

The Ocean Monarch Lecture

The Conscious and the Unconscious Mind

I do not necessarily intend to demonstrate hypnosis to you today so much as to discuss its use in psychiatry. However, the use of hypnosis in psychiatry actually applies to the use of hypnosis in any other medical field, whether dental, dermatology, or whatever it might be. The first idea I want to impress upon you is one way of thinking about your patients clinically. It is desirable to use this framework because of the ease of concept formation for the patient. I like to regard my patients as having a conscious mind and an unconscious, or subconscious, mind. I expect the two of them to be together in the same person, and I expect both of them to be in the office with me. *When I am talking to a person at the conscious level, I expect him to be listening to me at an unconscious level, as well as consciously.* And therefore I am not very greatly concerned about the depth of the trance the patient is in because I find that one can do extensive and deep psychotherapy in the light trance as well as in the deeper medium trance. One merely needs to know how to talk to a patient in order to secure therapeutic results.

Learning One's Own Method of Suggestion Following the Patient's Lead

Now the next thing I want to stress is *the tremendous need for each doctor to work out a method of suggestion for himself.* In developing my own technique, I worked out what I felt was a good hypnotic technique. It was about 30 typewritten pages, single-spaced, of the various types of suggestions necessary to induce a deep trance. And then I slowly cut it down from 30 typewritten pages single-spaced to 25, to 20, to 15, to 10, to 5, and so on, so that I could use the whole 30 pages or I could use just one page or one paragraph. But I learned thoroughly how to graduate my suggestions, and how to lead from one suggestion to another. When one does that sort of thing, *one learns how to follow the leads given by his patient.*

Trance Induction: Catalepsy to Heighten Responsiveness

In inducing a trance in your psychiatric patient or, for that matter, any patient, it is the fashion in which you present the suggestion to the patient that is important. For example, some of you have seen me demonstrate the proper way to take hold of a patient's wrist. Too often, a doctor will grab hold of a wrist and lift it up forcibly. But when I lift someone's hand, I purposely do so in a very, very gentle fashion so that there is just a suggestion that I am lifting the arm, and just a suggestion that I am trying to move it this way or that way. And the more gentle you can be in the physical touch of the arm, when you are lifting it up in the air to induce catalepsy, the more effective it is. Any forcible seizure of the patient's arm causes difficulty because you want to stimulate the patient to be responsive to you. Hypnosis is primarily a state in which there is increased responsiveness to ideas of all sorts. And one employs that responsiveness not by trying to force, but by trying to elicit an immediate response—and to elicit it by having the patient participate.

In exactly the same way, I do not like this matter of telling a patient, "I want you to get tired and sleepy, and to get tired and sleepier." That is an effort to force your wishes upon the patient. That is an effort to dominate the patient. It is much better to suggest that they *can* get tired, that they *can* get sleepy, that they *can* go into a trance. For it is always a matter of *offering them the opportunity of responding to an idea.*

Patient's Freedom to Respond: Positive and Negative Suggestions

I have found that patients often have the notion that hypnosis is a powerful tool that can

compel them to act according to my wishes. I like to *approach* my psychiatric patients—whether they are neurotic, emotionally disturbed, prepsychotic, or even psychotic—in a fashion that lets them *feel free to respond to whatever degree they wish.* I never tell a patient that he has to go into a deep trance, or into a medium trance, or for that matter into a light trance. I suggest also that he never tell me anything more than he really wants to tell me. I usually tell my patient that he can *withhold whatever he wishes,* and to be sure to withhold whatever he wishes. I am emphasizing this point because I want you to have some understanding of positive and negative suggestions. To tell a patient, "Now, tell me *all,"* is a rather threatening, even dangerous request to make. Rather, you want the patient to be willing to tell you this, willing to tell you that, so that as they begin telling you this and that, *they also begin to develop a certain sense of confidence.*

Rapport: Utilizing Ambivalence and Naturalistic Modes of Functioning

Now and again you will meet a patient with whom you have an immediate rapport, and then you can take the dominant attitude. But one really ought to be cautious. In using positive and negative suggestions, one tries to make it possible for the patient to exercise his own ambivalence for your benefit and for his benefit. He is both willing and unwilling to secure help from you, so you try to define the situation for him in such a way that he can get help in one direction and refuse help in another situation. In that way the patient develops a readiness to go along with you.

Now in hypnotizing the psychiatric patient I think one of the important things to do first is to establish a good conscious rapport. Let him know that you are definitely interested in him and his problems, and definitely interested in using hypnosis if in your judgment you think it will help. So often I have had patients come in and demand that they be hypnotized, to which I usually counter with the statement that it is better for the doctor to prescribe than for the patient to prescribe. And surely if they can benefit from hypnosis, I will employ it. But then I will ask their permission to employ it in the way that is most helpful to them.

And what have I really suggested? I have suggested that it be employed in a way most helpful to them. Usually I go through the preliminary explanation that they are going to remain conscious. But I point out to them that the fact that they can hear the clock on the wall, that they can see the bookcases in the room, that they can hear any disturbing sounds, is rather unimportant. The essential point is that they pay attention, not necessarily to me, but to their own thoughts—especially the thoughts that flash through their mind, including the manner and the sequence in which those thoughts flash through their mined. [Hypnotic suggestion always utilizes such naturalistic modes of functioning; it never imposes anything alien on the patient.]

Now, hypnosis is something that allows you to manipulate *[sic*—we now prefer *utilize!]* the personality in its various ways of functioning. One can ask a patient in the trance state to remember something of the past, or to speculate upon the future, or to shift from one gear to another gear. Too often there is an attempt to follow through in a consistent way on one particular problem, long after the patient has become too fatigued or too disturbed emotionally to do that. You must realize that hypnosis allows you to come back to a particular idea, or fear, or anxiety so that it is never necessary to ask a patient to experience too much distress or emotional discomfort at any one time.

Questions Facilitating Rapport and Trust

What are some of the uses of hypnosis in psychiatry? The first, and I think the primary, use of it should be in establishing a good personal relationship with the patient. Once you have hypnotized patients, they will often feel that they can trust you. And, it is important to give them the opportunity of discovering that they can trust you. Therefore, I usually ask patients in the hypnotic trance some question that I know they should not answer at that time. I ask a question, and before they can possibly hear it, I point out to them that it is a question

that should not yet be answered, and that they ought not to answer it until the right time comes along. Then I ask them to think about what I have said. As a result, they realize that they can answer questions freely and easily, but are under no compulsions to answer a question before the right time comes. I make this clear to patients in the waking state as well as in the trance state, because you are dealing with a person that has a conscious mind and an unconscious mind.

Integrating Conscious and Unconscious Learning

This brings us to another important point regarding the use of hypnosis. Because you are dealing with a person who has both a conscious mind and an unconscious mind, achieving good results with a patient in a deep trance does not mean that the patient will benefit from it in the ordinary waking state. There has to be an integration of unconscious learnings with conscious learnings. This should be foremost in your mind whenever you use hypnosis on psychiatric patients. You can recognize that you can resolve a conflict, a phobia, or an anxiety in the trance state. But unless you do something about it in the waking state, the patient is still likely to have that anxiety or phobia. You can remove a phobia for a certain color in the trance state so that the patient behaves normally. Nevertheless, when he awakens from the trance state, he will still have conscious habit patterns of response to that particular color. And therefore it is essential to integrate the unconscious learnings with the conscious learnings.

While a patient of mine was recovering a traumatic experience, she developed a fear of the color blue. She had seen her sister nearly drown, and her sister had looked decidedly blue in appearance. The patient didn't really recover from her fear of blue, although she could handle anything blue and look at anything blue in the trance state, until she had a feeling of conscious comfort while dealing with blue cloth and blue colors of all sorts in the waking state. She did not necessarily need to have a complete knowledge of her sister's near drowning, but she did need to have an awareness that blue used to be associated with very uncomfortable things. Therefore, in dealing with patients it is always necessary to decide how rapidly and how thoroughly they will need to integrate what they learn unconsciously with what they learn consciously.

Dissociating Intellect and Emotion in Dealing with Anxiety, Phobia, and Trauma

Hypnosis can also allow you to divide up your patient's problems. For example, a patient comes to you with some traumatic experience in the past which has resulted in a phobic reaction or an anxiety state. One can put him in a deep trance and suggest that he recover only the emotional aspects of that experience. I have demonstrated this phenomenon in the past by having one of my demonstration subjects recover all the merriment of a joke without knowing what the joke was. And yet that subject laughed and laughed in the merriest fashion over the joke, wondering at the time what the joke was! Later, I let my subject remember the actual joke. In other words, one can split off the intellectual aspects of a problem for a patient and leave only the emotional aspects to be dealt with. One can have a patient cry out very thoroughly over the emotional aspects of a traumatic experience and then later let him recover the actual intellectual content of the traumatic experience. Or, one can do it in a jigsaw fashion—that is, let him recover a little bit of the intellectual content of the traumatic experience of the past, then a little bit of the emotional content—and these different aspects need not necessarily be connected. Thus, you let the young medical student see the pitchfork, then you let him feel the pain he experienced in the gluteal regions, then you let him see the color green, then you let him feel himself stiff and rigid, and then you let him feel the full horror of his stiffness and rigidity. Various bits of the incident recovered in this jigsaw fashion allow you to eventually recover an entire, forgotten traumatic experience of childhood [a gangrenous wound from an accidental stabbing by a pitchfork] that had been governing this person's behavior in medical school and handicapping his life very seriously. [See

Erickson & Rossi, 1979, for detailed examples of these approaches.]

Facilitating Recovery and Amnesia of Traumatic Events

This brings us to the possibility of inducing a complete memory of traumatic experience, and then inducing an amnesia for it. Often patients come to you not knowing why they are unhappy or distressed or disturbed in any way. All they know is that they are unhappy, and they give you a wealth of rationalizations to explain it: Things aren't going right, the mortgage is too much of a burden, their job is too difficult, when actually it may be the lingering, unconscious effects of the father relationship, the mother relationship, of their childhood. One can actually regress the Patient, return him to his childhood, and get him to remember forgotten incidents with remarkable clarity and detail. One can secure all of that information from the patient which gives you complete understanding of many aspects about your patient, and then awaken the patient with a total amnesia of what he has told you. The patient doesn't know what he is talking about, but you know what he is talking about. And therefore, you can guide the patient's thinking and speaking closer and closer to the actual problem. You can detect the significant words that refer to the traumatic experience of which he is consciously unaware and thus understand the deeper implications of what he is talking about. [Eventually, the patient will probably be able to deal consciously with the traumatic experience. But while conscious awareness of it is still too painful, you can help him deal indirectly or metaphorically with the problem.]

Learning the Indirect Approach

In this regard, you need the practice of repeatedly attempting to get a patient to talk about something in ordinary, everyday life. You need the practice of trying to get normal hypnotic subjects to talk about the lighting, for example, in the corner of the room. Of course, the lighting is not important, but how you guide them to talking about it is important. How can you do this? You merely need to observe their ordinary utterances and casual conversation. Then, emphasize the fact that all of a sudden they said the word *corner,* and you wonder why. Soon, they will say something is light, and very shortly you can have them talking about the lighting in the corner of the room. It is a matter of directing them. In a similar way, as long as you know some of the traumatic past of the subject, you can guide every one of your remarks in that direction.

Psychological Reorientation for Discharging and Displacing Resistance: Facilitating a Yes Set

What are some of the obstacles that you will encounter in using hypnosis? Your patients in the psychiatric field are often exceedingly difficult. They are fearful to begin with, they are distressed—they do not know how to handle themselves or they would not be your patient. You can employ all of the various hypnotic phenomena. I can recall one of my patients who came to me and spent the time explaining that he just could not talk to me. There was nothing he had to say, and he felt too miserable to be able to have any thoughts at all. My response was simply this: That he could go into a light trance and experience some interesting and rather helpful phenomena. He agreed that he needed some help, but he didn't know how to get it. And so, in an apparently random fashion, I stated that I could place a chair right there, that it would be just about so far from the bookcase, about so far from the door, about so far from my desk, and it would be really very nice to sit in that chair and be able to talk when sitting in that chair. My patient tended to agree with me that if there were a chair over there, it would be so far from the bookcase, it would be so far from my desk, it would be so far from the door.

At this point I had elicited three excellent agreements from my patient which brought us to the statement that if he were sitting in the chair in such-and-such a relationship, he might find it helpful to him in talking about himself. Of course he risked nothing in saying that he

might find it helpful if he sat there in that chair—since there was no chair! I had not had him hallucinate one. I simply had him imagine it just as all of you can. But what is the subject really doing? He is agreeing with me without knowing it that he would find it easier to speak more freely if he were sitting in a different position in the office. Then I suggested that it was impossible, really, to talk in this chair—the one that he was actually sitting in—but all that would be necessary for him to do would be to take the chair, put it over there, sit down, and begin talking. I've had a patient more than once pick up his chair, move it to another side of the room, and immediately begin discussing his problems and giving me the information he needed to give. In effect, he has left all of his resistances in the room orientation that he had when sitting in *this* chair. But by sitting in *that* chair, which had just been moved over there, he saw the room in a different way entirely.

I have found that whatever you can do to alter the orientation of your patients in the office aids them tremendously in communicating with you and examining their problems. [Reorienting a patient physically and spatially often helps to reorient him psychologically. The chair in its old position represents the patient's old patterns of thinking and behaving. Moving the chair to a new position represents the patient's willingness to look at himself in a different way and gives him, literally and psychologically, a different perspective.] Hypnotically, of course, it is very easy to induce a deep trance and reorient patients completely, even to depersonalize them. That is why I emphasize the importance to all of you, no matter what field of medicine you are in, to work with normal subjects. Spending a little time with normal subjects will enable you to discover all the various hypnotic phenomena.

Harvey, the Sad Sack: Depersonalization and Projection to Free the Intellect for Therapeutic Change

Depersonalization and the projection of the self are other very helpful hypnotic phenomena. You can teach a subject to hallucinate a movie screen and to see his "self" up there on the screen. You can then have him forget his name, his identity, to forget everything about himself—the way all of us do normally in the theater when observing a suspense movie or anything that completely absorbs our attention. Then have your patient look at the screen and tell him that he is going to see a continuous series of events—you can have them in the form of moving pictures, or you can have them in the form of stills.

I can think of one person, a sad sack, who came to me, and the question was, could one ever make a man out of that sad sack? I was challenged to do that, and I had to conduct psychotherapy on that man using hypnosis and having an audience of antagonistic psychoanalysts and residents in psychiatry—some of whom were undergoing psychoanalysis. The simple procedure I used with the sad sack was this: Harvey had every known ache and pain, every known sense of inferiority. But he was intelligent, even though he didn't manifest much intelligence. He was fearful, and that was all I really needed to know about the man, because knowing that he was intelligent, I also knew that he could have a rather rich fantasy life. And so I suggested to him that he see a series of movie screens or crystal balls in which he would see still-life pictures of tremendous importance. I had Harvey forget his name, his identity, his age, the fact that Harvey as a person really existed. All he was was an intelligence that was looking at all those things that I had scattered around the room for him to look at. He saw the little boy on his way to school as a moving picture—most of them were moving pictures. He followed the little boy to school. He saw the little boy getting his hands racked by the school teacher. He saw the schoolteacher forcing the little boy to change from the left hand to the right hand in writing. He saw the little boy getting punished rather brutally by the teacher. One particular day, he saw that boy walking home very sadly. And Harvey looked and commented on the paltriness of the scene. He saw that little boy walking home, reaching home, and looking into the yard over the gate. And there he saw the sheriffs deputy with a gun in his hand. The deputy had just finished shooting the little boy's dog. And then he saw the little boy crying.

And then I told him to start there and see another picture several years later when that same emotion would come forth. And he saw that same boy at the age of 10 out in the

woods hunting with his brother and feeling terrible about killing a rabbit. Then he saw the boy about the age of 15 lying on the top of a ruined dam and thinking about all the dreadful things that can happen to human beings. And then seeing a young man of about 22 who had just been turned down by a girl and felt very wretched and very inferior. And then he saw that same young man in the same emotional state of depression who was walking out of a courthouse. He'd just been divorced and felt rather suicidal and tremendously inferior. And then he saw the young man at the age of 28 getting discharged from the job he liked. And then he saw the young man at the age of 30 feeling horribly wretched.

And I asked Harvey the intellect to review all of those pictures and what they probably meant, and Harvey reviewed and analyzed them for me. And we spoke about the thread of continuity and the repetition of traumatic experiences that goes through life. But Harvey didn't know that he was talking about himself, and Harvey didn't know that he was seeing himself. And I could ask him to speculate on what would happen to that young man. And his statement was that if anything more like that happened to him, he would undoubtedly try to commit suicide—always on the losing end, since he had lost out on everything throughout life, and maybe tried to commit suicide on the losing end. But the losing end meant what? [Erickson then helped Harvey resolve one of his problems in trance: He was to practice writing clearly instead of the self-humiliating scrawl he usually presented. Finally, Harvey was able to follow a posthypnotic suggestion to write clearly when he was awake.] "This is a beautiful day in March." He wrote that, looked at it, and jumped to his feet and said, "I can write clearly! I can write legibly!" And he went around and around that group of doctors and demanded that everyone praise his writing. He was literally a jubilant little boy. And he was utterly embarrassing to the audience because of his jubilance until they recognized the tremendous force of that.

Now Harvey's job was a fifth-rate job where his boss kicked him around. Harvey did this writing, and during the rest of the evening he bragged and bragged about his excellent handwriting. And I suggested that he would keep that sense of accomplishment, that sense of personal pride, with him, and that he would use it in every essential way. The next day when Harvey went to work, he talked back to his boss for the first time and he demanded an increase in payment in his salary. And he got it. Then he demanded a better desk. Harvey drove a car to work. He always parked it in a particular place in the parking lot. And there was one other employee there who always boxed him in with his car. And that employee worked half an hour longer than Harvey. Harvey would sit and fume helplessly, Casper Milquetoast fashion, in his car waiting for the other man to come to move his car. That night Harvey went out and told the guy, "Listen you big lug, I possibly could pick a fight with you for parking your car in that nasty fashion. You've done it for a long time and I've taken it. We could have a fight about it, but I'd rather invite you in for a glass of beer, so let's go talk it over."

That was the last time that guy ever parked his car in such a manner as to box in Harvey's car. Harvey repainted his car because he felt a joy of possession in it. He got new slipcovers. He changed his restaurant for a better one. He changed his rooming house for a better rooming house. That surge of joy over the simple matter of writing his name legibly and then writing a simple sentence, "This is a beautiful day in March," and giving him permission to feel that tremendous, boyish surge of jubilant joy was enough to carry him along.

I think it would have been an error for me to tell him to go down and demand better pay or to tell off that guy who parked that car in the wrong fashion—because he didn't need a direction about what to do. But he did need motivation. And that is one of the things in psychotherapy and the use of hypnosis—the motivation of a patient to do things. Not the things that you necessarily think they ought to do, but the things that they as personalities have the feeling that they really ought to do. And one usually starts with rather simple things. Because human beings are essentially, fundamentally, rather simple creatures. And therefore, you ought to start simply and let the patients elaborate in accord with their own personality needs—not in accord with your concepts of what is useful to them. You only interfere when they try to destroy themselves.

Indirect Suggestion and Implication

Much of hypnotic psychotherapy can be accomplished indirectly, like I had done with Harvey, with the use of posthypnotic suggestion. Often I will suggest to a patient, "Go home today and let your unconscious mind think over all the things that have been said, all the things that have been thought." I can think of one patient in particular who was making a psychoneurotic out of herself by going out into the sunlight and developing an extremely severe rash on her arms, neck, face. Then she would claw at the rash all night long until her arms and face and neck were horrible sights to look upon. She came to me because every dermatologist and doctor she had consulted had said that it was jut pure cussedness on her part. She stated very definitely that she also expected me to tell her that it was pure cussedness on her part. So I told her it wasn't necessary for me to tell her that because she had already told me, and I would take her word for it—but I was still entitled to believe my own thoughts on the matter. Thus, I accepted what she said to me, but at the same time I gave tremendous reservations. I was still entitled to believe my own thoughts, and she could believe her own thoughts.

My suggestion to her was rather simple—namely, that she ought to enjoy as much of the sunlight as she wished, that she really ought to enjoy the sunlight as much as she wanted to. I told her to go home (the patient was in a medium trance) and lie down for an hour or two and let her unconscious mind think over what that meant. She said that she didn't need to, that she consciously remembered what I had said. After she had gone home, after she had proceeded to sit down and rest for an hour, her reaction was to get up and go out into the garden. But she was also motivated to put on a very wide-brimmed hat and long sleeves. Now she found it very enjoyable out in her yard, and she worked in her flower garden.

In the past she had been told, sensibly enough, to avoid the sunlight, to keep out of the sunlight, to shade herself, to protect herself from the sunlight. I, on the other hand, told her to enjoy it. Now, what does enjoyment of the sunlight mean? It means putting yourself in a situation where you do not have to fight against it, do not have to protect yourself, but can really enjoy it. She did like her flowers very much, and they were out in the sun, and therefore she was able to enjoy the sunlight. Do you see the implications of my suggestion to her? I did not tell her to avoid the sunlight, I did not tell her to protect herself, I told her to enjoy it. And her enjoyment of the sunlight would include enjoying herself post-sunlight, enjoying herself during her sleep, enjoying herself the next day. All I needed to do was to give her the motivation to enjoy the sunlight. Since she was a rather hostile and antagonistic person, my suggestion did not leave her with anything to fight against. Her rash cleared up very promptly, at which point she protested that I charged too high a fee. And I told her, "Yes, my fee was high, but your enjoyment was much higher, and why not pay me my fee for the little that I have done." She sent me a total of 10 other patients, even though she protested my high fee. I had accepted her protests, and accepted them on the grounds that were acceptable to her. In other words, you try to accept the patient's ideas no matter what they are, and then you can try to direct *[sic*—we now prefer *utilize]* them.

Use of Regression and Amnesia: Gaining Control over Traumatic Experiences, Memory, and Repression

Regarding this matter of regression, I like to initially regress my psychiatric patients to something pleasant, something agreeable. I admit that we are wasting time because we are there to correct the unpleasant things, not the pleasant things. But in the trance state I impress upon them that it is tremendously important to realize that there are some good things in their past, and those good things form the background by which to judge the severity of the present. And so I use the happy memories of their past to train them to recover fully and completely the various traumatic experiences. I have them recover the traumatic experiences completely, then I repress them, then have them recover the memories again, and repress them again for the patient.

[The dynamics underlying this technique are the following.] A patient comes to you with

forgotten, repressed memories. Once you get a hold of the memories and relate them to the patient, once you have the patient remember them, he can again use his repressive powers and forget those things. But if you yourself repress or create an amnesia for those memories, the patient is unwittingly turning over the control of those traumatic experiences to you. This means that you are at liberty to reproduce the memory, to cover it up again, to bring it forth again, to cover it up again, until your patient builds up enough strength to face any particular issue. Since hypnosis provides you easy access to, and control over, both the recovery and repression of material, the repressions of the patient are not likely to take over and control the situation.

Suggestion and the Centering of Resistance

The type of suggestions you give to a patient depends upon the attitude of that patient toward you and the therapeutic process. I have dealt experimentally and clinically with the negative, hostile patient and found various ways of meeting this particular brand of resistance. The patient can come into my office, intending to be totally contrary, absolutely resolved to try my patience, absolutely resolved not to go into a trance. I can recall the doctor who came to see me for therapy. He had called me long distance several times and written letters previous to our meeting, and from these contacts I knew I had an exceedingly antagonistic man on my hands. When he walked into my office, his shoulders were thrown back, his jaw jutted out, he sat down perfectly upright in the chair, and said, "Now, go ahead doctor and hypnotize me."

I told him I thought he had far too many resistances. And he said that he didn't care about his resistance—my job was to hypnotize him, not to make excuses. Would I please get going. I told him I would, and I proceeded to suggest that he go into a trance. The man had some knowledge of hypnosis, so I used the straightforward, domineering technique, knowing full well that it would be a total failure. I worked on him for about an hour, using the best domineering technique I knew, while he sat there smiling at me and resisting me very effectively. After I had built up his resistance in every possible way, I abruptly said, "Excuse me for a moment." (I had prepared for this, having heard him over the phone, having read his letters.)

I stepped out into the other room and came back with a young college girl—a psychology student and hypnotic subject of mine. I brought her into the room and said, "Elsa, I would like you to meet Dr. X. Dr. X came here to be hypnotized. Elsa, would you please go into a deep trance right now." She went into a deep trance, and I demonstrated a few hypnotic phenomena on her. Then I told her to sit down and put the doctor in a trance and to call me just as soon as she had the doctor in a trance. With that, I totally walked out of the room. Fifteen minutes later, Elsa came to the door and called me back into the office.

What had I actually done? The doctor had his load of resistances, which I centered all on me so that when I walked out of the office, I carried out that whole load of resistance. Furthermore, how can you resist somebody who is in a trance, somebody who is merely responding to hypnotic suggestions? Of course Elsa used good hypnotic technique and was able to induce a very satisfactory trance. Very often I use this technique in training especially resistant patients or subjects to go into a trance. It is one thing to resist me, but how can you really resist someone who is in a trance, whose one and only purpose is to put you in a trance, not to make any other kind of allowances for you. It's very difficult to do that.

Indirectly Establishing Rapport with Resistant Subjects

I knew two doctors in Phoenix on whom you could work all night long without inducing trances in either of them. They are both excellent hypnotists and they were both very critical of me because I hadn't been able to put them in a trance. So one night I asked them to sit down facing each other, and I told them, "Doctor, you hypnotize Doctor, and Doctor, you hypnotize Doctor. And while you are hypnotizing each other, go into a trance yourself and really demonstrate to the other how deeply into a trance you want the other to go." They both

went very neatly, very deeply, into an hypnotic trance. But of course they went into the trance at my suggestion. After they had put each other into a deep trance, I took charge of the situation for both of them. That is one technique *[sic*—we now prefer *approach]* that I think all of you should try out sometime because it will teach you a great deal about establishing rapport. Neither of those doctors realized that my instructions would result in his being in rapport with me after he had put the other doctor in a trance. I quite often have my patients put into a deep trance by someone else, especially those patients who are utterly resistant and will not let the doctor do it. I usually try to get them to be as resistant toward me as possible, so that I can gather up all their resistances, leaving none for the person who is going to put them in a trance.

Resistance and the Surprise Technique

Another means by which I overcome strong resistance in my patients is the introduction of a surprise technique. Allow me to illustrate. One doctor had come 2,000 miles to have me put him in a trance. He walked into my office, laid a check in my desk, and said, "This is to compensate you for your time." I heard that word *time.* That check was to compensate me for my time. But he had come to be put in a trance by me. Now, obviously, the check was not to compensate me for putting him in a trance, but just to compensate me for my time. So I knew right then and there what he was going to do. And he did one of the most beautiful jobs of resisting me that I ever saw, although consciously he felt that he was cooperating. I spent two hours on the man, using every technique that I knew of to seduce *[sic*—we now prefer *facilitate]* him into hypnosis. But I failed absolutely, and finally I said, "Doctor, you've paid me for my time. And that is about all I've been able to give you. I'm awfully sorry I failed. But before you leave, I'd like to take you out into the other room and introduce you to my wife. She would like to meet you."

So we went out into the next room, and I called my wife and stated that Doctor Q was on his way home, that he had to leave immediately, but he thought he would like to meet you. Then I said, "I would like to shake hands before we leave, Doctor." He very graciously put out his hand and I lifted it slowly, induced a deep hypnotic trance, led him back into the office, and did the work that he wanted me to do.

Surely you do not hypnotize a man after you say goodbye to him! He had no defenses, no guard, no way of protecting himself. When I reached out to shake hands goodbye and slowly, gently, suggestibly lifted his arm, inducing catalepsy (see Section II for details of catalepsy and the handshake induction) all the other suggestions I had given him previously about going into a trance took effect. So I took him back into the office and spent a couple hours more with him, correcting some difficulties that had prevented him from using hypnosis for over 15 years. He had begun his practice using hypnosis but had run into a personal traumatic experience. Thereafter he could not induce hypnosis and was, in fact, terrified of it. But after I unexpectedly induced that trance in him, he returned to his practice and began using hypnosis extensively.

The Utilization Approach to Hypnotic Induction: Adapting Hypnotic Induction to the Patient's Behavior

In other words, one of the things I've mentioned is this matter of surprise technique. One always tries to use whatever the patient brings into the office. If they bring in resistance, be grateful for that resistance. Heap it up in whatever fashion they want you to—really pile it up. But never get disgusted with the amount of resistance. That doctor certainly had plenty of resistance unconsciously when for two hours I did everything I could to put him into a trance. And then when I took him out into the other room to introduce him to Mrs. Erickson, his resistances had been piled up and left in the office. One really ought to recognize that.

Now this may seem as if I'm using anthropomorphic thinking, but it's an easy way of conceptualizing these matters. *Whatever the patient presents to you in the office, you really ought to use.* If they prevent you from hypnotizing them by sighing or giggling or by shifting

around in the chair or by doing any number of things, *why not utilize it!*

One of my patients demanded that he be hypnotized by me, and I agreed to do so. He insisted on beating time with his foot—first his right foot, then his left foot, then his right hand, then his left hand. Next he would get up to stretch and then settle back down in the chair more comfortably. What I did in the matter of hypnotizing him was to note when he was about to shift from the right foot to the left foot; when it was too late for him to change, I would give him the suggestion that he shift from the right foot to the left foot. And then when he was shifting from the left hand to the right hand, I would note just when he was about to do that and then suggest that he use his right hand now, and then his left hand. When I saw he was about to stretch, I would suggest it was time to get up and stretch. What difference did it make to me whether I was inducing hand levitation, moving laterally, up or down—whether he wanted to beat time with his hands and feet and get up and stretch? If he wanted that type of behavior, let him have it. *But I really ought to be willing to use it.* If he wants to laugh at my technique, my suggestions, I encourage him to laugh, and gently suggest "that now here is another suggestion you will probably find very, very, funny. But then again I may be mistaken, and you may not find it funny at all. I really can't tell." And so I've covered all possibilities. He may find it funny, or he may not find it funny at all, but then I really don't know—he'll have to demonstrate to me whether it is funny or unfunny, but in doing so, he doesn't realize that he is obeying my suggestion that he demonstrate it is funny or unfunny.

Utilizing Ordinary Behavior and Resistance

You must observe ordinary behavior and be perfectly willing to use it. I have had patients come and spend their time cursing me because "you think that you are a such and such an hypnotist." And I tell them, "That's right, I *do* think I am such and such an hypnotist. And here are a couple of more words that you could have added to make it a much more emphatic statement." So, I can suggest even stronger words, and they can accept my suggestions, and the first thing they know they are accepting other words, other suggestions from me. In that way I can meet them easily on their own level. [They do not resist my suggestions because the suggestions accept, amplify, and utilize their resistance.]

Too often there is a tendency for the operator to think that he must correct the immediate behavior of the patient. One must not have that attitude. One takes the attitude that the patient is there to benefit *eventually*—perhaps in a day, a week, a month, six months, but within some reasonable period—*not* in the immediate moment. This tendency to correct the immediate behavior must be avoided because the patient really needs to show you that particular behavior.

Utilizing Silence: Facilitating Unconscious Process Via the Conscious-Unconscious Double Bind

Then there are the patients who make urgent appointments with you over the phone and them come into the office and sit there very silently. You might be inclined to express your lack of understanding of this behavior. But I tell them that no matter how silent they are, their unconscious mind is beginning to think, beginning to understand, that they themselves do not need to know consciously what is going on in their unconscious mind. What are you actually saying to them? *You are saying that their unconscious mind can now work, and work secretly, without the awareness of the conscious mind.* In this way you are making use of their conscious silence and letting them understand that they do not have to verbalize consciously at all. *Their mere presence within hearing distance of you allows their unconscious mind to work satisfactorily.* I see no reason why one should resent the patient sitting quietly for a whole hour. But it is a waste of time on your part if you don't use it for the patient. You don't need to say very much—simply tell the patient, "Let your unconscious mind work while your eyes roam around the office, while you note this book title and that book title, while you look at the carpet, while you ignore looking at me, while you attend to external noises." What happens? The patient's own unconscious mind begins to respond to your

suggestions, and you discover that the hour of conscious silence has been used to prepare the patient for experiencing an hypnotic trance in the future—perhaps even in the very next session.

Questions and Answers: Duration of Sessions

Q. How much time do you generally take for a session? For how much of the session do you prefer to have the patient in the hypnotic state? How much time do you like to spend with the patient out of the trance state for discussing consciously what took place under hypnosis?

A. I take the length of time necessary for the patient's needs. I use my judgment as to how much he can absorb. I've seen patients for as long as 16 consecutive hours. I had the patient hallucinate his meals, but during that time I went hungry! I've seen patients for 12 hours, for eight hours, preferably for four hours, and often for two or three hours, depending upon the patient's problem and the degree of urgency. Usually I like to see a patient for only one hour—the first part of the hour may be used for hypnosis and the last half-hour may be spent in discussion. Or, I may tell the patient in the trance state that this matter will come up for discussion at some future date and that he is to feel comfortable about it until such time. In other words, I use the hypnosis to govern the way in which things are presented to the patient. The patients that can learn and adjust rapidly I will see four, five, six, sometimes seven times a week. Other patients cannot integrate it any faster than once a week, and now and then I have worked with people who cannot tolerate the sessions any more frequently than once a month. Instead of having any set, routine pattern for my patients, I arrange a completely random schedule for them. I shift them from once a month to seven sessions per week, each a two-hour session. Or I might shift the patient from a four-hour session daily to once a week according to his capacity to digest psychotherapy.

Overcoming Effects of Previous Hypnotic Experiences

Q. How would you develop a rapport with an individual who has either been hypnotized previously or accidentally, and in both cases has no recall of the hypnotic experience? [How do you detect such an unconscious hypnotic state in the individual, and what techniques do you use to overcome possibly inhibitory suggestions from previous, amnesic hypnotic experiences?]

A. Very often a patient will go into an autohypnotic trance just to get away from you. The precatatonic and schizophrenic patients are especially excellent in this matter of going into an autohypnotic trance and literally defying you to touch them in any way psychologically. Occasionally you will encounter people who have been hypnotized previously and told that they must never, never, never be hypnotized again. And so you cannot succeed in hypnotizing them.

Recently at a seminar I conducted in Phoenix two of the dentists participating in the seminar brought in an excellent subject and told me that she was a newcomer and that they wanted me to train her to become a good hypnotic subject. But, unknown to me, they had carefully given her suggestions not to let me hypnotize her at all. As I was attempting to hypnotize her, I noticed one thing immediately—although she was very friendly, very cooperative, she overstressed everything she said to me: "I really don't believe you can hypnotize me, Doctor. I really *don't!"* And as I listened to those statements, I realized that they were not the simple statements of a person who truly didn't believe it possible to be hypnotized. Rather, I felt they were the statements of a person who was expressing a conviction too emphatically that was foreign or alien to her. So I asked her what members of the group she knew, and of course she promptly mentioned that she knew Meyer and Bill and several others. But Meyer and Bill were the first names she mentioned. I asked her how she felt she would respond to hypnotic suggestion given by Bill or by Meyer. She said that she might be able to respond more favorably to either of them. And I asked her if my technique in any way resembled Bill's or Meyer's. She said that their technique resembled

mine since I had taught them. Do you see what is happening to her already? Then I suggested that if Bill said that now your arms are getting heavy, would they get heavy? And if Meyer said that they were getting heavier and heavier, would they be getting heavier? And of course they began getting heavier. And all I did was to recognize that there must have been a previous hypnotic situation operating within her. I speculated as to who was guilty and then tried to identify myself with them in her mind. In this case, it had been Meyer and Bill who had given her the previous suggestions.

On another occasion a subject voluntarily stated, "I've been hypnotized before, and it's been tried by many doctors since, but I've always failed to go into hypnosis." I asked who the hypnotizers were, and how long ago did the hypnosis occur. "It was a stage hypnotist, and he told me never again to be hypnotized, and so while I've wanted hypnosis, I've always failed to go into a trance."

It happened five to seven years ago, in Chicago. Then I asked her a barrage of questions: "Do you remember the name of the theater? How many people were up on the stage with you? See how many of them you can remember. What are the other circumstances you can remember? Did you go there with friends? Did you leave with friends? Did you dine afterward? Did you have a drink? What happened when the stage hypnotist approached you? Did he tell you to close your eyes and get sleepy? Did he tell you to feel very sleepy? Did he have a voice like mine, or was he more commanding and domineering? Did he tell you to go to sleep now? Did he tell you to get your arms rigid?" In this way I am trying to evoke in her memory all the forgotten details surrounding the hypnotic experience and to identify myself with the stage hypnotist at the time.

Occasionally you will encounter patients who have been hypnotized by one of your colleagues who has told these patients not to let any other doctor hypnotize them. Very sympathetically and interestedly, inquire into the details of that situation. As they begin recalling the details, they begin to develop the trance behavior of that situation. And as they develop the trance behavior, they will then go into a trance, and at that point you put in the suggestions: "Yes, you were told not to go into a trance then, just as I am telling you now not to go into a trance again in the future. Just as I am telling you now not to go into a trance *again* in the future." But before they can accept that suggestion of not going into a trance again in the future, they have to go into a trance right there in order to accept the suggestion. Their past training has been to accept it. They have been abiding by that sort of suggestion for perhaps five years.

They will gradually go into a trance to accept a reinforcement of that suggestion, but after you've gotten them in a trance state, right then and there you can qualify that original instruction: "Never again will you go into a trance for silly purposes. Never again in the future will you go into a trance for a useless, worthless, uninformative purpose." [By evoking memories of the previous hypnotic experience, you evoke the conditions of another hypnotic experience. By accepting and utilizing the admonition *not* to let any other doctor hypnotize them, you in fact re-create the original experience, thus making it possible for hypnosis to occur again.]

This is something all of you ought to practice in cooperation with one another. Get a good, intelligent, normal subject. One of you put that subject in a deep trance and tell that subject *not* to let so-and-so put him in a trance. Then let so-and-so work out in his own mind the verbalization to correct that suggestion. You use the same technique in the matter of psychotherapy. A patient tells you, "For the last ten years I haven't been able to sit down at the table without first getting up and washing the silverware and the plates at least seven times." One of the first things I want to know about that is *how* did that person sit down at the table previous to the time of the problem, more than seven years ago. And if I can get him to demonstrate, I do so. The patient never recognizes that I am putting him in a trance and regressing him to a period of seven years ago.

I've had subjects tell me that they didn't think they could go into a trance for me. So I try to put them in a trance and let them demonstrate that they can't go into a trance. In that way, I've met their needs. Then I begin reminiscing with them about the time they used to go into a trance, and they promptly go into a trance [evoking past memories of trance tends to

reinduce another trance]. Then I point out to them in the trance state how I have tricked them, how I have manipulated them, and I offer to give them a posthypnotic suggestion never to go into a trance for me again. Or, I suggest that they might want to understand why they had a trance experience despite their expectation *not* to have one. In that way, you can meet their resistance to you and at the same time undermine that resistance while achieving a great deal in the way of psychotherapy. The one thing in the use of hypnosis is this: You really ought to know more about it than your patients do. You ought to know it so thoroughly that no matter what develops in the situation, you can think of something, you can devise something, that will meet your patient's needs.

Utilizing Sleep or Spontaneous Trance

[Someone from the audience notices that a woman named Mary is asleep. He shouts this out to Erickson, who then addresses Mary.] Did you want to speak to me, Mary? Are you asleep or awake, Mary? Whichever way you are, Mary, listen to me. I want you to continue sleeping if that is your wish. I want you to wake up if that is your wish. I want you to enjoy listening to me. I want you to enjoy hearing what I have to say. I want you to remember and give Glen whatever advice and counsel he needs. And I want you to remember things that he is likely to forget. And don't let anybody annoy you. Give them a merry push-aside whenever they try to intrude on you.

Hypnotizing an Entire Audience

Q. I made mention in one of your previous seminars that it might be better to hypnotize the entire group when these lectures are given. In fact, I am wondering if I am hypnotized now. My arm is beginning to feel funny!

A. That's right, doctor, you've always gone into a trance whenever I've been lecturing. Now keep your seat and your chair and hold it comfortably. And let your back and your shoulders be comfortable but sufficiently rigid. You have been listening to my lecture in a trance, and you will undoubtedly remember it all the better. There are some other members of the audience that have been doing some very nice hypnotic sleeping.

Duration of Posthypnotic Suggestion

Q. On the average, how long does a posthypnotic suggestion last?

A. It depends upon the posthypnotic suggestion. In the early 1930s I was doing some experimental work with a woman who had a Ph.D. in psychology. When it came time for Harriet to leave for some other part of the U.S., I asked her if we could investigate this matter of the persistence of posthypnotic suggestion. She thought it was a good idea. So I explained that I didn't know when we would meet again: "It may be next year, it may be five years, it may be 10 years, or 15, or 20 or 25. But this is the posthypnotic suggestion that I would like to give you. When we meet again, if the situation and the setting is suitable after greeting me, fall into a deep hypnotic sleep."

Fifteen years later I was attending the American Psychology Association meeting. I was in the company of Gregory Bateson, the anthropologist. We went into a restaurant for lunch and looked around for a booth that we could sit in while eating and conversing. He found only one booth available, but there was a woman sitting in it. He asked her if we could join her. I was in the front of the restaurant and not visible to her yet. She agreed, so he came down to the counter and picked up my tray and his tray and took them up to that booth.

As I entered the booth, I saw that the woman was Harriet, whom I hadn't seen for 15 years. Harriet looked at me, then looked at the man. I introduced her to Gregory Bateson. She recognized the name, acknowledged the introduction, and then went into a deep trance. The situation, the setting, was suitable. The stranger with me was obviously a friend of mine, he was obviously a student, she knew his name, knew that he had published in the field of anthropology, and therefore should be scientifically interested in hypnosis. There were only

three of us in the booth, and therefore Harriet went into a trance to the astonishment of Gregory Bateson. I asked Harriet how everything was going, how her work was, and then I had her awaken, at which point she thought I had just completed the introduction to Bateson. She didn't know that she had been in a trance. Clearly, the posthypnotic suggestion had endured for 15 years! And I am certain that if I meet her again after not seeing her for quite some time, and the situation is suitable, she will go into a trance.

I've done this with quite a number of my patients that I haven't seen for years. Upon meeting them, they will readily go into a trance again, will readily carry out some posthypnotic suggestion. Usually I give to my patients some little thing to carry along in life, a good feeling, toward me and toward themselves. I can think of one patient I had in Baltimore as an example. I certainly would not think of seeing that patient without a very bright purple tie at least. That patient first came to me because of morbid fear of the color red. Our work together helped to give her a very comfortable feeling about color, so that whenever there is a chance I might meet that patient, I'll put on one of my brightest purple ties. My action shows that I have a good feeling toward color, and my patient has a good feeling toward color. That is a posthypnotic suggestion that I hope stays with her for life.

Why Are Audience Members Hypnotized?!

Q. If you have given no direct verbalizations for induction to the audience, why is it that certain individuals in the audience are showing hypnotic behavior? Have these individuals worked with you before and are therefore more inclined to respond to you?

A. As far as I know, several of the people who went into a trance are strangers to me. To my knowledge, I haven't seen them before—although some of them may have been in the audience last Sunday when I last presented a lecture.

Q. What is the explanation for the trance induction?

A. The trance induction is this: I spoke to you at the beginning about the unconscious mind and the conscious mind. Their unconscious mind was listening, and they were unconsciously interested in trying to understand my ideas. Haven't you seen the parent who is very eager for the baby to chew solid food go through a chewing motion? Every time the parent wants the baby to open its mouth, the parent opens his mouth, hoping the baby will imitate the action. I have often found that people, when attending a lecture on hypnosis, will go into a trance in order to listen better, to hear better, to understand better. Dr. Rogers here always goes into a trance, and she remembers much more of the material that way—because she is listening with utter intensity. When you listen to a radio program of music, for instance, if you want to single out the instruments, you don't look at a bright light or thumb through a book. You close your eyes, you unconsciously turn your dominant ear toward the music, and you very carefully shut out visible stimuli. If you are holding a cold glass in your hand, you put it down so that the coldness does not divert your attention away from the music. You are not necessarily aware of performing these actions because your unconscious mind has directed their performance. It knows how you can best hear the music. Similarly, in a lecture on hypnosis, people will close their conscious mind so that they can listen better with their unconscious mind.

Q. Will the people present in the audience who are now in a trance state take personally your descriptions of all these posthypnotic phenomena?

A. They are very aware of the fact that this is a lecture, that it is not personally directed to them, and that all that is directed to them is the general understanding of the lecture.

Indirect Suggestion Facilitating Unconscious Processes

I might say something about indirect suggestion. I'm going to give indirect suggestion to somebody in this audience right now—someone I looked at, eye to eye, just a little while ago, and who is aware of it. In that person's mind the identification has been made. And what are the indirect suggestions? *There are a lot of things that you want to accomplish. Your unconscious mind can work on them. And really work on them.* [E's voice has softened and

his speech has slowed considerably here.] *Work on them at its convenience and work very hard. [Pause] And three months from now, six months, nine months from now a great deal can be accomplished. Your unconscious mind can really work on those matters. [Pause] Really work on them. There are a number of them, [Pause] and you can really work on them, and that applies to everybody in the audience. There are a lot of things that you can do, there are a lot of things that your unconscious minds are interested in. And you can really work on them in the next few months, the next six months, the next nine months, the next twelve months, a tremendous amount can be accomplished. And I hope all of you take a tremendous unconscious pleasure in letting your unconscious mind work for you. And I think I'll call it an afternoon, so rouse up everybody, wider and wider awake.*

B. UTILIZATION APPROACHES TO INDIRECT COMMUNICATION

While the previous lecture began as a straightforward presentation of some of the important dynamics in hypnotic induction and hypnotherapy, by the end it becomes apparent that it is also a demonstration in group hypnosis: Those members of the audience who choose to do so can let themselves go into trance, the better to receive the material. This is the reason we suggested that the reader might obtain important values by listening to the cassette recording before reading the written material.

There are several frames of reference that could be used to conceptualize this approach to group hypnosis or the hypnotic facilitation of learning. From the frame of classical theory in the history of hypnosis, the senior author uses the format of a lecture to evoke a series of important *ideodynamic processes* within the audience. That is, the presentation of ideas on an apparently intellectual level actually evokes psychodynamic processes that alter the listener's psychological state: This is the essence of the utilization approach to indirect communication; talking about food can make us actually hungry; a discussion of the dynamics of hypnosis with interesting case histories can evoke an actual experience of hypnosis in the listener. Many of the senior author's statements in this lecture-demonstration had ideodynamic implications that could evoke the following within the audience: (1) interest, motivation, and expectancy; (2) learning sets; and (3) patterns of inner search and autonomous unconscious processes that could facilitate the experience of trance and the enhancement of the listener's own professional skill over a period of time. A number of these statements with such ideodynamic implications were placed in italics.

It is by now a truism to say that most words, gestures, and statements can have multiple levels of meaning. The senior author's naturalistic approach to indirect communication is one of the first that seeks to utilize these multiple levels in a systematic manner, however. He maintains that he is simply following nature's way in this (Erickson, 1958). To believe that the mind processes information in a linear, one-track, single-cause-and-effect manner is an illusion, perhaps perpetuated by our widespread reliance on technical devices such as linear type and printing, the digital computer, and the use of logical argument that proceeds systematically from premises to conclusion. But these are only tools, artifices. Nature does not work that way. Nature is economical in adapting and utilizing its already existing forms for new evolutionary purposes. In an analogous manner, Erickson helps people break out of their learned limitations so they can then reframe their life experience from a broader perspective. He believes that our current-day emphasis on expanding awareness and heightening consciousness is essentially this process of breaking out of our limiting preconceptions to a broader understanding of our human possibilities.

The application of modern linguistic and communication theory to the process of therapeutic communication emphasizes the view that multiple levels of meaning (metalevels) can structure any statement in many ways (Rossi, 1973a, 1973b, 1973c; Erickson & Rossi, 1974, 1976, 1979; Erickson, Rossi, & Rossi, 1976; Watzlawick, Weakland, & Fisch, 1974; Bandler & Grinder, 1975; Grinder, Delozier, & Bandler, 1977). Neuro-psychological studies suggest that the left and right hemispheres of the brain have different styles of handling information, and thus any communication can be processed in more than one way (Rossi,

1977; Watzlawick, 1978; Erickson & Rossi, 1979; Shulik, 1979). The common denominator of all these approaches is that human relations involve vastly more than the simple exchange of objective information on one level. Every word, phrase, pause, sentence, voice inflection, and gesture we use can have multiple meanings and neuropsychological effects. The study of indirect communication involves the investigation of all these multiple meanings and neuropsychological processes that take place automatically, in an involuntary manner, below our usual level of awareness.

From his earliest childhood, Erickson developed an unusually high degree of awareness of how everyday conversation can proceed on many levels of meaning (Erickson & Rossi, 1977). That is, he developed a sensitivity to implication and the unconscious aspects of communication. In what follows we will first present a few recent conversations wherein he indicates how he developed this sensitivity, then outline how it was used in the foregoing Ocean Monarch Lecture.

1. Language and the Art of Suggestion

E: The art of suggestion depends upon the use of words and the varied meanings of words. I've spent a great deal of time reading dictionaries. When you read the various definitions that the same word can have, it changes entirely your conception of that word and how language may be used. You can *run fast* or hold *fast*. And then some women are *fast.* Take the word *change.* A *change* of mind is very different from *change* in your pocket or a *change* or horses. And when you *change* horses in the middle of a river, that is a different kind of change. When you *change* clothes, that is another different thing entirely. You are not *changing* the clothes, you are *changing* what you are wearing. And on and on it goes. There are so many words with multiple uses! When you begin to recognize them, you can then know the difference between *really* and ***really*** (spoken with a deeper and more emphatic intonation). *Really* for ***real*** means something certain to a small child.

R: So much of the art and science of suggestion is in knowing and correctly utilizing these multiple meanings of words, as well as the vocal emphasis and dynamics with which they are spoken.

2. Multiple Levels of Communication in Hypnosis

E: From my childhood on, I practiced talking on two or three levels. I could be talking to some playmates, and one playmate thought I was talking about the dog, another thought I was talking about a kite, and another thought I was talking about a football.

R: You were always dabbling in multiple levels of communication?

E: That's right; now it becomes automatic when I do hypnotic work. Therapeutic trance enables patients to receive multiple levels of communication more easily.

R: Can you provide any general principles of how this works? How would you set up multiple levels of communication?

E: You have to know enough about the other person, especially their interests.

R: You use words that have connotations, associations, and patterns of meaning that have multiple applications for the person's interests and individuality. Is that the basic principle you use in your indirect approach to hypnotic communication?

E: Yes.

3. Internal Responses as the Essence of Suggestion

Erickson's meaningful use of vocal dynamics is demonstrated by the following commentary on his use of pauses. This example provides clear evidence of his view that *the*

essence of suggestion is in the patient's internal responses to stimuli offered by the therapist. These internal responses are the indirect aspects of hypnotic communication.

E: I'll sometimes begin a hypnotic induction by saying,
I don't know

> This is a negation whereby I pick up their resistance and utilize it for constructive purposes.

[Pause]

> The pause implies, "What have you not told me that's important for the problem at hand?"

when

> *When* then means by implication that an event (trance) will take place.

you'll go into a deep trance.

> This is a direct suggestion that does not seem like one, since it is buried in a broader context of "I don't know."

R: You make a lot of statements to patients that evoke certain *natural associative responses* within them. It is these responses *within them* that are the essence of hypnotic suggestion.

E: That is the hypnotic stuff, yes!

R: So this is an indirect or utilization approach to effecting hypnosis: You provide verbal stimuli that will by association evoke the hypnotic responses within the patients. You facilitate the patients' saying the suggestion to themselves.

E: *Yes, cause them to say it to themselves!*

R: Could we develop a hypnotic dictionary—words and phrases that you know will evoke certain predictable responses (the actual hypnotic suggestion) in the subject? We need not even talk about hypnosis at all; we just give certain verbal stimuli and gestures that will evoke in the patient certain responses that are of a hypnotic nature.

E: Such an hypnotic dictionary would probably have only limited application because you must attune your vocabulary to the individuality of each listener. [Erickson tells an anecdote of how his wife had to hide the Easter eggs for one of their children because this child did not readily understand her reasoning. If Erickson hid the eggs, the child found them quickly because he understood the way his father's mind worked. The child would ask at the beginning of the hunt, "Are they hidden the way Daddy does or the way Mommy does?" This anecdote reveals how even a child can become intimately attuned to the behaviors and by implication the internal associations of the different people about him. It is just this sensitivity that hypnotherapists need in their work.]

4. Indirect Communication in the Ocean Monarch Lecture

We will now outline a few of the approaches to indirect communication that the senior author discussed in the Ocean Monarch Lecture while at the same time he evoked them within some members of the audience. That is, while the audience initially expected to hear a lecture about hypnosis in psychiatry, some members of the audience actually experienced hypnosis. An apparently objective lecture about the naturalistic and utilization approaches to communication actually gave rise in an indirect manner to hypnotic experiences within responsive people in the audience.

Implication and the Negative

Erickson's very first statement, "I do *not necessarily* intend to demonstrate hypnosis to

you today ..." contains the implications of its opposite—as do all communications containing negatives, disclaimers, or limiting qualifications. Politicians know this well: They will introduce unpopular measures or their own candidacy to the public by first proclaiming that they would never support such-and-such a measure, or they are definitely not a candidate at this time. The listener's conscious mind may accept these denials at face value. Simultaneously with this surface acceptance, however, most listeners will also explore and process on an unconscious or metalevel the opposite of any denial and the implications of even the most trivial remarks. When these automatic inner explorations are at great variance with the surface message, the listener will be flooded with conflict that must be resolved via his or her own particular patterns of psychodynamics. The history of the investigation of psychopathology from Freud (Breuer & Freud, 1895/1957) to Bateson (1972, 1979) is the record of our efforts to understand these psycho-dynamics.

The Conscious and Unconscious Double Bind

In the first paragraph of the Ocean Monarch Lecture Erickson introduces a form of the double bind: "When I am talking to a person at the conscious level, I expect him to be listening to me at an unconscious level, as well as consciously." Few in the audience will recognize this as a subtle form of the conscious-unconscious double bind, which we have discussed in detail previously (Erickson & Rossi, 1975,1979). Many in the audience who are listening to Erickson carefully "at the conscious level" will now, without quite realizing it, also be listening and receiving ideodynamic suggestions "at an unconscious level." Certainly not all listeners will be receptive to this indirect communication. It is primarily those members of the audience who have a heightened expectancy and favorable rapport with Erickson who will be most likely to receive and utilize his words on a personal level.

Matters are not quite this simple, however, for some in the audience will not be disposed to the lecturer and will not have a positive expectancy and motivation at the conscious level. However, even some people with such conscious resistance will receive and utilize some of the indirect communication being offered. Evidently something within them on an unconscious level can recognize and accept the value of what's being offered in spite of the limitations of their conscious attitudes.

Catalepsy to Heighten Responsiveness

In the next sections on methods of learning suggestion and catalepsy to heighten responsiveness, Erickson provides a number of ideodynamic suggestions to the audience while discussing one of his major innovations in trance induction and hypnotherapy. Catalepsy is not just an interesting hypnotic phenomenon; it can be utilized to heighten a patient's sensitivity and responsiveness when it is induced in a very gentle manner. In hearing about "increased responsiveness," many members of the audience will respond with increased responsiveness in the here-and-now situation of listening to Erickson "offering them the opportunity of responding to an idea."

The audience members next hear that they can "feel free to respond to whatever degree they wish," but they can "withhold whatever [they] wish" so that "they also begin to develop a certain sense of confidence."

We could go on for many pages, analyzing phrases within each topic of this lecture for their possible communication value for members of the audience as well as the patients Erickson is ostensibly talking about. Our readers will by now probably prefer to do this for themselves as a valuable training exercise, however. Simply reviewing the successive topic headings on Rapport, Ambivalence, Integrating Conscious and Unconscious Learning, Dissociating Intellect and Emotion, and so on can provide the reader with sound understanding of Erickson's naturalistic approaches to communication and the wealth of ideodynamic associations members of the audience can pick up automatically to utilize in their own unique way. In the following sections of this volume we will explore further illustrations of the practical means of utilizing this indirect approach to facilitating hypnotic processes and the

experience of altered states in a manner that can bypass some of the learned limitations of so-called normal, everyday consciousness.

SECTION II

Catalepsy in Hypnotic Induction and Therapy

Catalepsy, the suspension of voluntary movement, is generally recognized as one of the most characteristic phenomena of trance and hypnosis. Because its significance and meaning have changed over the generations, we will begin this section with an overview of catalepsy in historical perspective. Since we regard all hypnotic phenomena as aspects or derivatives of normal behavior, we will then outline some of the spontaneous forms of catalepsy we can observe in everyday life. When these spontaneous catalepsies are seen in the consulting room, they become important cues regarding the patient's inner state and offer an important avenue for inducing therapeutic trance in the most natural manner. As we can infer from the previous section, a simple discussion of these everyday occurrences of catalepsy could be an excellent way of beginning an hypnotic induction, evoking ideodynamic aspects of catalepsy and trance before the patient even realizes it.

We will then present some of the senior author's approaches to facilitating catalepsy in a formal process of trance induction. Since it is essentially a nonverbal process, catalepsy becomes an unusually effective means of bypassing the learned limitations of many of our typically modern and overintellectualized patients, who want to experience therapeutic trance but have misunderstandings that interfere with its development. Catalepsy can then be used as a means of sensitizing a patient's receptivity to the nuances of inner and outer stimuli so he or she can more readily accept and carry out processes of therapeutic change.

While it may be interesting for professionals to receive these new conceptions of the utilization of catalepsy on an intellectual level, it can become truly effective therapeutically only when the hypnotherapist has developed a facility in coordinating the observational and performance skills in evoking catalepsy in a practical manner in the consulting room. Because of this, we end this discussion with a number of exercises to guide the practitioner's acquisition of these skills.

We will then provide an extended demonstration of the use of catalepsy by the senior author. This demonstration was recorded recently (1976), when the junior author had the opportunity of tape-recording the senior author's efforts to induce hypnosis in a blind subject by the hand-levitation approach. Erickson failed in this demonstration; that is, the subject responded in such a minimal manner that Erickson was challenged to use a vast repertory of his approaches. Because of this the demonstration is an excellent vehicle for studying his work.

An audio-visual record of Erickson's approaches to catalepsy that emphasize processes of dissociation is available for his demonstration with Ruth, which is presented in Section III under the title An Audio-Visual Demonstration of Ideomotor Movements and Catalepsy: The Reverse Set to Facilitate Hypnotic Induction. In the fourth section is another recent demonstration of catalepsy with particular reference to how it is experienced subjectively by a skeptical consciousness that is in the process of learning to experience altered states.

A. CATALEPSY IN HISTORICAL PERSPECTIVE

Historically, catalepsy was regarded as one of the earliest defining characteristics of trance. Esdaile (1850/1957) used mesmeric passes to achieve a state of catalepsy wherein patients were able to experience surgical anesthesia as follows:

> I usually proceed in the following manner, and am inclined to think that its comparative rarity in Europe is owing to the mesmeric influence not being at once sufficiently concentrated on the patient, by transmitting it to his brain from all the organs of the operator, and through every channel by which it can be communicated. With the necessary degree of patience, and sustained attention, the following process is so effectual in producing coma, that in a large enough field, and with properly instructed assistants, it may here be obtained daily, for the purpose of procuring insensibilities to surgical operations. No trial under an hour should be reckoned a fair one: two hours are better; and the most

perfect success will often follow frequent failures, but insensibility is sometimes induced in a few minutes.

Desire the patient to lie down, and compose himself to sleep, taking care, if you wish to operate, that he does not know your intention: this object may be gained by saying it is only a trial; for fear and expectation are destructive to the physical impression required. Bring the crown of the patient's head to the end of the bed, and seat yourself so as to be able to bring your face into contact with his, and extend your hands to the pit of the stomach, when it is wished; make the room dark, enjoin quiet, and then shutting your patient's eyes, begin to pass both your hands, in the shape of claws, slowly, within an inch of the surface, from the back of the head to the pit of the stomach; dwelling for several minutes over the eyes, nose, and mouth, and then passing down each side of the neck, go downwards to the pit of the stomach, keeping your hands suspended there for some time. Repeat this process steadily for a quarter of an hour, breathing gently on the head and eyes all the time. The longitudinal passes may then be advantageously terminated, by placing both hands gently, but firmly, on the pit of the stomach and sides;—the perspiration and saliva seem also to aid the effect on the system.

It is better not to test the patient's condition by speaking to him, but by gently trying if the cataleptic tendency exists in the arms. If the arms remain fixed in any position they are left in, and require some force to move them out of every new position, the process has been successful; the patient may soon after be called upon by name, and pricked, and if he does not awake, the operation may be proceeded with. It is impossible to say to what precise extent the insensibility will befriend us: the trance is sometimes completely broken by the knife, but it can occasionally be reproduced by continuing the process, and then the sleeper remembers nothing; he has only been disturbed by a night-mare, of which on waking he retains no recollection. (1957, pp. 144-145)

There are a number of observations in this passage that are noteworthy for our current understanding of trance and catalepsy. The first is that *time* itself is a very important consideration. Trance sufficient for surgical anesthesia required one or two hours of induction. Then as now, however, there was extreme variation in susceptibility to hypnotic experience; some patients required only a few minutes.

Another interesting observation is the importance of the element of surprise; fear and a knowledge of the doctor's intention "are destructive to the physical impression required." This sort of "surprise surgery" is certainly not in keeping with modern tastes, though we can understand how it may have been needed in Esdaile's day. It does indicate the importance of distraction and surprise as an important facilitator of hypnosis. What is an appropriate distraction and surprise can vary from one subject to another, however. It is a part of the art of the hypnotherapist to utilize appropriately constructed surprises suitable for the individuality of each subject.

The use of catalepsy as a test of the adequacy of the trance state was also characteristic of the Esdaile period. The operator's uncertainty about the patient's condition has always been a basic problem in studying hypnosis and in its practical utilization. The natural and spontaneous variations in trance "depth" made early hypnotic anesthesia an apparently unreliable phenomenon, so that "trance is sometimes completely broken by the knife." Fortunately, trance could be reinduced and the patient frequently had an amnesia for the entire process.

From this early description we gather that Esdaile believed there actually was some sort of a physical "mesmeric influence" transmitted to the patient from all the organs of the operator. In other passages Esdaile confirms this view by maintaining "that the imagination has nothing to do with the first physical impression made on the system by Mesmerism as practiced by me" (1957, p. 246). He believed "that water can be charged with the mesmeric fluid" and that the mesmeric influence could be transmitted through the air for considerable distances and even through dense metals (1957, p. 246).

Subsequent experimentation by other pioneers in hypnosis such as Braid (1855) established that trance required no fluids or magnets but was simply "a state of abstraction or concentration of attention." The italics in the following passage quoted from Braid (cited in Tinterow, 1970) are ours to emphasize Braid's clear articulation of this modern view of hypnosis.

It was in 1841 that I first undertook an experimental investigation for the purpose of determining the nature and cause of mesmeric phenomena. Hitherto it had been alleged that the mesmeric

condition arose from the transmission of some magnetic fluid, or occult influence, fluid, or force, projected from the body of the operator, impinging upon, and charging the body of the patient. However, I was very soon able to demonstrate the fallacy of this objective influence theory, by producing analogous phenomena simply by causing subjects to gaze with fixed attention for a few minutes at inanimate objects. It was thus clearly proved that it was a subjective influence, resulting from some peculiar change which the mind could produce upon the mental and physical functions, when constrained to exercise a prolonged act of fixed attention. I therefore adopted the term hypnotism, or nervous sleep, to characterize the phenomena producible by my processes. I became satisfied that *the hypnotic state was essentially a state of mental concentration, during which the faculties of the mind of the patient were so engrossed with a single idea or train of thought as, for the nonce, to render it dead or indifferent to all other considerations and influences.* The consequence of this concentrated attention, again, to the subject in hand, intensified, in a correspondingly greater degree, whatever influence the mind of the individual could produce upon his physical functions during the waking condition, when his attention was so much more diffused and distracted by other impressions. Moreover, inasmuch as words spoken, or various sensible impressions made on the body of an individual by a second party, act as suggestions of thought and action to the person impressed, so as to draw and fix his attention to one part or function of his body, and withdraw it from others, whatever influence such suggestions and impressions are capable of producing during the ordinary waking condition, should naturally be expected to act with correspondingly greater effect during the nervous sleep. when the attention is so much more concentrated, and the imagination, and faith, and expectant ideas in the mind of the patient are so much more intense than in the ordinary waking condition. Now, this is precisely what happens; and I am persuaded that this is the most philosophical mode of viewing this subject; and it renders the whole clear, simple, and intelligible to the apprehension of any unprejudiced person, who may at once perceive that *the real object and tendency of the various processes for inducing the state of hypnotism or mesmerism is obviously to induce a state of abstraction or concentration of attention—that is, a state of monoideism*—whether that may be by requesting the subject to look steadfastly at some unexciting, and empty inanimate thing, or ideal object, or inducing him to watch the fixed gaze of the operator's eyes, his pointed fingers, or the passes or other manoeuvres of the mesmerizer. (pp. 372-374)

While Braid had a clear insight into the psychological aspect of hypnosis, other investigators continued to search for its physiological basis.

In his early efforts to establish hypnosis as a somatic phenomenon Charcot (1882) outlined three progressive stages—the cataleptic state, the lethargic state, and the state of artificial somnambulism. He described the first as follows (cited in Weitzenhoffer, 1957):

The Cataleptic State—This may be produced: (a) primarily, under the influence of an intense and unsuspected noise, of a bright light presented to the gaze or, again, in some subjects, by the more or less prolonged fixing of the eyes on a given object; (b) consecutive to the lethargic state, when the eyes, which up to that moment had been closed, are exposed to the light by raising the eyelids. The subject thus rendered cataleptic is motionless and, as it were, *fascinated.* The eyes are open, the gaze is fixed, the eyelids do not quiver, the tears soon gather and flow down the cheeks. Often there is anesthesia of the conjunctiva, and even of the cornea. The limbs and all parts of the body may retain the position in which they are placed for a considerable period, even when the attitude is one which is difficult to maintain. The limbs appear to be extremely light when raised or displaced, and there is no *flexibilitas cereas,* nor yet what is termed the stiffness of a clay figure. The tendon reflex disappears. Neuromuscular hyperexcitability is absent. There is complete insensibility to pain, but some senses retain their activity at any rate in part—the muscular sense, and those of sight and hearing. This continuance of sensorial activity often enables the experimenter to influence the cataleptic subject in various ways, and to develop in him by means of suggestion automatic impulses, and also to produce hallucinations. When this is the case, the fixed attitudes artifically impressed on the limbs, or, in a more general way, on different parts of the body, give place to more or less complex movements, perfectly coordinated and in agreement with the nature of the hallucinations and of the impulses which have been produced. If left to himself, the subject soon falls back into the state in which he was placed at the moment when he was influenced by the suggestion, (p. 283)

Charcot's use of the word *fascinated* to characterize the early stage of catalepsy is entirely in keeping with our modern view of catalepsy as a state of heightened sensitivity and receptivity. The problem with his overall description is that it does not give sufficient recognition to individual differences. Different subjects experience to varying degrees the associated phenomena of fixed gaze, tearing, anesthesia, lightness or stiffness of limbs, and

alterations of auditory and visual sensation and perceptions, etc. It is an important aspect of the therapist's skill to learn to recognize just what spontaneous alterations in functioning the subject is experiencing.

Many of Charcot's contemporaries were unable to reproduce his results, and thus believed that they were actually the result of suggestion or preeducation. Bernheim then gave a classical description of "suggestive catalepsy" as an early stage of hypnosis in his *Suggestive Therapeutics: A Treatise on the Nature and Uses of Hypnotism* (1886/1957) that could hardly be improved upon today:

> This degree is characterized by suggestive catalepsy. By this word the following phenomenon is meant. If, as soon as the patient falls asleep, the limbs being relaxed, I lift his arm, it stays up; if I lift his leg, it remains uplifted. The limbs passively retain the positions in which they are placed. We call this suggestive catalepsy, because it is easy to recognize that it is purely psychical, bound up in the passive condition of the patient, who automatically keeps the attitude given just as he keeps the idea received. In fact, in the same or in different patients, one sees the phenomenon more or less marked according to the depth of the hypnotic influence and the psychical receptivity. At first, this cataleptiform condition is hardly apparent. The lifted limb remains up a few seconds, but falls down afterward with a certain hesitancy; or the fore-arm only remains lifted. If one wishes to lift up the whole arm, it falls down again. The individual fingers do not keep positions into which they are put, but the entire hand and the forearm remain fixed.
>
> With some patients, for example, if one arm be quickly raised and let alone, it falls back again, but if it is held up for a few seconds to fix the idea of the attitude in the brain, so to speak, then it remains up.
>
> Finally, with others, catalepsy is only obtained through a formulated verbal suggestion. The person hypnotized has to be told, "Your arms remain up. Your legs are up." Then only do they remain so. Some keep the new position passively, if nothing is said to them, but if they are dared to change it they regain consciousness, so to speak, call upon their dull will power, and drop the limb. Then they often wake up. (1957, pp. 6-7)

A more modern view of catalepsy would emphasize that it is a function of an *actively accepting and receptive attitude* rather than a "passive condition" due to a "dull will power." The patient who quickly and easily responds to a guiding touch is actually in a cooperative and responsive mood. Patients who maintain their limbs in a fixed position after being given a nonverbal suggestion to do so (as when the therapist simply holds the limb in one position for a few seconds) are actually responding with exquisite sensitivity to the therapist's slightest directive. We may, therefore, expect that patients who quickly learn to maintain a catalepsy are experiencing a favorable attitude and acceptance set for further trance work. This may be the reason why Erickson developed so many ingenious approaches to catalepsy, not only in the selection of good subjects for demonstrations of hypnosis, but for the induction and deepening of trance as well.

B. RECOGNIZING SPONTANEOUS CATALEPSY

The senior author's concept of the "common everyday trance" is actually a form of catalepsy. We frequently describe these spontaneous catalepsies as a period of reverie, inattention, or quiet reflection. At such moments people tend to gaze off (to the right or left, depending upon which cerebral hemisphere is most dominant—Baken, 1969) and get that "faraway" or "blank" look. The eyes are usually fixed in focus, immobile, and they may actually close. The face tends to lose its animated expression and becomes lifeless, taking on a certain flat, "ironed-out" look. The entire body remains immobile in whatever position it happens to be in, and certain reflexes (e.g., swallowing, respiration) may slow down. Such individuals seem momentarily oblivious to their surroundings until they once again recover their general reality orientation (Shor, 1959). We have hypothesized that in everyday life consciousness is in a continual state of flux between the general reality orientation and the momentary micro-dynamics of trance (Erickson & Rossi, 1975).

Recent research on the 90-minute dream cycle during sleep indicates that this cycle is also present throughout the entire 24 hours of the day in what has been named the Ultradian Rhythm (Hiatt & Kripke, 1975). Fantasy intensity, alpha waves, eye movements, and hunger

are all related in this basic rest-and-activity cycle throughout the day. It may well be that what the senior author calls the "common everyday trance," wherein catalepsy tends to be manifest spontaneously, is actually coincident with the rest, high-alpha, and fantasy portion of the circadian cycle. If this is so, we may expect that future research will establish that, in general, trance induction and hypnotic experience will be experienced more readily during this rest period of the 90-minute Ultradian Rhythm.

It is noteworthy that the senior author likes to spread important hypnotherapeutic sessions over a period of a few hours. It may well be that at least a portion of his success in facilitating deep trance work is that he intuitively selects that rest period of the circadian cycle, when the patient is spontaneously manifesting tendencies to catalepsy, fantasy, and inner focus. We strongly recommend that experimental research be conducted to test the hypothesis that trance induction can proceed more easily—and more hypnotic phenomena be manifest—during this high-alpha and fantasy portion of the circadian cycle.

There is actually a vast array of diverse phenomena described as catalepsy in the literature of hypnosis (Weitzenhoffer, 1953). These phenomena include practically every form of human and animal immobility, whether brought on *by fascination* (an experience of the unusual or awesome), *startle* or *fright* (a sudden bright light or intense noise), or *fatigue* or *illness.* Many authors also describe various forms of "animal hypnosis" (more properly called "tonic immobility"), which appears to have survival value in nature. The opossum, for example, will "freeze" when trapped by a predator, who then gives up his prey as dead (Cheek & LeCron, 1968; Hallet & Pelle, 1967). Other investigators have demonstrated how to induce catalepsy in an animal through shock and fear by turning it over quickly and holding it immobile for a few moments (Volgyesi, 1968; Moore & Amstey, 1963). The similarity between animal and human tonic immobility when humans are exposed to deep-threat conditions has been described (Milechnin, 1962). It is the association between catalepsy and the deeper nonverbal levels of the personality that makes its use of such potential value in hypnotherapy.

For the purposes of modern hypnotherapy, Erickson's functional definition of *catalepsy as a form of well-balanced muscle tonicity* is probably broad enough to help us understand most of its applications. The following examples taken from everyday life extend our traditional understanding of what catalepsy is and prepare us for a more incisive understanding of its utilization in modern hypnotherapy.

A. When writing a letter, one pauses for a moment to think. During that moment one is oblivious to the pen in one's hand, which is maintained comfortably poised in an immobile, cataleptic position. In fact, the entire body is usually immobile in a cataleptic pose during that moment when consciousness is focused and receptive to one's inner thoughts.

B. When considering a question or problem, one will frequently glance to the left or right and usually a bit upward with eyes fixed in what we can regard as a comfortable cataleptic position. Again, this is a moment of special sensitivity and receptivity to one's inner processes.

C. When absorbed in a book, lecture, or movie, one's entire body will remain immobile, cataleptic, for long periods of time. One's arm may even be nudged to a new position by a seatmate without our realizing it. The arm may then remain comfortably fixed in its new position. With our attention focused on the interesting movie, we pay no attention to the irrelevant stimuli related to our body position. Intense interest and receptivity to certain stimuli are apparently compensated by a corresponding cataleptic insensitivity to other stimuli.

D. At an athletic event an entire crowd will frequently lean forward and remain momentarily suspended in a fairly awkward cataleptic position. This moment of cataleptic suspension, of course, is precisely the moment when a critical event of absorbing interest is being played.

E. Address an absorbing question to one engaged in a motor activity like writing, painting, tying a shoelace, mixing a cake, sawing a board, or whatever, and the person frequently stops activity in mid-stroke to remain cataleptic in that fixed position for a moment while considering an answer. The question actually suspended external muscle activity so

that an answer could be received through an inner focus of attention.

F. Erickson likes to point out how an Eskimo will sit immobile in a comfortable cataleptic pose for 24 hours or more beside a hole in the ice waiting for a seal to appear. Like hunters in many societies, he can instantly respond to the appropriate stimulus even though he seems completely oblivious to all the irrelevant environmental stimuli.

G. In most critically important or emergency situations of everyday life people tend to "freeze" with *fascination* and remain cataleptically immobile as *they focus* their entire attention to *receive* and understand the important event. Thus someone must finally shout, "Don't just stand there, call a doctor!"

In all these examples there tends to be a gap in the subjects' awareness as they wait expectantly for an appropriate response from within themselves or from the outside. At such moments, when they are cataleptically posed in immobile suspension, they are open and receptive to appropriate stimuli. *At such moments an appropriate suggestion can be received and acted upon in a seemingly automatic manner. This momentary gap in awareness is essentially a momentary trance. The heightened receptivity during that moment is essentially what we mean by the term* hypnotic.

An association between catalepsy, or body immobility, and heightened receptivity to important stimuli was characteristic of all our examples. It is also apparent in the teacher's perpetual injunction for students to "sit still and pay attention!" Recent research (Dement, 1978; Goleman & Davidson, 1979) has established that this immobility of the body is likewise associated with the heightened periods of intense inner mental activity during dreaming. During REM (Rapid Eye Movement, which occurs during those stages of sleep when dreaming takes place) sleep most physiological variables (e.g., EEG, respiration, pulse, penile erection, eye movements, etc.) indicate a state of heightened arousal. Only the correlates of muscle tension are depressed, indicating an immobility of the muscles. The frequent analogy drawn between trance and dreams, wherein mental activity seems to proceed effortlessly and autonomously while the body remains apparently inert (cataleptic), thus has some empirical confirmation. Just as dreaming may indicate a state of heightened vigilance during sleep, so is catalepsy a state of heightened expectancy while awake.

C. FACILITATING CATALEPSY

Catalepsy is facilitated by any procedure that (1) arrests attention and (2) leads to progressive body immobility with (3) an inner attitude of inquiry, receptivity, and expectancy of further directing stimuli from the therapist. The receptivity that allows a part of the body to become immobilized reflects a corresponding mental receptivity to the therapist's further suggestions. Catalepsy thus becomes a major means for facilitating and gauging a patient's state of mental receptivity for appropriate stimuli.

This can be illustrated even with a subject who cannot or will not experience catalepsy by the typical approach of guiding an arm upward.

Catalepsy can usually be achieved indirectly by handing the subject an article such as a book and then withdrawing it with a distracting remark when the subject reaches to take it. The subject's arm will remain momentarily suspended in a cataleptic position, as if still awaiting the book. During that precise moment, when arm and hand are suspended, the patient's mind is also suspended and open; this momentary gap in awareness can be filled by any appropriate suggestion offered by the therapist at that precise moment.

This openness is well illustrated in Erickson's description of a dental colleague's casual utilization of catalepsy to facilitate his patient's receptivity to suggestions for relaxation. (direct quotations of the senior author that are not otherwise cited are from his workshops, seminars, and audio recordings with the junior author; the quotations span two decades of work from the 1950s through the 1970s)

"He doesn't attempt to relax them directly. He doesn't attempt a coaching technique. He asks the patient to sit down in a chair. He asks the patient if he, the dentist, can take a hold of the patient's wrist and very carefully lay it on the arm of the chair. In so doing he moves the patient's hand up and down while addressing some simple, casual remark to the patient.

What he is really doing is asking the patient's permission to manipulate the arm. Then he proceeds to manipulate the arm up and down a bit. The patient cannot see any particular purpose in it. As the patient wonders and speculates about it, he is literally wide open for the presentation of an idea.

"In hypnosis what you want your patient to do is to respond to an idea. It is your task, your responsibility, to learn how to address the patient, how to speak to the patient, how to secure his attention, and how to leave him wide open to the acceptance of an idea that fits into the situation. When the dentist takes hold of the wrist and then starts moving the hand slowly up and down, the patient can wonder, 'Is he testing me for relaxation? Is he trying to fit my hand over the end of the arm of the chair? What does he want my hand to do?' With the patient fixated in that sort of receptive wondering, the dentist can effectively suggest to the patient, 'and just continue relaxing more and more.' That technique lasts about 10 to 30 seconds. The patient in that moment of inquiry— 'What does he want my hand to do?'—is completely ready to accept whatever idea is presented to him. Now all of you have seen me take hold of a volunteer's wrist, lift the arm, and suggest that they go into deep trance. That is exactly the same sort of technique as the dentist uses. I do it in front of a group because I want to demonstrate hypnosis as a deep phenomenon rather rapidly. I am willing to attract attention and then allow the patients to be in mental doubt as to what they should think and do in that particular situation. This makes the patients amenable to any suggestion that fits that immediate situation.

"Hypnosis doesn't come from mere repetition. It comes from facilitating your patient's ability to accept an idea and to respond to that idea. It doesn't have to be a wealth of ideas—it can be one single idea presented at the opportune moment so that the patient can give full attention to that particular thing. In dealing with patients, your entire purpose is to secure their attention, secure their cooperation, and to make certain that they respond as well as they can."

Erickson's actual technique of guiding a patient's arm and hand to a cataleptic pose is an art in itself. In his paper on pantomime techniques in hypnosis (Erickson, 1964b) he describes how he induced trance nonverbally:

"I showed the girl my hands, which were empty, and then I reached over with my right hand and gently encircled her right wrist with my fingers, barely touching it except in an irregular, uncertain, changing pattern of tactile stimulation with my fingertips. The result was to attract her full attention, expectant, wondering interest in what I was doing. With my right thumb, I made slight tactile pressure on the latero-volar-ulnar aspect of her wrist, as if to turn it upward; at the same moment, at the area of the radial prominence, I made a slightly downward tactile pressure at the dorso-lateral aspect of her wrist with my third finger; also at the same time, I made various gentle touches with my other fingers somewhat comparable in intensity but nonsuggestive of direction. She made an automatic response to the directive touches without differentiating them consciously from the other touches, evidently paying attention first to one touch and then to another.

As she began responding, I increased varyingly the directive touches without decreasing the number and variation of the other distracting tactile stimuli. Thus, I suggested lateral and upward movements of her arm and hand by varying tactile stimuli intermingled with a decreasing number of nondirective touches. These responsive automatic movements, the origin of which she did not recognize, startled her, and as her pupils dilated, I so touched her wrist with a suggestion of an upward movement. At that her arm began rising, and I gently discontinued the touch so that she did not notice the tactile withdrawal, and the upward movement continued. Quickly shifting my fingertips to hers, I varied the touches so as to direct in an unrecognizable fashion a full upward turning of her palm; then other touches on her fingertips served to straighten some, to bend others, and a proper touch on the straightened fingertips led to a continuing bending of her elbow. This led to a slow moving of her hand toward her eyes. As this began, I attracted her visual attention with my fingers and directed her attention to my eyes. I focused my eyes for distant viewing as if looking through and beyond her, moved my fingers close to my eyes, slowly closed my eyes, took a deep

sighing breath, sagged my shoulders in a relaxed fashion, and then pointed to her fingers, which were approaching her eyes.

"She followed my pantomimed instructions and developed a trance that withstood the efforts of the staff to secure her attention or to awaken her in response to suggestions given in English." (p. 66)

On other occasions Erickson described his approach together with its rationale as follows.

"You take hold of the wrist very, very gently. What is your purpose? Your purpose is to let the patient feel your hand touching his wrist. That is all. The patient has muscles that will enable him to lift his arm, so why should you do it for him? *The body has learned how to follow minimal cues. You utilize that learning. You give your patient minimal cues. When he starts responding to those minimal cues, he gives more and more attention to any further cues you offer him. As he gives more and more attention to the suggestions you offer, he goes deeper into trance. The art of deepening the trance is not necessarily yelling at him to go deeper and deeper; it is giving minimal suggestion gently, so the patient pays more and more attention to the processes within himself and thus goes deeper and deeper.*

"I think all of you have seen me take hold of a patient's arm and lift it up and move it about in various fashions. I induce a trance in that way. 1 have tried to teach a number of you how to take hold of a wrist, how to take hold of a hand. You do not grip with all the strength in your hand and squeeze down on the patient's wrist. What you do is take hold of it so as to very, very gently suggest a grip on his wrist, but you don't actually grip it; you just encircle the wrist with your thumb and index finger with light touches. You suggest a movement of the wrist with only the slightest pressure. You suggest a movement of the hand upward. And how do you suggest it upward? You press with your thumb just lightly, while at the same time you move your index finger this way to give a balance (Figure 2). You move your fingers laterally, and while the patient gives attention to that, you have your thumb actually lifting the hand. This is essentially a distraction technique: while the thumb very lightly and consistently directs the hand upward, your other fingers make touches and distracting movements in a variety of other directions that tend to cancel out each other.

"Another approach to guiding the hand upward is to attract the patient's conscious attention with a firm pressure by your fingers on top of his hand and only a gentle guiding pressure by your thumb on the underside of his hand. The only way the firm touch can remain firm is for the patient to keep moving his hand up against your fingers. At the same time the lower touch of your thumb is kept gentle by the patient by constantly moving upward away from it. The therapist needs to practice these movements over and over because they are one of the quickest and easiest ways of distracting the conscious mind and securing the fixation of the unconscious mind.

"You lift the hand in that fashion, letting your fingers linger here and there so that the patient unconsciously gets a sense of the lingering of your hand. You want the patient to have that nice comfortable feeling of the lingering of your hand because you want his attention there in his hand and you want the development of that state of balanced muscle tonicity which is catalepsy. Once that state of balanced muscle tonicity is established to achieve catalepsy, you have enlisted the aid of the unconscious mind throughout the patient's body. Because you can get catalepsy in one hand, there is a good possibility there will be catalepsy in the other hand. If you get catalepsy in the other hand, then you probably have catalepsy in the right foot, in the left foot, and throughout the body, face, and neck. As soon as you get that balanced tonicity of the muscles, then you have a physical state that allows the patient to become unaware of fatigue, unaware of any disturbing sensations. It is normally hard to maintain that balanced muscle tonicity and pay attention to pain. *You want your patient giving all of his attention to that balanced muscle tonicity because that distracts him from pain and other proprioceptive cues so that numbness, analgesia, and anasthesia are frequently experienced in association with catalepsy. If you have balanced muscle tonicity throughout the body, catalepsy throughout the body, you have reduced the sensations that exist within the body to those sensations that go into maintaining that catalepsy. A patient then becomes decidedly responsive to a wealth of other ideas."*

The introspective comments of subjects who have experienced the induction of catalepsy

in this manner tend to support Erickson's view of the dynamics of distraction in the process. Most subjects report that their hand seemed to have a peculiar tendency to move upward and about by itself because they could not distinguish the consistent pressure upward by the therapist's thumb from the distracting touches and movements by his other fingers. The therapist's minimal cues and the patient's responses to them take place at a faster rate than the patient's cognition can follow. Most of the tactile stimuli and responses are mediated automatically by the proprioceptive-cerebellar system so that the patient's ego awareness on cortical levels is bypassed.

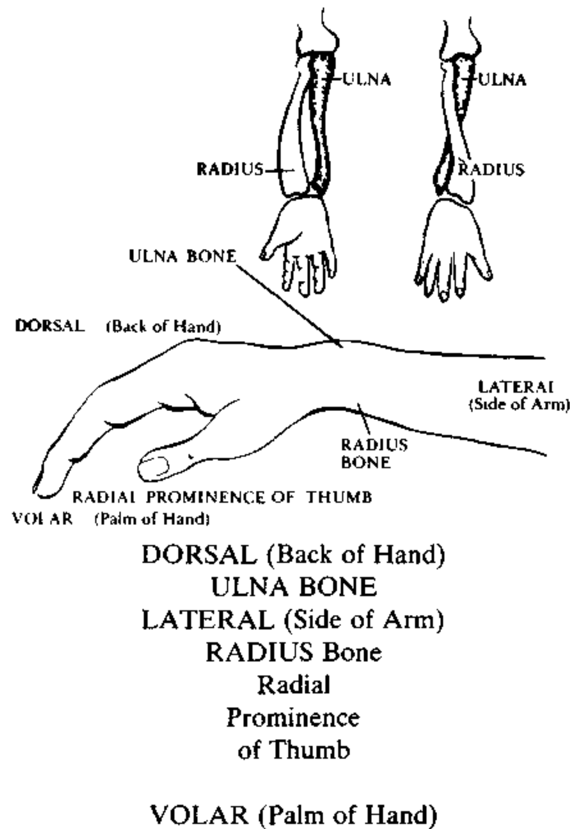

Figure 1: An orientation to the anatomy of hand and arm catalepsy

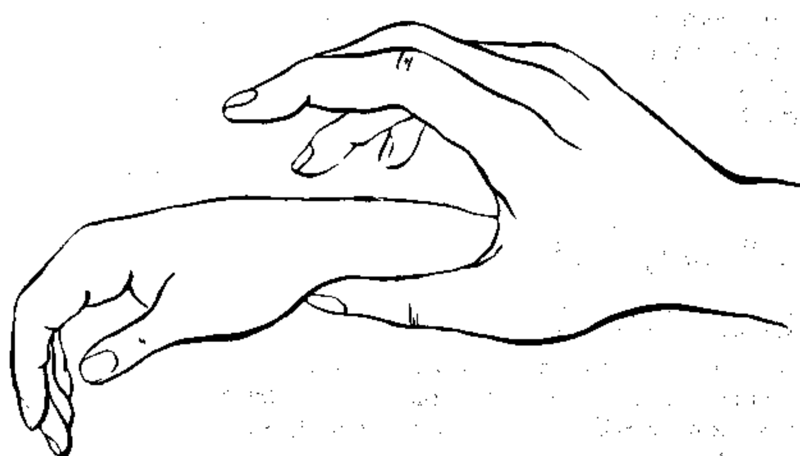

Figure 2: Thumb and finger placement during a cataleptic induction

Facilitating Catalepsy with the Resistant Subject

When we speak of resistance, we are not usually concerned with the classical Freudian psychoanalytic problem of a preconscious or unconscious force actively blocking the entry of

certain material into consciousness. Rather, resistance to hypnotic work is usually a function of a patient's lack of understanding of what responses are required or of how to allow the required response to happen all by itself. Many highly intelligent patients, for example, need some background understanding before they will permit a catalepsy to occur. Erickson provides this background understanding in a preinduction talk somewhat as follows:

E: You can forget anything. You forget that you had to learn to lift your hand as an infant. You had to learn how to move your hand. At one time you didn't even know it was your hand. There was a time when you did not know how to lift it. There was a time when you were surprised to watch that interesting thing [the infant's own arm] move. There was a time when you tried to reach with your right hand to touch your right hand. You didn't even know it was attached to you.

R: It is these early infantile memories that you are reactivating so they can be utilized to effect a catalepsy?

E: Yes. Once you can get that through to some of these highly intellectual, skeptical subjects, then they can recognize the truth and possibility of such a cataleptic experience.

D. UTILIZING CATALEPSY

In a letter to Andre Weitzenhoffer in 1961 Erickson outlined a number of other approaches to facilitating catalepsy and utilizing it to induce sleep or trance, to evaluate hypnotic susceptibility, and as a springboard for facilitating other hypnotic phenomena. His edited notes are as follows:

Catalepsy is a general phenomenon that can be used as:
1. a testing procedure for hypnotic susceptibility
2. an induction procedure
3. a reinduction procedure
4. a procedure for deepening trance

Absolutely requisite for the successful facilitation and utilization of catalepsy are:
1. a willingness on the part of the subject to be approached
2. an appropriate situation
3. the suitableness of the situation for a continuation of the experience

CATALEPSY TO INDUCE SLEEP WITH ARM LIFT AND LOWERING

Erickson's letter to Weitzenhoffer continues:

I have tested absolute strangers while waiting in line or seated in restaurants, train stations, and airports. I have secured excellent cataleptic responses followed by startle and questioning reactions. I then rely upon some casual comment both to justify our interaction and close the incident.

In airports and only in the presence of both parents with children under six (usually when the children are tired) I will strike up an appropriate conversation with the parents. I identify myself as a doctor, remark upon how tired the child is, how medically I can see that the child is about ready to fall asleep, that if the child only for a moment would stop wiggling or shouting, it would immediately fall asleep. This can be said in the presence or the absence of the child. I further explain that you can't hold the child still, that you just move its arm gently. "Look, I'll show you," and I slide down to the other end of the waiting room bench. The wiggling child looks me over. I gently pick up its arm and perhaps gesture as if to lift the other arm. I carefully lift the arm to get the child to look at the hand and then lower the hand close to the body so that the child will lower its lids as I lower the hand gently to the body. (Sometimes you may have to follow through with the other hand.) As I let the hand come to rest gently on the child's lap, there will be a closure of the eyes, a deep breath, and the child obviously falls asleep. I hastily but casually remark, "You know, that child was a lot more tired than I realized." I then lose all apparent interest in the child and promptly start a conversation with the parents about themselves.

I avoid children over six and mothers under 25—society reaches false conclusions too easily—and I avoid the mother not accompanied by her husband. However, once in a large airport about midnight I saw a harried mother whom I diagnosed (correctly) as having the flu with four children, ages four to nine, all tired, cranky, and overactive. I sat down beside the mother and made all the appropriate comments. She started to say something but then closed her mouth. She seemed attentive and interested, so I explained that the kids were tired, overactive, had to have their attention attracted, and would fall asleep the second they were still. Thereupon I ostentatiously and laboriously tore a couple of narrow strips from a newspaper, tied them awkwardly into a knot, laid them on the floor. The kids sat quietly watching that performance. I then did the hand lift close to their bodies so their eyelids would lower as the hand lowered. All four went to sleep immediately, and I quickly turned to the woman to ease myself conversationally out of the situation, but she said, "Here comes my husband. He was getting a cup of coffee." Then to her husband she said, "Honey, Dr. Erickson has just been demonstrating child hypnosis to me." Both husband and wife were M.D.s. She had recognized me, but I had not recognized her. They both had taken a seminar under me a couple of years before. That's the only time I ever got caught.

Catalepsy by Apparently Maintaining an Arm

Another approach for facilitating catalepsy with adult strangers is by apparently maintaining an arm. In an airport I will notice someone seated, staring into space in what I recognize as the *common everyday trance.* I will sit beside him and begin to stare into space until he begins to notice me. I may nod and look appreciatively at the ring on the stranger's hand resting on his knee. I'll comment on the ring and then casually lift his hand to see it more closely. I then gently release my contact with his arm in such a subtle fashion that it appears as if I'm still holding it. The catalepsy is manifest when the stranger's arm simply maintains itself comfortably in that fixed position for a minute or two while I continue to verbalize about the ring.

The Handshake Induction

(This section of Erickson's 1961 letter to Andre Weitzenhoffer was published in *Hypnotic Realities* (Erickson, Rossi, & Rossi, 1976) and is reprinted here with permission of the publishers.)

Initiation: When I begin by shaking hands, I do so normally. The "hypnotic touch" then begins when I let loose. The letting loose becomes transformed from a firm grip into a gentle touch by the thumb, a lingering drawing away of the little finger, a faint brushing of the subject's hand with the middle finger—just enough vague sensation to attract the attention. As the subject gives attention to the touch of your thumb, you shift to a touch with your little finger. As your subject's attention follows that, you shift to a touch with your middle finger and then again to the thumb.

This arousal of attention is merely an arousal without constituting a stimulus for a response.

The subject's withdrawal from the handshake is arrested by this attention arousal, which establishes a waiting set, an expectancy.

Then almost, but not quite simultaneously (to ensure separate neural recognition), you touch the undersurface of the hand (wrist) so gently that it barely suggests an upward push. This is followed by a similar utterly slight downward touch, and then I sever contact so gently that the subject does not know exactly when—and the subject's hand is left going neither up nor down, but cataleptic. Sometimes I give a lateral and medial touch so that the hand is even more rigidly cataleptic.

Termination: If you don't want your subjects to know what you are doing, you simply distract their attention, usually by some appropriate remark, and casually terminate. Sometimes they remark, "What did you say? I got absentminded there for a moment and wasn't paying attention to anything." This is slightly distressing to the subjects and indicative of the fact that their attention was so focused and fixated on the peculiar hand stimuli that they were momentarily entranced so they did not hear what was said.

Utilization: Any utilization leads to increasing trance depth. All utilization should proceed as a continuation or extension of the initial procedure. Much can be done nonverbally. For example, if any subjects are just looking blankly at me, I may slowly shift my gaze downward, causing them to look at their hand, which I touch as if to say, "Look at this spot." This intensifies the trance state. Then, whether the subjects are looking at you or at their hand or just staring blankly, you can use your left hand to touch their elevated right hand from above or the side— so long as you merely give the suggestion of downward movement. Occasionally a downward nudge or push is required. If a strong push or nudge is required, check for anesthesia.

There are several colleagues who won't shake hands with me, unless I reassure them first, because they developed a profound glove anaesthesia when I used this procedure on them. I shook hands with

them, looked them in the eyes, slowly yet rapidly immobilized my facial expression, and then focused my eyes on a spot far behind them. I then slowly and imperceptibly removed my hand from theirs and slowly moved to one side out of their direct line of vision. I have had it described variously, but the following is one of the most graphic. "I had heard about you and I wanted to meet you and you looked so interested and you shook hands so warmly. All of a sudden my arm was gone and your face changed and got so far away. Then the left side of your head began to disappear, and I could see only the right side of your face until that slowly vanished also." At that moment the subject's eyes were fixed straight ahead, so that when I moved to the left out of his line of vision, the left side of my face "disappeared" first and then the right side also. "Your face slowly came back, you came close and smiled and said you would like to use me Saturday afternoon. Then I noticed my hand and asked you about it because I couldn't feel my whole arm. You just said to keep it that way just a little while for the experience."

You give that elevated right hand (now cataleptic in the handshake position) the suggestion of a downward movement with a light touch. At the same time, with your other hand, you give a gentle touch indicating an upward movement for the subject's left hand. Then you have his left hand lifting, right hand lowering. When right hand reaches the lap, it will stop. The upward course of the left hand may stop or it may continue. I am likely to give it another touch and direct it toward the face so that some part will touch one eye. That effects eye closure and is very effective in inducing *a* deep trance without a single word having been spoken.

There are other nonverbal suggestions. For example, what if my subject makes no response to my efforts with his right hand and the situation looks hopeless? If he is not looking at my face, my slow, gentle out-of-keeping-with-the-situation movements (remember: out-of-keeping) compel him to look at my face. I freeze my expression, refocus my gaze, and by slow head movements direct his gaze to his left hand toward which my right hand is slowly, apparently purposelessly moving. As my right hand touches his left with a slight, gentle, upward movement, my left hand with very gentle firmness, just barely enough, presses down on his right hand for a moment until it moves. Thus, I confirm and reaffirm the downward movement of his right hand, a suggestion he accepts along with the tactile suggestion of left hand levitation. This upward movement is augmented by the facts that he has been breathing in time with me and that my right hand gives his left hand that upward touch at the moment when he is beginning an inspiration. This is further reinforced by whatever peripheral vision he has that notes the upward movement of my body as I inhale and as I slowly lift my body and head up and backward, when I give his left hand that upward touch."

Erickson's description of his handshake induction is a bit breathtaking to the beginner. How does one keep all of that in mind? How does one develop such a gentle touch and such skill? Above all, how does one learn to utilize whatever happens in the situation as a means of further focusing the subject's attention and inner involvement so that trance develops? Obviously a certain amount of dedication and patience are required to develop such skill. It is much more than a matter of simply shaking hands in a certain way. Shaking hands is simply a context in which Erickson makes contact with a person. He then utilizes this context to fix attention inward and so set the situation for the possible development of trance.

As he shakes hands, Erickson is himself fully focused on where the subject's attention is. Initially the subjects' attention is on a conventional social encounter. Then, with the unexpected touches as their hand is released, there is a momentary confusion and their attention is rapidly focused on his hand. At this point "resistant" subjects might rapidly withdraw their hand and end the situation. Subjects who are ready to experience trance will be curious about what is happening. Their attention is fixed and they remain open and ready for further directing stimuli. The directing touches are so gentle and unusual that subjects' cognition has no way of evaluating them; the subjects have been given a rapid series of nonverbal cues to keep their hand fixed in one position (see last paragraph of the initiation), but they are not aware of it. Their hand responds to the directing touches for immobility, but they do not know why. It is simply a case of an automatic response on a kinesthetic level that initially defies conscious analysis because the subjects have had no previous experience with it. The directing touches for movement are responded to on the same level with a similar gap in awareness and understanding.

The subjects find themselves responding in an unusual way without knowing why. Their attention is now directed inward in an intense search for an answer or for some orientation. This inner direction and search is the basic nature of "trance." Subjects may become so preoccupied in their inner search that the usual sensory-perceptual processes of our normal reality orientation are momentarily suspended. The subjects may then experience an anesthesia, a lacuna in vision or audition, a time distortion, a deja vu, a sense of disorientation or vertigo, and so on. At this moment the subjects are open for further verbal or nonverbal suggestions that can intensify the inner search (trance) in one direction or another.

The following demonstration in front of an audience illustrates how catalepsy may be initiated and utilized to facilitate trance experience and the learning of other hypnotic phenomena.

Establishing Rapport

E: And you're?

J: Janet.

E: You certainly made an impression on that tape recorder. It gave the best whistle it could. How do you feel about being in front of an impressive audience like this?

J: I'm *scared to death.*

E: Actually, you know, I think that they're the ones that are likely to be put in a trance. Can you tell me how you feel?

J; Better.

E: Are you quite as frightened as you were?

J: No.

R: The first movement is to establish rapport—a humorous remark about the whistle in the tape recorder and a question about her feelings in front of the audience to evaluate her here-and-now emotional status. She responds that she is "scared to death." Since it is said in a semihumorous vein (in response to Erickson's initially humorous remark about the tape recorder's inadvertent whistle), she is already following Erickson's lead. He responds by making an effort to reassure her. It is important that this reassurance and rapport be established as the first stage of an induction. Her immediately positive responses of "better" and not being frightened now indicate that a favorable climate for a formal induction is established.

Arm-Lift Catalepsy

E: Just relax. I am going to lift your hand up. And I would like to have you watch it.

R: As you simultaneously do a hand-lift catalepsy and request that she watch her hand, her attention is being fixed and focused via two sense modalities.

Visual Hallucination

E: Now look at this hand. And watch it. And you *see it right there.*

R: "See it right there" is a two-level suggestion: On one level it means simply to see the hand. On another level it is a suggestion for a possible visual hallucination to continue seeing the hand "there" even when it is no longer there."

Fixing Arm Catalepsies

E: And I'm not going to put it down. I am going to leave it right there. And just keep watching that right hand. And you can watch your hand. And just keep watching your right hand. And I am going to leave your left hand right there. And now, slowly . . .

R: Many subjects initially do not maintain their arm in a fixed position but let it fall back heavily to their lap when the therapist lets go of it. Erickson then gives these indirect suggestions for maintaining the arm in catalepsy. Having learned a right-arm catalepsy, a left-arm catalepsy is rapidly established to compound her involvement.

Dissociation

E: . . . your hands will open. That's right. And I would like to ...

R: Opening a hand "slowly" while watching it carefully is a fairly unusual task that tends to promote a dissociated attitude and automatic response.

Questions for Inner Focus

. . . have you watch your hands. Your hands are opening. Would you like to watch your hand?

R: We don't normally have to watch our hands so carefully, so the peculiar dissociated attitude continues to develop, spurred on by a *question* as a hypnotic form that now focuses attention within the subject's own associative processes.

Indirect Eye Closure

E: And you can continue watching your hand, if you wish, with your eyes closed. And your hands are opening more and more.

R: This indirect suggestion for eye closure is made contingent on (1) her continuing to watch the hand (that is, a visual image or hallucination is to be maintained within her mind), and (2) her own *wishes.* The first is another step toward learning visual hallucination, while the second tends to mobilize her positive motivation. If she now closes her eyes to relieve them of the strain of this peculiar situation, then by implication it means she is following her own *wish.* Erickson's suggestion for eye closure has become the subject's own wish; the suggestion is completely internalized as an ego-syntonic response.

Pause to Permit the Learning of Automatic Responses

[A 47-second pause]

E: If there is anything that you would like to have me understand, you can nod or shake your head.

R: The hands opening very slowly is a positive indication of trance behavior. She is relearning movements—from voluntary self-directed control to that automatic quality where the hands open slowly, seemingly by themselves, at the therapist's suggestion.

Head Signaling

E: And so that you will get a little practice, I would just like to have you nod your head very slowly. And now turn your head from side to side very carefully.

R: This is a peculiar suggestion with many implications: (1) She is to begin learning ideomotor signaling with her head. (2) She is to communicate only in this restricted way, so most of her faculties can remain "asleep." (3) If she wants Erickson to understand something and simply lets him know by head nodding or shaking, that may imply a great deal of imagined or hallucinated conversation and communication between them. Rehearsing the "slow" head movement allows that automatic aspect of hypnotic behavior to develop.

Questions to Motivate and Deepen Involvement

E: And now, is there anything in particular you would like to learn or that you would like to have me do? [She shakes her head No.]

R: Such questions allow subjects a respectful degree of control in the situation. Why shouldn't their ego be allowed to make requests for trance behavior? This heightens motivation and can deepen involvement in trance processes.

Utilizing Comfort

E: All right, are you *pleased* with the feeling? [Head nods Yes.] Are you *enjoying* feeling more comfortable? [Head nods Yes.]

R: Questions about being "pleased," "enjoying," and feeling comfortable are actually powerful suggestions that enable the subject to evoke her own kinesthetic memories of comfort and utilize them to facilitate the current trance. *Comfort is a natural characteristic of trance.*

Contingent Suggestions for Awakening

E: And now, *what I would like to have you do* is to *discover that you can let your hands lower* to your lap *after* you have opened your eyes, and when they reach your lap, you can awaken.

R: There is actually a series of suggestions in this single sentence. "What I would like to have you do" suggests that she is following Erickson. As she carries out the following chain of three contingent suggestions, she is reinforcing her tendency to follow Erickson.

"Discover you can *let* your hands lower" implies that the subject is learning how to experience the automatic behavior of hand lowering.

Letting the hands lower *after* opening the eyes usually gives the subject a dissociated feeling because she is watching her hands move automatically while not yet completely awake.

An implied directive is utilized, so awakening is made contingent on the hands reaching the lap. If she must "awaken," this implies she must have been in a trance.

Structured Amnesia

E: *How do you feel?* How do you feel? J: Fine.

R: Returning again to the same question—"How do you feel?"— that was asked just before the cataleptic induction was begun tends to structure an amnesia for all trance events that came between the two identical questions.

E. SUMMARY

Although catalepsy was historically one of the earliest defining characteristics of trance, our understanding of its significance and utilization has shifted in recent decades. Whereas catalepsy was regarded by early investigators as a "passive" state of "dull will" characteristic of certain stages of trance, we now regard the ease with which individuals can learn to maintain a limb comfortably in a state of well-balanced muscle tonicity as a measure of their sensitivity and receptivity to suggestion. Erickson's approaches to catalepsy are designed to secure a patient's attention, to focus that attention inward, and to arouse an attitude of wondering or expectancy for further suggestion. Catalepsy is thus an ideal approach for inducing trance and assessing a patient's receptivity. It can be utilized as a basic foundation on which other hypnotic phenomena may be structured.

Catalepsy has a special relation to amnesia and analgesia-anesthesia. We hypothesize that the special focus of attention to minimal stimuli required during the induction and maintenance of catalepsy distracts and occupies an individual's attention so he or she tends to ignore other stimuli. On occasion this gives rise to an amnesia for other events occurring simultaneously with the catalepsy. When the patient's full attention is centered on the minimal proprioceptive stimuli of a well-balanced muscle tonicity characteristic of catalepsy,

the patient tends to experience an analgesia or anesthesia for other sensations or pain in the body.

As is the case with all hypnotic phenomena, there are extremely wide individual differences in response to catalepsy. Associated phenomena— such as: fixed gaze; lightness, heaviness, or stiffness of the limb; a sense of automatic movement and dissociation, wherein the limb does not seem to be part of the body; visual and auditory perceptual alterations; spontaneous age regression, etc.—all tend to accompany catalepsy to different degrees in different individuals. Many of these associated phenomena occur spontaneously, seemingly as a result of the partial loss of the generalized reality orientation that occurs as the subject experiences the novel, unexpected, and surprising stimuli of a cataleptic induction. The well-trained hypnotherapist learns to recognize the spontaneous, incipient development of these associated phenomena, which can be further enhanced and utilized to achieve therapeutic goals.

F. EXERCISES WITH CATALEPSY

It is easy for the beginner to feel overwhelmed by some of Erickson's descriptions of his incredibly skillful inductions of catalepsy. It is well to be aware of the fact that these skills were developed only gradually over the decades of Erickson's life after much painful trial and error (see Erickson & Rossi, 1974, 1975, for examples). The student can therefore expect that the acquisition of these skills will require much patient observation and actual practice. These skills continue to develop over a lifetime of clinical practice and constitute one of the rich rewards of a therapist's dedication to the healing arts.

It is important that beginners obtain a certain degree of proficiency and confidence in their skills by practicing first with volunteers in the laboratory of the university or the workshops of organizations such as the American Society of Clinical Hypnosis. One does not practice on strangers and patients. Erickson's experiences with strangers took place only after he was a master of his art. Patients have a right to expect that a clinician has already acquired the requisite skill to be confident, comfortable, and effective in any therapeutic encounter.

1. Catalepsy to Induce Trance by Guiding an Arm Up and Down

The simplest use of catalepsy to focus attention and induce trance may be by gently guiding a subject's arm to a point just above eye level and then slowly allowing the arm to lower to a resting position. The subject is requested to watch his hand carefully without moving his head. As the arm is lowered, the eyelids also lower. As the arm reaches the next position, the therapist can suggest that the subject allow his eyes to close completely—if they are not already closed.

Therapists develop their skills as they learn to observe and assess the subject's responses during the entire process.

a. Observe the readiness and cooperation that the subjects demonstrate in permitting the therapist to guide their arms upward. As the arm is guided to the highest point, the therapist can hesitate for a moment and very gently release contact with the arm. Does the arm tend to maintain a catalepsy in that position, with the therapist apparently maintaining it there?

b. How comfortably and well are the subjects able to follow the suggestion of focusing their eyes on their hands? This is another indication of their sensitivity and receptivity to suggestion. The therapist carefully watches the subjects' eyes in order to reinforce the suggestion, should the subjects' attention waver. This facilitates rapport between therapist and subjects and gives the subjects training in following the therapist's suggestions.

c. As the arm is lowered, the therapist can again test for catalepsy by gently disengaging touch while apparently still maintaining contact. Does the subject's arm stop and maintain itself in a stationary catalepsy? Does it continue to lower at the same rate as the therapist was moving? Both are satisfactory indications that the subject is following, but a stationary catalepsy might be the more sensitive indicator of trance potential.

d. As the subjects watch the progress of their hands, to what degree do they begin to manifest the eye and facial characteristics of trance? . . . The blank look, blinking, a possible dilation of the pupils, tearing, a softer or more flaccid facial expression, and so on.

e. The therapist learns to gauge the subject's level of expectancy and need for further suggestions. Every parent, teacher, and therapist learns to recognize when someone wants to ask a question: there may be a frown, a certain pucker or tautness of the mouth, a thrust of tongue, a fixed expression in the eyes, a slight holding of the breath, etc. The therapist then supplies such directives in the form of suggestions that will enhance trance or whatever hypnotic phenomenon or therapeutic goal is appropriate at that moment.

Therapists learn initially by observing only one or two of these stages. As they become familiar with the overall process and gain acquaintance with the range of possible responses given by a variety of subjects, therapists are better able to assess more observations and direct each subject in an individual and optimal manner.

How do therapists formulate their verbal suggestions to facilitate this trance induction by guiding the arm up and down? Obviously, a therapist will spend some time learning how to utilize the various hypnotic forms outlined earlier. Therapists can begin by utilizing each of those forms (truisms, compound and contingent statements, questions, etc.) to give suggestions for comfort, relaxation, or whatever during the arm lift and lowering. A few are as follows:

And how comfortable can that arm be

A *question* about comfort tends to facilitate comfort

resting right there?

while *implying* the arm will remain stationary in a cataleptic position.

You are looking at that hand

A truism facilitating a yes set.

and

A compound introducing the following suggestion

you don't need to see anything else.

of a negative visual hallucination for everything but the hand is phrased as a form of *not doing.* If trance and a literalness of perception exist, the subject will see nothing but the hand. Otherwise, nothing is lost, since most subjects will not even recognize that a suggestion for a negative visual hallucination has been given.

As your arm continues lowering to a resting position, you can feel more and more comfortable.

A *contingent* suggestion whereby comfort is made contingent on the ongoing and inevitable behavior of arm lowering. This is also a *truism:* We usually are more comfortable when we bring a limb to a resting position. The word *resting* keys all feelings of comfort by *association.*

2. Catalepsy by Guiding an Arm to a Stationary Position

A catalepsy whereby an arm is guided up and then nonverbally induced to maintain itself comfortably in a stationary position represents another stage of skill. All the observational competence of the first exercise is needed, along with new skills in orienting the subject's arm and hand with *directive* and *distracting* touches. There will be as wide individual differences in the tactics of therapists' approaches to such a catalepsy as there will be in the patients' responses. Beginners can initially follow Erickson's directions outlined in this chapter, but they will soon find their own ways of hand placement, movement, etc., for facilitating a stationary catalepsy. There are many creative variations that can be

experimented with. For example, instead of the therapist's thumb actually lifting the hand, it can simply brush upward on the lateral radial prominence (side of the thumb). This very light upward brush may not be recognized by the subject, but it can serve as a cue for lifting the hand and arm.

With subjects whose arm remains heavy and limp, ready to fall back in their lap when released, it is important to use verbalizations to help secure the stationary catalepsy.

How comfortably can it remain there? And I'm not telling you to put it down.

It stays there all by itself.

Does the arm become fixed right there?

And you don't have to move it.

In working with volunteers when learning to induce catalepsy, it is important for therapists to get feedback from their subjects. To what degree was a therapist able to make distracting touches so that the subject did not realize that the therapist was actually guiding arm movement with his or her thumb? To what degree did the subject get a dissociated feeling in the arm so that it seemed to move by itself? To what degree did it not seem to belong to the subject's body? What other hypnotic phenomena tended to accompany the catalepsy spontaneously? How can the therapist learn to recognize them? How can the therapist facilitate and heighten the further experience of these associated hypnotic phenomena in each subject?

An interesting test of the therapist's success in the use of distracting touches in guiding the hand to a stationary catalepsy is to work with the subject's eyes closed. When subjects evidence a spontaneous sense of surprise at the peculiar position their arms are in when they open their eyes, the therapist has been successful in confusing their sense of kinesthetic localization. As one confuses more and more such senses, the subjects gradually lose more and more of their generalized reality orientation and become amenable to experiencing trance.

3. Moving Catalepsy

A moving catalepsy, whereby a subject's arm is given a direction of movement that continues all by itself when the therapist has released contact, represents another stage of skill. The therapist learns to recognize when the patient's hand and arm begins to pivot easily around the wrist, elbow, or shoulder and utilizes that ease of response to impart a motion to the arm. The therapist then releases contact so gently that the subject does not recognize just when it happened. Most subjects readily experience a sense of "unreality" or dissociation when they watch the arm pleasantly float by.

It is important that the subject receive sufficient warm and empathetic support from the therapist at this point.

And that can be so comfortable moving all by itself.

You can enjoy just wondering about that.

Isn't it interesting to just continue watching your hand?

And you are at liberty to share as much as you would like about that interesting movement.

As the movement continues, involvement deepens, and the therapist can now create other verbalizations to give direction to the arm, hand, and finger movements. When both arms become involved, they can be made to rotate around each other in one of the traditional movements of trance induction and deepening.

Once the subject has the experience of a limb moving by itself, or has witnessed a demonstration of it, sensitivity can be further heightened by not actually lifting a limb but simply brushing lightly upward on the side of the arm to indicate a lifting motion. The therapist

may even utilize a modified "pass," by lightly brushing the palm of his hand or fingertips from the subject's elbow, under the forearm, and up around to the back of the hand. This indicates a gently upward motion to the subject, whose arm will lift as if stuck to the therapist's hand. Having had this experience, most subjects will continue to respond to lighter and lighter "passes," until the therapist does not have to touch at all but simply makes a "pass" an inch or two above patient's arm for it to lift. The patient's arm and hand will then simply follow along wherever the therapist's hand moves. With a sensitive and agreeable subject, the therapist's motions can be abbreviated even further, so that finally only a "significant look" or slight gesture with a hand or finger will be enough to set the subject's arm afloat.

It is interesting to obtain the subjective reports of naive subjects about why their hand and arm is following the therapist's. Some subjects will say they feel a "connection," "a magnetic force," "a warmth," or "a mysterious power" that seems to be drawing their hand. Indeed, some subjects can close their eyes and be effectively blindfolded (so *effectively* that they cannot peek through or under the blindfold) and their limbs will still follow the therapist's, even though there is no actual tactile contact between them. It really does seem as if there is some sort of mysterious magnetic force! We can easily understand how early investigators were led to this belief. How are we to account for such sensitive following behavior? The question is still an open one. Is the subject responding to the warmth or sound of the therapist's hand? Can the subject sense movement from air currents set in motion by the therapist's hand? Is there a combination of these and other factors?

With such heightened sensitivity it will be easy for the therapist to experiment further by adding associated phenomena to the moving limbs. To what degree can tingling, warmth, coolness, pressure, numbness, and other sensations be experienced? Visual and auditory alterations?

4. The Handshake Induction

Having completed the above exercises on a few hundred subjects, therapists may now be ready for the handshake induction. Therapists will find their own individual variations and means of coordinating each step of the process after first experimenting with Erickson's approach outlined earlier.

Erickson has added other dimensions of *confusion* to the handshake induction in what he calls the "absentminded professor routine." As Erickson begins to release the hand in that gentle, uncertain manner, the subject naturally looks at Erickson's face and eyes for clarification of his developing question about what is happening. Erickson then adds to this confusion by focusing his eyes at a point beyond the subject. Searching in vain for eye contact, the subject gets a peculiar feeling of being unseen or "being looked through," and questions now multiply as confusion about the situation increases. Erickson then further compounds this confusion by mumbling something incoherently, so the subject is now desperately trying to understand what this absentminded professor is trying to say. At that precise moment when the subject is cataleptically poised in total, focused, inquiring attention, Erickson will make a clear, concise, clarifying suggestion that will then be seized upon by the subject as a means of terminating this uncomfortable uncertainty.

5. Electronic Monitoring of Catalepsy: A Two-Factor Theory of Hypnotic Experience

While the pendulum of current scientific thought has swung to the opinion that no objective measure of hypnotic trance exists, there is a long scientific tradition of measuring catalepsy. As early as 1898 Sidis published remarkably clear and convincing sphygmographic records distinguishing normal awakeness from catalepsy experienced during hypnosis. More recently Ravitz (1962, 1973) published tracings of the body's D.C. electrical activity (measured on high-impedance recorders) that underwent characteristic changes during the induction of catalepsy. The junior author has utilized a high-impedance recorder (input impedances ranging from 10 to 1000 megaohms with nonpolarizing

electrodes placed on the forehead and the palm of one hand) for a number of years in his clinical practice as a convenient and convincing indicator of an objective alteration that takes place during trance. The record of a highly intelligent, normal, 24-year-old female subject during her first hypnotic induction is presented in Figure 3. The erratic, fast activity at the beginning of the record (A) is characteristic of normal waking awareness. Every impulse to activity seems related to an upswing, which then drops as soon as the impulse is carried through. During simple relaxation, meditation, and hypnosis the record smoothes out and usually drops dramatically as the subject gives up any active effort to direct mind or body (B). In Figure 3 a few slow upswings are noted during the beginning of the hypnotic induction, as the subject makes an effort to attend to the therapist's remarks (C). These drop out as trance deepens, and the record shows a characteristically flat, low plateau with only low-amplitude slow waves (D). With more trance experience even this low-amplitude activity drops out, and a smooth line record is obtained. As long as the subject remains mentally quiescent with an immobile (cataleptic) body, there are no peaks or valleys in the record. When the subject initiates mental activity or moves, peaks and valleys are usually recorded. The awakening period is also followed by a typical pattern (E). The waking-fast activity usually appears at a higher level than the initial basal waking level. This higher level is maintained for a few minutes until the record comes back to normal.

The difficulty with accepting such records as valid measures of trance is that they appear whenever the subject quiets down during relaxation, meditation, or sleep, whether or not hypnosis has been formally induced. We would therefore offer a two-factor theory of hypnotic experience. First, there must be a state of openness and receptivity wherein subjects are not making any self-directed efforts to interfere with their own autonomous mental activity or the suggestions of the therapist. Ravitz's measurements, like those in Figure 3, are probably an effective indication of this state of quiet receptivity. The second factor might be called "associative involvement." This is the process whereby the hypnotherapist engages and utilizes a subject's associations, mental mechanisms, and skills to facilitate a hypnotic experience. We regard this process of utilizing a patient's own mental associations as the essence of "suggestion." Hypnotic suggestion is *not* a process of insinuating or placing something into the subject's mind. Hypnotic suggestion is a process of helping subjects utilize their own mental associations and capacities in ways that were formerly outside the subjects' own ego controls.

Students and laboratory workers who have access to the proper electronic equipment (the Heath-Schlumberger Model SR-255B Strip Chart Recorder is suitable) can explore a number of interesting relations between hypnotic experience and the electronic monitoring of the body's DC potential. Is the depth of the curve (Area D in Figure 3) related to "trance depth"? It will be found that some subjects are able to speak during this low portion of the curve without any raise in DC potential. Are these people better hypnotic subjects? Do any hypnotic phenomena other than catalepsy have a characteristic curve? Are the classical hypnotic phenomenon more readily evoked during the low plateau (D) of the curve?

DEMONSTRATION IN THE USE OF CATALEPSY IN HYPNOTIC INDUCTION:
Hand Levitation in a Blind Subject

Dr. Z was a blind subject with professional training in psychiatry. She was in her fifties and had been blind since the age of two. She came to Erickson to determine if she could recall through hypnosis some of her early visual images. Could she learn to recall, in particular, the image of her mother's face? This was her first visit with Erickson. After being introduced to the junior author, she gave permission for him to record this session. The session began with a casual conversation about some differences between the functioning of sighted and blind people, during which Erickson recounted a few anecdotes from his extensive practice with the handicapped. Erickson then casually began the induction almost as if it were a natural part of the conversation.

The reader should be forewarned that this was a first induction and that there was only a

minimal response. So unresponsive was Dr. Z, in fact, that Erickson was challenged to use a very wide range of his verbal repertory for induction by the hand-levitation technique. These verbalizations warrant careful study by the beginner in hypnosis, since (1) they provide an excellent demonstration of the wide range of verbal approaches a professional must be able to marshal when the occasion demands it and (2) they clearly reveal Erickson's active thought processes during an induction as he gropes for the appropriate concepts that will help Dr. Z's unique individuality learn to experience hand levitation. Erickson's verbalizations are not a routine and cliché-ridden "patter" but the expression of intense observation and inferential thinking about the dynamics of the "live" subject he is working with right here and now.

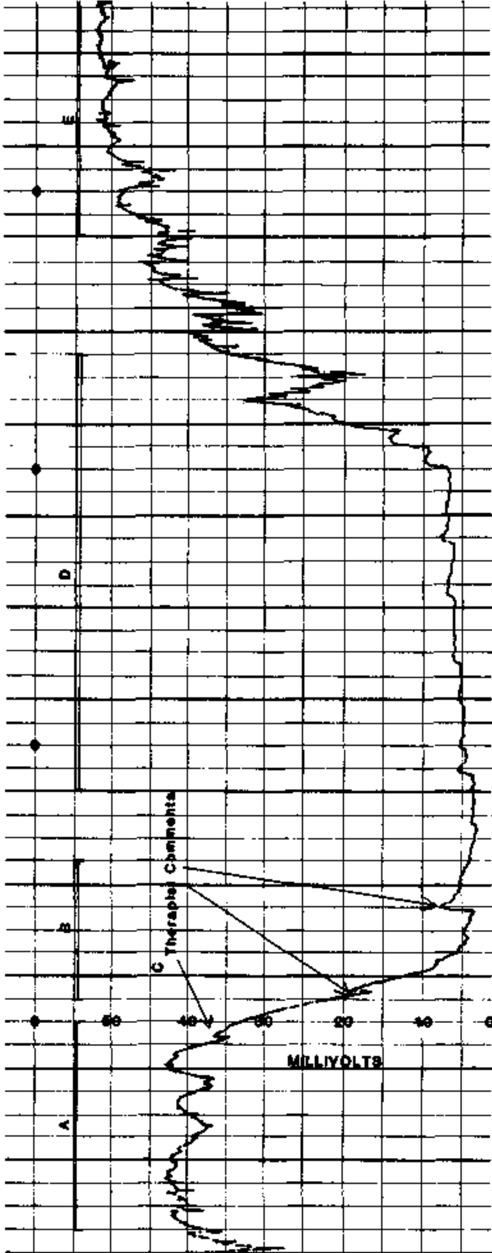

Figure 3: Electronic monitoring of DC body potential during catalepsy— millivolts on vertical axis, Time scale of 0.5 inch per minute on horizontal axis: (A) normal awakeness; (B) drop in DC potential during relaxation; (C) momentary response to therapist remarks; (D) characteristically low activity during catalepsy; (E) typical awakening pattern at higher level than (A).

Structuring Accepting Attitudes and Exploratory Sets

E: Now, can you sit straight with both feet together in front of you? Put your hands on your thighs. Elbows comfortable against the sides of your body. And learning something about a trance is essentially learning about the way you experience. *You don't know* just how changes take place in your feeling from the conscious state to the unconscious state.

R: You introduce hypnosis to a fellow professional by emphasizing that she will learn about the way she experiences. You thereby establish a learning and exploratory set that will probably be highly acceptable to her. But you immediately point out that "You don't know" how changes take place. The implication is that her experiential learning will not be the usual conscious, intellectual learning so typical of professional training.

An Indirect Approach to Confusion, Evoking Expectancy, Receptivity, and a Need for Closure

E: Now the unconscious state of mine, the fact that the mind------ You know how to tie shoestrings, but if you are asked to specify the movements in order, you don't know them. [Pause]

R: You begin this section with two dangling phrases ("Now the unconscious state of mind, the fact that the mind-----") that seem preparatory to what follows, but I wondered if they were errors in your sentence structure?

E: That is a technique. Nobody likes hesitation. [Erickson now gives a nonverbal demonstration wherein his hand reaches and then hovers hesitantly over a few knicknacks on his desk. Since that arm is in part paralyzed, Rossi felt an obvious relief when Erickson finally managed to pick up one knickknack and present it to him.] There, I knew you'd be glad to accept it, since you formed an acceptance attitude and a desiring attitude as you watched me struggle to pick it up.

R: The dangling phrase develops an expectancy and an acceptance attitude in the patients because they want to grasp something, they want a closure to happen.

E: Yes! They want a closure to happen. They think, "Why the hell don't you finish your sentence?" That's the whole basis of the confusion technique, also.

R: On the conscious level the patients are only aware of their disconcerting uncertainty and confusion. They are not aware of the fact that this is your indirect approach to evoking the confusion that will automatically give rise to attitudes of expectancy, receptivity, and a need for closure. They will then be ready to accept whatever suggestions you can give them that will resolve this need for closure.

Loss of Body Orientation as an Initial Indicator of Trance: Doubt and not Knowing for Exploratory Sets

E: *You do not know* what the body orientation is in the matter of developing a trance. [Dr. Z is gradually sliding awkwardly to the side of her chair without making any effort to correct her position.] I have to watch for different orientations in your body responses. Now there is no hurry on your part. There is no rush.

R: That she is beginning to lose body orientation indicates she's already in an altered state. This is the third time within the first few sentences of this induction that you tell her something she does not know, and you continue this emphasis throughout this entire session.

E: You don't know all these things, but you would like to know something, wouldn't you?

R: This again sets up an expectant and desiring attitude in the patient.

E: It also implies that there is something to be learned here, even though I don't know what it is yet.

R: By introducing doubt and not knowing, you develop an exploratory set wherein the patient now wants to learn more about the things you are alluding to.

Not Doing: Indirect Suggestion for Relaxation and Comfort

E: You simply wait. *You let me do the talking.* In time I'll ask you certain things. And as it becomes a natural feeling with you, you will answer, but in your own way. [Pause]

E: When you wait and know you have to wait, you may as well be comfortable. I didn't have to tell her to relax.

R: Oh, so you're implying comfort here without asking for it directly.

E: "You let me do the talking" implies you don't have to do anything.

R: That attitude of not having to do anything is what you want in the patient, because trance performance is on an automatic or involuntary level. That is what actually defines trance behavior.

E: Yes.

Meeting the Patient's Individuality: An Indirect Approach to Evoking Autonomous Unconscious Processes

E: Now I'm going to call your attention to your hands. There are memories associated with your hands, with your arms, with your elbows. Just what all those memories are would be impossible to state. Now I'm going to make a statement to you about your behavior.

E: What are the memories you have of just how you sit down in a chair?

R: It's impossible to state verbally each individual muscular movement. But why do you bring this up here?

E: Because since she is blind, she has to depend upon the feel of the chair on her calf, etc.

R: So you're actually adjusting your induction verbalizations here to suit her particular individuality.

E: Yes. She has to know if she is right in front of the chair or to the side. Because of past memories she will know about her elbow in relation to the arm of the chair, etc., but because she has been blind since the age of two, these memories are by now all automatic on an unconscious level.

R: With a sighted person you would not use these particular phrases?

E: No, no! I'd take something they can watch *but not see,* like tying a shoestring, buttoning a coat. How does a woman put on her bra—right side first? Left side first? Or simultaneously?

R: Why do you want to point out something the patient can do but cannot specify consciously in verbal terms how it is done?

E: The knowledge is there in the unconscious. The unconscious can understand, but the conscious mind does not know.

R: This is your indirect approach to activating and facilitating her reliance on unconscious processes: You emphasize things her unconscious knows but her conscious mind does not. Her unconscious has relevant responses to your questions even if her conscious mind

does not. Because of this your questions and comments on her behavior evoke a set of automatic, unconscious behavior patterns which, of course, are the raw material out of which hypnotic responses will be facilitated.

Differences in Conscious and Unconscious Behavior: Evoking Expectancy

E: When you just brushed back the hair from your face, the movement of your hand was that of strictly conscious mental set. The unconscious moves the hand in a *different* way. I'll call your attention to your hands again. I want you to *wait* until one of them begins to move toward your face very slowly. Which one? You'll have to find out.

E: When you watch students in a classroom, you notice such differences. One student can brush back her hair with a deliberateness that says, "I hope the son-of-a-bitch reaches the end of the lecture soon." Then there's that unconscious brushing back of the hair that indicates they are attending to you.

R: The same behavior performed in different ways can say different things. The hypnotherapist comes to recognize the difference between consciously directed deliberate behavior and the more-or-less automatic behavior that is mediated unconsciously when the conscious mind is occupied elsewhere. In this case you point out that her hand movement in brushing back her hair was on the conscious level so she will learn that unconscious movements will be different.

E: By having her "wait," you build a desire to have something happen. And it's safe because she can wait till her hand starts lifting. She is now waiting with an expectation that her hand will lift.

R: And it's something in her that's doing it and not you. You are not being overdirective.

E: Yes. Her entire history is that she has to direct every movement with care and caution.

R: For a successful trance experience she needs to let go of that long history of watchful consciousness associated with physical movements.

Illusory Choice: A Double Bind Covering All Possibilities of Response

E: There will be a choice.

E: This is an illusory choice. There actually is no choice, because in the next three sentences I'm taking away "choice." It may be the right hand or it may be the left, but either way a hand will lift!

R: It's an illusory choice for her ego consciousness in the sense that you are determining there will be a response. When you offer such choices—as you do in the next section—that cover all possibilities of response, you are structuring a double bind that leaves it to her unconscious to choose a response.

"Ping-Pong": Depotentiating Consciousness to Facilitate Unconscious Activity

E: Maybe your right, maybe your left. If you are righthanded, it may be your left. If you are left-handed, it may be your right. Or it may be the dominant hand. You really don't know.

E: Now here her conscious mind must jump back and forth— right, left, right, left.

R: What does that do? You've got her following you?

E: Yes, she keeps jumping. You're keeping her in a state of shifting thought, so her unconscious will take over because her conscious mind is bouncing back and forth.

R: You play ping-pong with consciousness; you bounce consciousness back and forth in such a manner that it is depotentiated, thus allowing the unconscious to take over and actually levitate one hand.

E: That's right.

Waiting to Build up Expectation

E: *You just wait* and let your unconscious mind make the choice. And slowly you will become aware that the hand begins to lighten. [Pause as there is no evident movement or noticeable changes in the pulsations in the hand or the micromovements of her fingers.] *It may* feel somewhat different. [Pause] And you sense a tendency in the elbows, *a tendency to behavior.* You *may or may not* become aware of that.

E: Here I'm saying, "You just wait," again to build up an expectation that something will happen.

R: That expectant attitude makes the patient ready to achieve something from the unconscious. That is the ideal psycho-therapeutic attitude for the patient to have, since healing will come from inside once the rigidly erroneous sets of the conscious mind are bypassed. This is characteristic of your approach: When the patient is not responding readily, simply ask her to "wait." This waiting automatically builds up an expectancy that will tend to facilitate the response.

E: "It may" is giving a definite instruction.

R: Even though it sounds as if you are just being casual.

E: "A tendency to behavior" is an awfully elusive phrase.

R: It's a fail-safe phrase; whatever happens, you are still in tune with her behavior.

E: That's right, the patient will give you credit for whatever happens. You "may or may not" is another such safety phrase.

Depotentiating Conscious Sets to Facilitate Autonomous Responses

E: *It is sufficient that only your unconscious mind becomes aware.* [Pause] And be willing to show an increasing dominant choice. [Pause— no evident movement] Wait and enjoy *waiting.* * * * (asterisks indicate passages that have been omitted for economy in publication) *Certain things have been occurring of which you are unaware. Your blood pressure has altered. That you are unaware. Your blood pressure has altered. That is a matter of course in all subjects. [Pause—some minor movements in her hands]*

E: With this sentence, "It is sufficient that only your unconscious mind becomes aware," I'm really throwing out her conscious mind.

R: You are depotentiating conscious sets by implying that they are unimportant relative to the unconscious.

E: I'm not pushing her. We are both waiting. For what? For something! She may not even be aware that this waiting is exerting a pressure on her for something to happen.

R: Expectant waiting tends to facilitate unconscious responsiveness: Autonomous response tendencies tend to become manifest whenever we depotentiate some of our habitual conscious sets.

Indirect Associations Facilitating Ideomotor Response

E: Your hand is responding just a bit more, and *soon your elbow will come into play.* * * * *You may* be aware your breathing rate has altered, and the pattern of breathing. And now the thing is your heart rate has changed. I know this by virtue of the fact that I can observe your pulse in the neck. I can also watch it in the ankles. Sometimes I can see it in the temple.

E: "Soon your elbow will come into play." How do you play with your elbow? To sort out the meaning of that, she must begin thinking about the elbow; that thinking is the beginning of ideomotor responses of bending the elbow and moving it.

R: Simply talking about movements in a provocative manner is an indirect way of facilitating movement responses: That's the ideomotor response.

E: "You may" means I'm giving her permission. I'm also ordering her. In common parlance and childhood games, "You may look now" means what? "You look!"

R: Yet it does not sound as if you are giving an order.

Multiple Levels of Meaning: The Paradox of Facilitating Unconscious Processes as the Essence of Erickson's Approach

E: But the important thing is for you to discover that *hand lifting* slowly upward. There is enough *dominance* in one hand for you to become aware of it. *You will be patient* because the unconscious is learning for the first time how to take over, *intentionally* responsive to another person. * * * *Your body has been responding in many ways on an unconscious level without your knowledge.* When you meet a person for the first time, there are certain muscles that contract, there are certain muscles that relax. And you respond differently to different people. [Hand shows some lifting, about half an inch.] Now your hand is lifting away from your thigh. *Lifting up.* And it will become higher and higher.

R: You are actually speaking of two different things in close proximity here—hand levitation and hand dominance. The word *dominate* in this context could refer to hand dominance or the fact that one hand is gaining dominance in levitating. Just which meaning she takes it to be doesn't matter.

E: It doesn't matter which way she takes it; heads I win, tails you lose. When I say "you will be patient," I'm utilizing the fact that a blind person has learned to be "patient."

R: You facilitate rapport by casually mentioning things she knows to be true; she has to agree with you. You are using a truism that is valid for any blind person in order to set up a yes set.

E: Without her awareness of it.

R: All she knows is that she feels at one with you, but she does not know the how or why of your metapsychological use of truisms.

E: Take the word *intentionally.* That is a brand-new idea to her because she previously thought that you could take over intentionally only with your conscious mind.

R: There is an interesting paradox in that: The unconscious that functions *autonomously* is to take over *intentionally.* Such paradox tends momentarily to depotentiate the patient's conscious sets. That is a very critical and important learning

for a person who wants to experience hypnotic trance: Allow the unconscious to take over: let the unconscious be dominant to permit latent and therapeutic response potentials to become manifest. That is the essence of your approach, isn't it?

E: Yes.

R: "Your body has been responding in many ways on an unconscious level without your knowledge" is a very safe statement to make. It sounds profound and pregnant with meaning when you say it. And that, of course, tends to further facilitate unconscious processes.

Conscious Process Facilitating the Unconscious

E: Now think of it coming up, coming up ...

R: When you ask her to "think of it coming up," you are actually enlisting her conscious ideation to help the unconscious or involuntary levitation. It is as if conscious motivation or energy can spill over into the unconscious to facilitate its learning.

E: Yes. It is just like when the hero of a cowboy movie yells at the bad guy, "Look out behind you!" He evokes a startle response of turning on an involuntary level from a command shouted on the conscious level.

Emphasizing Individuality for Spontaneous Behavior

E: . . . and perhaps you can *feel it moving toward some object* just above your head. [Pause] A little bit higher. Now the elbow will get ready, and the wrist will lift. Now all of your learning has a certain carefulness. A slowness, a preciseness, inculcated in your pattern of learning. This is one bit of learning in which you do not need to learn to be responsible, and there is no rigid pattern for it to follow. It is purely a *spontaneous* sort of thing. Spontaneity of muscle effort on your part has been trained into one position and care. And that's one thing that is going to have to be altered. [Dr. Z's hand jerks up visibly a few times.]

E: The purpose of movement in a blind person is more goal-directed than in a sighted person. Sighted people are free to move spontaneously because they can see. Movement in the blind person is totally different than in the sighted. Because it is more goal-directed, the suggestion to "feel it moving toward some object" is particularly appropriate for someone blind.

R: In the next sentences about slowness and precision of movement you are again adapting your verbalizations to her particular individuality. A blind person since the age of two of necessity would have learned a certain cautiousness and more goal-directedness in body movements.

E: I'm defining her rigid pattern of learning and telling her she does not have to stick with it. The word *spontaneous* has for her the important associations of *involuntary* and *dissociated."* For a blind person such movements are normally disaster, since they cannot correct them as early as a sighted person.

R: Movements that are normal and spontaneous for a person who can use sight to automatically correct and control would be dissociated and involuntary if performed by the blind person— they do not have the automatic feedback control mechanisms of visio-motor coordination. That's rather profound: What's "normal" in the sighted becomes dissociated in the blind. There's an intimate relation between sensory processes and the continuum of voluntary-involuntary (dissociated) behavior.

Reinforcing Spontaneity and Individuality

E: And now you are making *still more progress!* [Pause] Showing your own particular pattern of hand levitation. And you are showing your elbow movements are not those of a sighted person. They are your patterns of elbow movement. That's fine because your arm has risen. And you begin to wonder when your hand will get all the way off your dress. Or you can wonder which will be the first to lose contact with your dress. It is losing contact here, there. *I don't even know if you know which hand it is,* but that is *not* important. [Pause.]

R: Your suggestion is apparently working because these upward jerks, the strongest thus far, seem to come in direct response to what you are saying. You quickly reinforce it, of course, by remarking on her "progress."

E: That's right. I'm emphasizing that her elbow movements are not those of a sighted person. I'm again emphasizing her individuality and spontaneity. When I admit that I don't know which hand is levitating, it implies that it's what she is experiencing and learning that is important.

Pauses Evoking Internal Questions That May Depotentiate Conscious Sets by Implication

E: Your pattern of learning may be to occlude the exclusion of your own awareness. [Pause] The exclusion of your awareness is not wrong, it's not necessary. You've been trained by experience to be *very aware,* as if awareness in this situation were important. But you're actually accomplishing something. It's going up more and more. You've already accomplished enough to achieve awareness if it's a necessary part of your learning. [Pause] To me it is important you learn in any way that you can. And I'm fully aware that your part is to learn a pattern of responses not common to me. [Some upward movements are apparent.] It's lifting higher and *higher!* Your unconscious mind has moved the hand. It's already made the elbow move, [Pause] and it is altering contact with your dress.

R: Here you are directly suggesting the possible exclusion or occlusion of awareness.

E: Yes.

R: You're continuing to depotentiate her awareness by locating the source of her training to be "very aware" and telling her this is a different situation. Hypnosis is a different situation in which your careful training in awareness need not apply.

E: During the pauses of this section I'm giving her time to ask herself, "Why should I be aware?" I'm telling her it isn't necessary. I pause here (the second pause) while she thinks it out. You see movements without complete conscious awareness in kids all the time. At the dinner table a child will ask, "Can I go to the movies?" And as he waits for an answer to this very absorbing question, you notice he's picked up a glass of milk and brings it to his lips, and only when it actually touches his lips does he make a slight startle of recognition that the milk is there ready to drink. You see that type of thing over and over again in work with children.

R: Children tend to do things automatically without conscious awareness.

E: Yes, on an automatic level.

R: It's that automatic level of functioning that you capitalize on in trance.

Push and Pull in Hand Levitation

E: And now sooner or later there'll be a push by your unconscious mind. It's going to *pull or push* your hand upward. [Pause] And you are actually increasing your learning.

In a way you had a double purpose, which is very nice. You have a tendency of learning more than you are aware of. You can be aware of some and be unaware of some.

R: By including both "pull or push" you are covering more than one possible response; you are permitting her to utilize whichever mode of response she has more strongly built into her from previous life experience.

E: Her double purpose is: (1) to learn to be responsible at a motor level, and (2) without a conscious awareness. For a blind person it is so necessary to have a conscious awareness of any motor movement. A blind person has to be aware that such and such is just so far from my shoulder, my back, my thighs, etc. [Erickson demonstrates nonverbally with his body.] But sighted people have peripheral vision and are unaware even that they have it to handle such problems. Blind people have to goal-orient their movements as a consciously done thing; it is an entirely different type of movement than that of a sighted person. Now in hand levitation I'm asking her to learn to make movements that have no goal.

When you question subjects about hand levitation, some experience it as a force pushing their hand, while others experience it as a pull. Now blind people know what a pull is and what a push is. They relate that to goal-oriented purposes. So you isolate that pull or push knowledge into a nongoal-directed area.

R: A nongoal orientation is what we want in trance.

Uncertain Trial-and-Error Learning in Hand Levitation

[Dr. Z's hand is levitated a few inches, and though it bobs uncertainly in the air, it is actually always "actively trying," even when it momentarily lapses back on to her thigh.]

E: Lifting higher and *higher more rapidly.* And now it is lifting up very, very smooth. Your head is bowing down toward it very slowly.

E: This uncertain bobbing up and down, trial and error, is typical of all learning. You try to do something new, but there are many partial and abortive efforts—

R: —before you can get a smooth lifting of the hand autonomously.

E: With the emphasis on "more rapidly," I'm taking her attention away from the lifting to the question of speed.

R: Implying, therefore, that it will lift, it's now only a question of how rapidly.

Autonomous Head Movements as an Indicator of Trance

E: Bowing down toward your hand, and as your head bows, your hand will lift easily. Bowing down very slowly, and the hand lifting to meet the face. [Pause. Dr. Z's head bowing was a very slow micromovement indeed! R had to study Dr. Z very carefully to ascertain that it actually was taking place.]

E: How do you move your hand to your face? [R demonstrates a direct hand movement to his face without moving his head.]

R: Oh! You mean there is a difference in trance: In trance people tend to also move their head toward their lifting hand. So when you observe that head moving toward the lifting hand, you can take it as an indicator of developing trance?

E: Yes. Your guest at your dinner table is not going to ask you for a second piece of cake. You can watch him not ask you: His head moves toward the cake, his eyes look,

there is a parting of the lips. But he is not asking verbally.

R: Nor does the guest always know what he is doing. Those head, eye, and lip movements sometimes occur involuntarily.

E: Yes.

R: So these head movements in trance are involuntary. That is why you prefer to use head movements for signaling Yes or No rather than finger signals; head movements are much more built into the person, and so can function more easily on an involuntary level.

E: That's right.

The Rhythm Induction: Yo-yoing Consciousness to Get into the Therapist's Rhythm

E: Bowing down slowly, down, down, up, down, up, down, down, up, down, up. [Pause] Your head is getting lower. Your fingers are about ready to lose contact. More of that slight jerk, and some of the fingers will be off. Lifting. Lifting. [Pause]

E: What I'm doing with this down, up, down, up, etc., is associating the head and arm movement. This is also a yo-yo on the patients' thinking; they can't solidify their thinking. They can't think, "Now it's down, now it's up" because I've taken over that down and up, and it's now in my rhythm. Only they don't know it is my rhythm. They get into the therapist's rhythm.

R: It is important for the patient to get into the therapist's rhythm because it will enable her to follow a suggestion that will come eventually.

E: That's right. I am getting her away from her own habitual conscious patterns.

R: Which is the essence of your whole procedure.

E: But I would not say, "I will tell you when to breathe in and out," because then you would be making her consciously aware of her rhythm! A child with whom I worked had a father who used medical hypnosis. When her father asked her about the differences in our approaches to hypnosis, she replied: "Daddy, you tell me to sleep, but Dr. Erickson breathes me to sleep." You adopt the child's rhythm of breathing, and then you start altering your rhythm and let the child now follow you. We all have a lot of rhythms, and rhythm is a very powerful force. [See Vol. I of *The Collected Papers of Milton H. Erickson on Hypnosis* for a detailed account of the Rhythm Breathing Induction.]

R: We can thus utilize rhythm as a method of inducing trance or of deepening trance. It is particularly potent because (1) it is indirect, in that the subject does not know it is being utilized, and (2) rhythms all have a natural biological grounding within us. When we get in synchrony with a subject's rhythm (whether it is breathing, movement, a verbal pattern, etc.), and then by degrees succeed in altering it, we are changing a very deep function and may be thereby capable of effecting deep therapeutic change.

Implied Directive to Reinforce Hypnotic Learning

E: When your right hand is off, you *will have learned a great deal* about hypnosis.

R: Here you subtly capitalize on her eagerness and motivation to learn hypnosis by saying she "will have learned a great deal" when her right hand has lifted. This is a form of the implied directive that reinforces a covert internal state of learning. Some learning certainly will have taken place by the time her hand does lift off her dress—not much, but some—and however little it is, it will be strongly reinforced by your rewarding

her with the statement, "you will have learned a great deal." Thus emphasized and rewarded, the little bit she has learned will serve as a foundation for later learning

Disguising Authoritative Suggestions

E: *Only you won't know* what it is you have learned. But it will be a sizable amount with which you can work. If you want to know something of how to that's *right!* A nice *jerk!* Soon there will be another. [Pause]

R: You make this statement "Only you won't know" to keep the new learning experience of hypnosis safe from the neutralizing and destructive influence of the doubting sets of consciousness.

E: Yes, and that is a direct authoritative statement, only it isn't heard as such. The word *only* takes off the authoritative sound. Even when you make a direct suggestion, you typically disguise it with casual diminutives (only), probabilities (it may, perhaps), and subtle use of negatives (it will, will it not) to disarm the usual doubts so characteristic of the patient's learned limitations.

Immediate Reinforcement of Involuntary Jerks

E: Your head is going a bit lower. Hand lifting [Dr. Z's hand gives a noticeably stronger upward jerk.] *That's right! Another jerk!* [Pause] Wonder why there would be jerky movements? There are always jerky movements as part of physical learning. [Pause]

R: A very nice immediate reinforcement of an obviously involuntary upward jerk takes precedence over anything else you may be saying, so you break right into your own stream of verbalization here.

E: Yes, I may be saying something to her, but I immediately change the subject to her behavior.

R: This phrase "That's right" whispered with intense interest and conviction has become a catch phrase among members of the American Association of Clinical Hypnosis who have observed your work and learned from you first hand. When I experienced that phrase while in trance with you on one occasion, I felt a burst of pure energizing joy that motivated me to a point where anything seemed possible.

E: Yes, that's the power of reinforcement utilized at the right time. This jerkiness of her movements is characteristic of all learning—it helps patients to actually tell them that.

Slowness of Normal Learning and Clinical Retraining

E: Learning smooth movements and slowness is not anything to be distressed by. [Pause] That's right. *Lifting!* All of its own, up it comes. And now it extends to your forearm and elbow. [Pause]

E: [Describes the importance of allowing learning to take place slowly, as it does naturally. Children with stuttering and speech problems, for example, can learn to speak normally by going through a period of retraining during which they are taught to speak very slowly.] The problem in learning to speak well is in your willingness to learn slowly. All little kids can learn to speak because they are usually willing to take a year or two to say "drink of water" instead of "dink a wa-wa."

R: Normal learning in speech, walking, reading, arithmetic, spelling, etc. actually requires the coordination of an indescribable number of neurones, muscles, and sensory organs. Reorganization is constantly taking place in the synaptic connections of the brain throughout our entire lifetime (Hubel, Torsten, & LeVay, 1977; Changeaux

& Mikoshiba, 1978; Greenough & Juraska, 1979). That is why such skills usually require years to develop. In clinical retraining we must therefore emphasize that a normally slow and patient period of learning will enable a genuine organic growth and reorganization to take place. This patience is sometimes required for hypnotic training as well. I remember the first time you used a hand-levitation induction on me—it actually took an hour before my arm got all the way up. But a lot of genuine learning about trance experience took place in that hour that served as a foundation for our further work.

Tension for Hand Levitation

E: And the tension will increase in the elbow. [Pause]

R: This reminds me of the fact that some tension in the arm is required for successful hand levitation. Dr. Robert Pearson actually builds in this needed tension in a variation of hand levitation—he has the patient begin by resting the fingertips lightly on their thighs. In this variation there is naturally more tension in the forearm, which must hold up the hand, so only the fingertips touch the thigh.

E: I know, I taught him that.

Depotentiating Conscious Sets with Suggestions Only the Unconscious Can Carry Out: Occupying the Conscious and Unconscious on Their Respective Tasks

E: Now it isn't necessary for me to speak to you. You've heard what I had to say. [Pause] Your experience of learning to retain the spoken word, and you can repeat this on and on through your mind. [Pause] And make your response fit your *memories* as my words flow through your memory. [Pause]

R: In this section you're instructing her to internalize your suggestions and associate your words with her own "memories" of how responses are made. Actually, of course, she probably does not know consciously how to fit her responses to her memories. You are giving her a suggestion that only her unconscious can carry out. In this way you again indirectly depotentiate her habitual conscious mental sets in favor of unconscious or autonomous processes. This is to take place while her conscious mind continues to reverberate your words in her memory. Thus, you have given a task to both her conscious and unconscious mind.

Coping with Consciousness and Depotentiating Habitual Conscious Sets: The Inserted Command to Enhance Learning

E: In that way you are going to *enhance your learning.* [Pause as a little hand jerk is noticeable.] That's right. [Pause as another very little hand jerk is noticed.] That's right. [Pause]

E: This is an example of an *inserted command.* I've made a general statement there about learning, but I've used the word *enhance,* which makes it into a command.

R: It is actually your vocal emphasis on the word *enhance* together with a slight pause before it makes the command "enhance your learning." It is really incredible how such slight vocal changes can lead to such great shifts of meaning. These shifts of meaning are so swift and unexpected that consciousness usually cannot follow them; it usually cannot grasp their implications and then debate or negate them. This is the essence of your art of coping with consciousness: Suggestions are presented in such a way that

they quickly slip through conscious defenses without ever being picked up. The suggestions finally come to rest within the subject's preconscious, unconscious, or memory banks, where they can now interact with other associations to effect their therapeutic work. The conscious mind is then presented with a fait accompli from within—without ever knowing quite how it happened.

Covering and Reinforcing All Possibilities of an Hypnotic Response: Unconscious Association and Therapeutic Suggestion

E: *Now soon* you will tie the movement of your hand to the recognizable movement of your head. [Long pause] That's right. You are trying to orient your entire forearm, elbow, and hand. [Pause] And I can see the action, and I can feel it. [Pause]

R: This is a fascinating juxtaposition: "Now soon" means a response could take place *now* or *soon,* depending on the readiness of the subject. In two words you've again managed to cover all possibilities and reinforce behavior whenever it happens.

E: "Now soon or later, or sooner than you think," would be another one. With that you've really covered all possibilities. You've also given them full permission to "think," though they don't notice that you've given them that permission to think. They are paying attention to the "now" or "soon" or "later." They ignore the "think."

R: This subtle inserting of "think" would be another example of your technique of associating your suggestions with what they are naturally doing in such a way that their consciousness does not recognize it. This unnoticed association, however, builds a strong connection between your words and their unconscious, so eventually your words will trip off processes within them on an unconscious level. At a later time you might be able to use this association to have them "think" about something for therapeutic purposes that they might not ordinarily think about.

Catalepsy in Blind and Sighted: The Failure of Hand-Levitation Cues

E: Be *unconcerned and uninterested* in what I do. [Erickson now moves closer to Dr. Z and begins to touch the lower edge of her slightly levitated hand with his. He is giving a tactile signal for lifting without actually lifting.] I do not need any assistance. [Pause] What I do is my responsibility, and you do not need to correct it or alter it in any way. [Pause] It will not be an interference with you. [Pause] It will be an effort by me to let you become aware of certain things that have happened in your physical orientation. [Pause] Keep on with that effort to lift your hand at the unconscious level without concern for what I do. [Pause. Dr. Z's hand apparently does not accept his tactile cues to remain up and lift further; paradoxically, it drops down after he gives hand-levitating cues.] I'm putting your hand here. [More firmly, Erickson places her hand in a cataleptic pose about midway between her lap and head and holds it there lightly for a moment, then, as imperceptibly as Possible, he removes his support. Most subjects, whether in trance or not, usually take this as a cue for the hand to remain suspended in that position. Dr. Z does not seem to pick up Erickson's nonverbal cues to maintain that position, however, and in several attempts her hand either flops back to her lap or descends within a moment or two] *I'm not putting it in any other place, just here.* And you are not to correct it or alter it. You are slowly beginning to understand [Pause] that you don't know what I mean by *altering it.* [Dr. Z's hand continues to drift down to her lap after Erickson positions it. Then there is another pause as Erickson again positions her arm, and again it rapidly drifts down.] Now that was a correction, an alteration. [Pause] And now I'm leaving the fingers there. [Erickson now contents himself with leaving two or three of her fingers lifted, even though the remainder of her hand rests on her lap. . . . Pause. Even the fingers lose their position so that

Erickson has to reposition them.]

R: Why do you ask her to be "unconcerned and uninterested" at this point?

E: When you touch a blind person, it isn't the same as when you touch a sighted person. The blind are obligated to try to place a meaning on that touch. You don't look an Arab in the eye when you talk to him because he considers that an insult. In certain parts of South America people stand so close to you that you're belly to belly, but you don't move away or they take it as an insult. Blind people also have their own culture; the sighted person has no awareness of what touch means to the blind.

A touch to the blind means, "do something." And what is that something you are to do with your hand? Your hand has been touched for a purpose. But what is that purpose here? She can't find any purpose. I've learned from working with a lot of blind subjects that catalepsy is an awfully hard thing to achieve. Catalepsy in a sighted person who does not understand a word you say is easily achieved.

R: You feel this is because in the blind person, hand positions and movements always have an object orientation—a purpose orientation. And yet you are trying it [catalepsy] here even though you know it probably won't work.

E: Yes, this session is for didactic purposes. Anybody doing therapy ought to get to know the range of human behavior.

R: When you say firmly, "I'm not putting it in any other place, just here," it seems to be as direct a suggestion as you could make without saying, "Please hold your hand in this position." But true to form, you make your suggestions as indirect as possible so that the conscious mind will have as few cues as possible to do things in its own characteristic way.

E: She really doesn't know what I mean by saying "altering it."

The Failure of Direct Authoritative Suggestions as a Paradoxical Indication of Trance

E: There, right there! *Right there!* [Erickson makes repeated efforts to have her maintain that arm in the air.] It's contradicting your total education, but keep it right there up, up, up! Up, up, up up! You are learning! [Several of Erickson's dogs are barking loudly outside the office, but at least Dr. Z doesn't seem to be paying any attention to them. Only Dr. Rossi silently mourns their disruption of the tape recording.]

R: *In extremis* even Erickson is capable of fairly shouting a direct, authoritative command, "Right there!" But all to no avail! The hand flops haplessly back to a flaccid resting position on her thigh. The very fact that she cannot follow a direct command for the voluntary maintenance of her hand in the air indicates that she is in an altered state of consciousness.

You have made a shift from an indirect and permissive mode to very direct, authoritative commands, but she cannot follow you now with a voluntary response. This peculiar rigidity of not being able to respond even on a voluntary level may be an indication of the psychomotor retardation that is characteristic of trance. Actually, a kind of pandemonium is taking place with the loud barking of the dogs, your unusually assertive intrusions, and the air conditioner clicking on and off just above her ear, but she ignores it all, as is characteristic of trance behavior. Those dogs have never been such a bother. I wonder it they picked up your loud voice and are trying to come to your defense?

Utilizing Natural Mental Mechanisms and Limitations

E: You may not know you have yet learned anything about hypnosis. You may not feel you have learned anything. Your unconscious mind may know that it has learned. [Pause]

R: This is highly characteristic of your approach for bypassing the doubting attitudes of consciousness. Consciously, the patient may not realize that something has been learned. Consciousness is typically unaware of latent learning, the formation of unconscious associations, etc. You use this basic fact about human learning, this basic truism, as the foundation to facilitate an acceptance attitude toward her training for involuntary signaling that occurs in the next section. You take advantage of natural limitations of consciousness to introduce a set for involuntary or hypnotic responses. I believe this is the fundamental basis of the effectiveness of your work: *You utilize natural mental mechanisms and limitations to channel responsiveness in ways that the conscious control system cannot yet do.*

The Double Bind in Hypnotic Induction: Criteria for Valid Ideomotor Head Signaling

E: So I'm going to pose a situation, and in the situation we will both wait for the answer. If your unconscious mind knows that you have learned something, your head will slowly nod Yes. If your unconscious mind thinks No, it will slowly shake No. Now we will wait for the answer. Has your unconscious learned something about hypnotic response? [Long pause] Now a positive answer is a nod of the head. A negative answer is a shake of the head. So far what you have attained has been a slight nodding and a slight shaking, meaning: I don't know. Now the unconscious mind does have a lot of repressed knowing. That's why we call it the unconscious. Now slowly move your head down, down until your chin touches your dress. Not rapidly, just slowly. [Pause] Now I want to point out to Dr. Rossi things he should notice. But you need not pay attention to what I say to Dr. Rossi. It will be without meaning to you.

R: You use a double bind to introduce involuntary head signaling with your suggestion, "If your unconscious mind ... it will shake No." This is that neat situation that actually induces a hypnotic state or deepens it. Your double bind tends to evoke an autonomous or dissociated (involuntary) response from the unconscious. When the answer comes, it really doesn't matter whether it is Yes or No. The mere fact that an involuntary response occurs means that the subject has entered trance—even if only momentarily to make the involuntary response.

E: Yes. A head can nod for Yes, shake for No, and make all sorts of movement in between for "I don't know." You accept such movements as valid only when they are (1) *slowly* and (2) *repetitively* done. When they are done quickly and not repetitively, that means they are from the conscious mind. The Yes of trance is a repetitive movement that may last for a minute.

There is no need to terminate it because there is nothing else going on in the trance state. In the waking state there is something else going on that stops and replaces the Yes response.

The blind have no possibility of relating a visual value to a nodding of the head; only the sighted person can have that understanding. Therefore, the blind person who knows what a nod and shake means can do it, but does it without any conscious understanding of what is taking place because of never having acquired the visual associations.

In this patient a nod of the head came slowly and imperceptibly because it was not

necessary to become consciously aware of it. Only the viewer needed to see the slight, slow movement because only the viewer could place a meaning on it. The fact that it took place meant that the unconscious did understand but did not know how to nod the head to meet visual requirements.

A sighted person can lower her chin to touch her dress. That can be seen as a meaningful thing. A polite bow can be seen and understood, but it can't be understood at all by a blind person. It is totally without meaning. Asking her to touch her dress with her chin is asking for a performance that has no visual meaning of any sort. The only conscious meaning is to feel the dress with the chin.

R: That is the only cue she has, touch, but no visual meaning.

E: Now, when the only cue for understanding is a touch of chin against cloth, how far down do you bend the head to touch? She has no cues until she gets to the goal. It is going to seem long.

Depotentiating Conscious Sets: Tasks with No Conscious Referents

E: [To Dr. R] Location is undefined, *lost.* The need for exploratory activity is [To Dr. Z, regarding her head's micromovement downward] down and down and down. [To Dr. R] Now, the slow smoothness of the movement there is not possible by the conscious mind. This indicates there is a lack of the guidance of the conscious mind. [To Dr. Z] Down further. [To Dr. R] There is an altered time sense. [Pause] [To Dr. Z] Down still further. [To Dr. R] I would judge it's contracted time.

R: Yes.

E: [To Dr. R] Though sometimes it is expanded time. You have to learn that from the subjects later. [To Dr. Z] Down still further, and keep on going till your chin touches your dress. [Pause] It seems so long and far away, the dress does, but you can get your chin on it eventually.

E: The movement is undefined, and the purpose is lost. I'm getting something done by her for me that I can understand, but it has lost all significance for her conscious understanding. Her conscious mind has no referents for it, and she does not realize.

R: This is another way of depotentiating conscious sets. Patients may have awareness in trance, but by having them do tasks they cannot understand, by having them engage in behavior for which they have no conscious referents or orientation, you are temporarily rendering their left-hemispheric consciousness incapable of its habitual modes of action. Perhaps that is a way of understanding what trance is: *Trance is a state of awareness wherein the normal organizing and structuring function of left-hemispheric consciousness or the ego is minimal.* In keeping with recent research, we would hypothesize that it is typically the organizing functions of the left hemisphere that are depotentiated (Erickson & Rossi, 1979; Watzlawick, 1978). In this less organized state awareness can maintain its receptive function and sometimes its observer function as well. I wonder if this is similar to the state of "no-mind" which the Zen Buddhists strive for. It is in this receptive state that the patient's defenses and erroneously limiting conscious sets and attitudes are in abeyance. In this state the mind is open to receiving the seeds of therapeutic suggestion, which must then sprout in the medium of its own unconscious associative processes.

Gaining Control by Giving Permission

[Long pause as Dr. Z's head begins to lift with an almost imperceptible micromovement.]
E: And slowly now the head begins to lift up *without requiring any permission* from me, a little bit to the left, and lifting a bit easier and comfortable, much easier, much

more comfortable. * * *

R: The head movement spontaneously changes direction in a manner you had not anticipated. Yet you immediately approve of it with your mentioning that it moves "without requiring any permission" from you.

E: You wait for that movement, and then you mention it so the blind person knows you are attending to them. That is the only way they have of knowing. Mentioning it also gives "permission" for it.

R: By giving "permission" you also gain control over it. You gain control over symptoms by the paradoxical procedure of giving the patient permission for them (Watzlawick, Beavin, & Jackson, 1967).

Indirect Generalization of Hypnotic Effects by Implication: Shifting from the Known to the Unknown: Facilitating Creativity

E: By sensing your hand or your forearms or your neck or your thighs or your calves, by paying attention to first one part and then another part of your body. And last of all, [Pause] feel the comfort in your head. [Pause] And feel the sense of being rested. *Now in learning hypnosis it is not important to know what you have learned.* [Pause] What is important is the acquisition of the knowledge, and having it ready to utilize when the proper stimulus conies.

E: I previously emphasized hand levitation and head nodding, and now I'm mentioning all the other parts of her body— apparently to generalize, but specifically I'm relating them to my hypnotic suggestions about hands, arms, elbows, head. And yet I'm not telling the subject, "There will be an association." When I say, "I see you've lost two fingers of your right hand," I'm also saying (implying), "but you haven't lost your fingers of your left hand."

R: So here you are actually generalizing your hypnotic work with her head and hands to other parts of her body without giving her any conscious cues to that effect. The generalization of the hypnotic effects takes place on an unconscious level because consciousness does not grasp the implications of your associations.

Next your truism, "Now in learning hypnosis it is not important to know what you have learned," tends to depotentiate her habitual conscious sets by implying that it's more important to be able to respond appropriately to a proper stimulus than simply to know. This tends to shift functioning from the knowing conscious system to the unknown processes by which the unconscious mediates responses. This continued shifting of emphasis from what is known to the unknown is highly characteristic of your approach. You do not presume to know yourself. By continually evoking the unknown, however, you are constantly breaking through the limitations of a patient's conscious sets and setting the stage for unconscious creativity.

The Patient's Cues Signaling the Wish for Trance Termination

E: Now I know that you would like to awaken, so very slowly come awake. Not all over. I want you to learn to enjoy, [Pause] sensing what trance feelings are in various parts of your body.

R: How do you know when a subject wants to awaken? Do people get fidgety?

E: Experience can be very informative. [Erickson here gives an analogy with toilet training. Mothers soon sense that youngsters begin to look up and all around in a certain way, it's time to put them on the pot. "Is he looking for the chamber pot?" R asks. "No, no," Erickson answers, "the child is looking all around wondering where that

pelvic pressure is coming from. It takes some time and life experience for the child to locate its own bodily sensations—the location of internal functions tends to come later."]

Hypnotic subjects like trance up to a certain point the first time, and then by their movements and alterations of facial expression, alterations in sound of voice, altered tension of the body, altered breathing rate, they let you know in some way they want out. You see two people talking, suddenly you notice one losing interest, you can see their interest evaporating.

Ratifying Trance: Learning to Maintain the Body Sensations of Trance

E: You won't get all the feelings in all the parts all at once. It is a learning process. [Pause] I would like to have you as soon as you are ready in your own way to speak and say, "I am awake," when you *feel* you *are* awake.

Z: I am awake [spoken in a low whisper as she reorients to her body].

E: How do you know that?

Z: Well, as far as I know I always was, but I, uh, know for instance that this hand [Pause] it had a feeling like it was raised up. *But I didn't dare move my fingers to tell if it was or not because I didn't want to spoil the illusion that it was.* And then you said that the fingers were leaving the dress, so apparently it was.

E: You don't learn all at once. You learn in segmented fashion.

R: You are going to learn you have lost a certain part of your body: That is, a certain part of your body is heavy, anesthetic, or it has a "pins-and-needles" feeling. All those altered sensory responses are indicators of trance, and different parts of the body will pick it up at different times. The therapist must make sure that patients know that whatever alterations they feel are aspects of trance.

E: Yes, that is the purpose in having them describe the sensations. It ratifies the trance.

R: When she says that she "didn't dare move my fingers . . . because I didn't want to spoil the illusion," she is undergoing a very characteristic experience of highly intellectualized subjects who are learning to experience trance. She wants to maintain her body immobility, her catalepsy, to experience the altered sensations of trance. The catalepsy maintains a slightly dissociated condition of not knowing that is necessary for trance experience. She is now voluntarily blocking her own left-hemispheric mode of orientation to give the more curiously interesting right-hemispheric experience an opportunity to assert itself. The subject of Section IV, Dr. Q, illustrates this phenomenon of learning to experience trance in more detail.

The Spontaneous Discovery of Altered Sensations in Trance

Z: Later, after you tried to make it stay, it wouldn't stay up, but it did stay like that, [the heel of her hand resting lightly on her lap with her fingers uplifted] perfectly comfortable. Until you told me to feel perfectly comfortable, and *all of a sudden it was tired and went down.*

E: "All of a sudden it was tired ..." That is an important learning. Anything else that you can recall?

Z: Yes. The going down of my head, which I would have said was voluntary except that you said it was going more slowly than it could voluntarily. Maybe it was, and it was sort of turning itself with my breathing. I mean, I wasn't trying to say anything with it,

really. I started it down voluntarily, I suppose, because you told me to. But *I don't know why it went smoothly.*

***E:* It was so very unimportant for you to know *why* it went smoothly. It was very nice that you had the idea that you timed your head movement to your breathing.**

Z: And the breathing I did notice—at the beginning you said it had changed, but *I did not notice* it had. But I did notice later, when the head was going down, that *the breathing was sort of more like sleep breathing.* I mean, it was a more relaxed kind of breathing.

> E: This section contains many beautiful statements from a blind person. She is trying to tell you what movements mean to her and how she senses reality.
>
> R: You did not know that your request for comfort would have the effect of flaccid relaxation, but that was her own unique and individual response. Perhaps that is why her hand wouldn't levitate or maintain a catalepsy—she was too relaxed. But was that an important learning?
>
> E: "All of a sudden" means that she suddenly noticed the violent contrast of sensations in her hand between a trance condition and being more awake.
>
> R: I see, it is a ratification that a trance effect was experienced-it is a self-ratification of trance!
>
> E: A ratification independent of my words! You don't normally associate the turning of your head with your breathing, but blind people do. You look around to see if someone else is in a room; the blind listen for breathing. When she says, "I don't know why it went smoothly," she is again verifying the trance condition. She did not understand an altered movement. She knows her movements, but here is a brand-new movement.
>
> R: Her not understanding an altered movement, movement that is alien to her habitual pattern, is described by you as a trance condition. This supports our analysis of trance as a condition wherein the patient's habitual and familiar mental sets—the structuring function of their left-hemispheric consciousness—is minimal.
>
> E: Her recognition that "the breathing was sort of more like sleep breathing" is another ratification of trance.

The Problem of Ratifying Trance for Modern Consciousness: Altered Experience and Time Distortion

E: That's right. And you're sure you are wide awake now?

Z: Yes.

E: No doubts!

Z: Do you? You did not know whether time was contracted or extended, but *I don't know* if it was either one, but of course I don't really know.

E: What time do you think it is right now?

Z: What time did I get here, do you know?

E: Yes.

Z: Well, I would say it's been half an hour.

E: How are you in noting the passage of time ordinarily?

Z: Sometimes very good, and sometimes I can be two hours off. I think it usually depends on whether I am doing familiar things. When I'm doing familiar things, particularly if there has been something like an interesting discussion or playing with

the kids and there aren't any time units—then I can be way off.

R: In this section and the previous one you are both involved in the interpretation of experience that is so characteristic of the initial session of many highly intellectualized patients. Her left hemisphere, with its characteristic limitations, tried to point out how it was awake in its normal state at all times. You try to cast doubt on that appraisal by searching for evidence of time distortion. I believe you both may be right, each in your own way. Her left hemisphere is correct in the sense that it was present and "normal," at least occasionally, in its observer function. Her left hemisphere does not realize, however, that in suspending some of its ordinary directing and controlling functions during "trance," other modes of functioning (all the classical phenomena of hypnosis) may have become manifest in ways that its observer function could not recognize. Your task as the hypnotherapist is to somehow ratify that altered experiences have taken place without so alerting her left hemisphere that it prevents these altered experiences from happening again. You make a move to this end by attempting to ratify trance via an altered time sense in trance.

E: Yes. A blind person cannot tell time visually. They do it by the amount of movement, exertion, the amount of tiredness or the lack of it. This can also be equated with interest and pleasure. You can expand time by being bored and contract time by being interested. A blind person can never use visual cues for time experience, so it is a totally different thing. Time is measured by breathing, just as you measure a drink on a hot summer day automatically by the number of swallows. Only you don't know it.

Altered Sensations in Trance: Touch

E: Now, without changing anything, I want you to notice the difference in sensations, the sensations will be different in your hands. [Pause] Can you describe that difference?

Z: We obviously know there is a difference with the position of the hands. The left hand has a *certain odd feeling in the left finger.*

E: That's right.

Z: Sort of the kind of lack-of-sensation feeling.

E: That's right.

Z: Except *it also feels as if there is something wrapped around them.* It is hard to describe it.

difference between your left and right hand. How long has that unusual sensation been present?

Z: *I don't know. I* didn't pay attention. When one hand was supposed to be going up, it was not there. But there is no question that the hand decided to rise up, except it really couldn't make it.

E: That's a blind person's description. She first mentions a position of the hands in terms of geographical location before she can attend to feeling in the hand. A sighted person can see where his hands are. He doesn't have to locate his hands; he sees them. And that visual orientation is so rapid he doesn't know he has made it. A blind person has to locate the hands physiologically.

"A certain odd feeling in the left finger"—what is she saying there? How does a blind person feel things? I have to note the feeling in this finger. This finger, and this finger, and this finger. A sighted person doesn't pay any attention to the sensation between one finger and the next; he doesn't need to. A blind person has to. How does your hand feel if you are blind? The hand is a feeling, sensory organ receiving things. How would you feel if your hand was "wrapped" up?

R: That then is another trance effect. If it feels "as if there is something wrapped

around" your hand, you are not feeling or receiving normally. So her very important organ of touch was sealed off as a result of trance.

E: Only roughly sealed off because she can feel the wrapping, but there was an altered sensation due to trance.

R: But even with a sighted person all these alterations in feeling, sensation, and perception are verifications of the trance condition for you. That is why you don't have to give challenges or other kinds of tests, because you have learned through experience that these altered sensations are all indications of trance.

Language as a Clue to the Sensory-Perceptual Differences Between the Blind and Sighted: Healing and Love

Z: The tension was there and the elbow, and the coolness was there in the Palm, and that told me that that part of the arm had gone up. But the arm wouldn't go up.

E: AH right. Now, what do you think is odd about that lifting?

Z: Nothing. I mean, apparently it didn't happen, but that's how I felt it happen.

E: Ordinarily, when you feel your arm lifting, it is lifting.

Z: Not always. I've *occasionally had to wiggle a finger to find out where my hand was for sure,* because I have played around to see if I could hypnotize myself. And if I put that hand out there and concentrate on it or something, *I cannot know for sure* whether it is or not [levitating],

E: All right, now. Let me state one problem that you are going to face. You have learned to rely on your ears to detect the direction of, let's say, a moving car, the presence of a person, the direction in which a voice comes. That geographical orientation is going to control you to a large degree if you don't know how to make spontaneous movements such as the sighted person makes. But you can make them. You just did.

Z: You mean I just nodded my head?

E: Yes.

Z: *I don't know* that you would call that *spontaneous,* actually.

E: It was not called for.

Z: No, it wasn't called for.

E: That's spontaneous. And you are extremely aware of bodily movements.

E: This is the language of a blind person. Tension in elbow and coolness in palm; no sighted person is ordinarily that sensitive to sensations. Notice that she "occasionally had to wiggle a finger to find out where my hand was for sure"! That's a clear example of movement in the blind to determine position. That's why I tell you language means a lot!

R: This whole session is an example of the different meanings words can have for different people. How sensitive and skilled the hypnotherapist must become to deal with these different meanings for people with handicaps, special talents, social and cultural differences! We all seem to have our own special language: The Tower of Babel is here and now. I'm coming to believe that the ordinary everyday conversation wherein we do not pay attention to these differences may be a comedy of errors in which we continually bounce off of each other's projections and idiosyncratic meanings. A real relationship is hard to find. When it does develop, however, we do have those special moments of communion that permit surprisingly effective responses to take

place— healing as well as love.

Developing New Induction Techniques: Hypnosis Defined as a Technique of Communication Utilizing Automatic Responses

E: But that really isn't important because it is *a new kind of learning going into a trance.* And you don't have to know any of the learnings that you need. You can get knowledge without depending on a conscious understanding of what it is. * * * A child's body tells him how many swallows for a good drink before he has a chance to absorb much of that water. Do you understand? So you don't need to be any more aware of your learning than a child is of the number of swallows of water. * * *

R: It's the hyperawareness and extra training in body movements that make hand levitation a rather inappropriate technique to use with blind subjects. This throws an added light on the development of new induction techniques. Induction techniques usually center around the operator making contact with a response system within the subject that usually takes place in a more or less involuntary or spontaneous manner. The subject does not have too many associative connections between his conscious mind and the unconscious that usually controls the more or less involuntary system. Yet there are some connections that the operator can pick up and utilize much to the subject's surprise.

E: Yes, I think that's right. The blind person is oriented to movement and touch and no visual cues. The sighted person relies on visual cues and disregards movement and touch.

R: So movement and touch are more autonomous in the sighted, and the hypnotherapist can gain control over them more easily. That's why you find that hand levitation and the approaches to catalepsy are so effective in inducing trance in normally sighted individuals.

E: You search out for those things that are peculiar to the person. For example, with a stutterer who is not interested in speech therapy (he has accepted his stutter), you will have a much more difficult time using free speech to put him in a trance than if you stutter yourself.

R: If the therapist stutters, he gains better entry into the stutterer's own associative patterns.

E: That's right! Though you have to be sure you make the stutter not too apparent. You make it look as if you are not quite sure of what you are going to say or how to say it. But you are not *trying* to stutter.

R: Likewise with the obsessive-compulsive person?

E: You phrase things obsessively and compulsively, and that will facilitate induction. In other words, you adopt the individual style and culture that you recognize in the patient. For a farmer you throw in a few country words; for a lawyer a few legal terms. But never obtrusively.

R: You adapt yourself to the patient's mental milieu.

E: *Hypnosis is a technique of communication whereby you make available the vast store of learnings that have been acquired, the usefulness of which lies primarily in the way of automatic responses*. In hypnosis we make a direct call on these learnings that have been dropped into the area of automatically available learnings.

R: *Therefore you could develop any number of new techniques of hypnotic induction by learning how to recognize and utilize in a subject past learnings that now function in an automatic or semiautonomous manner*.

Structured Hypnotic Amnesia via Questions

E: Now what time do you think it is?

R: Did you slip in this question about time here to distract her from the subject at hand? She seems to be in a bit of a restless mood, so you make an important statement and then actually distract her before she can dispute it. In this way your statement remains within her—without her conscious biases having an opportunity to debate and possibly negate it.

E: Yes. That's the way you change a subject quickly: Ask a question. There is something else involved here. You ask a question, and then before an answer can be given, you say a lot of meaningful things, and then you go back to the original question. You've thereby drawn a blanket over the meaningful material; you've put a parenthesis around it. This is a very important principle of producing hypnotic amnesia in order to prevent the patient's consciousness from negating meaningful suggestions.

R: Since it is so carefully structured by the therapist, we call this a *structured amnesia,* in contrast to the spontaneous or suggested types of hypnotic amnesia that are usually discussed in the literature.

E: When I ask her what time it is the second time in this section, she has to go back to the original asking of that question several sections back. (See section entitled "The Problem of Ratifying Trance for Modern Consciousness: Altered Experiences and Time Distortion.") So everything that occurs between the two identical questions is as if covered by a blanket.

Dynamics of Questions and Answers: Confusion Facilitating Creative Flux

E: Now, your chin didn't touch your dress, did it?

Z: No. I was curious, I *didn't even know* if it could!

R: You didn't let her answer your question from the last section. Why?

E: You're keeping them off balance by asking and not answering questions. You are keeping them reaching out hopefully.

R: You are keeping their conscious biases off balance, and you keep an expectant and receptive attitude so you can deposit important suggestions they will then seize upon.

E: Yes, they will retain them better.

R: You don't give people a chance to experience closure by answering their questions.

E: That's right! Because once a question is answered, that closes and disposes of it.

R: No more learning can take place. You keep all questions open and keep learning at a high pitch. This is an aspect of your use of confusion: to keep a patient's learned limitations in flux so there is a greater possibility of the unconscious intruding with a new and more creative response (Rossi, 1972a, 1973b).

Ratifying Trance via Amnesias

Z: Then I wanted to ask you, *which chin?*

E: I mentioned amnesia there to Dr. Rossi.

Z: Yes, you mentioned conscious amnesia, and I presume that you meant I would not remember, but *I don't know* for sure if that is what you meant.

R: Again you don't answer her about "which chin?"

E: She is self-conscious there. She doesn't know really what she looks like, what her weight is, she doesn't really know. She is telling you in that question, "I don't know what my chin looks like. I have heard of double chins, triple chins. But I don't know." It is an unconscious question, a betrayal of a lack of physical knowledge of herself.

Then I go back to the subject of amnesia. All along I want her to develop as many amnesias as possible.

R: Why?

E: Because the more of my communications that are in her unconscious, the better she will be as a hypnotic subject.

R: The more amnesia you are able to obtain, the better the subject. So amnesia is not only a criterion of trance, but it facilitates future trance work. Because it is a function of autonomous or involuntary behavior?

E: Yes, and it is being elicited by you and named by you, and it is becoming a part of their personal experience. A patient no longer has any doubts about the trance.

The "I Don't Know" Set Facilitating Amnesia: Voice Locus to the Conscious and Unconscious: Indirect Trance Induction

E: Now you had lost your body sensation, and you vacillated from right to left in the downward movement of your chin.

Z: Did I? This *I did not know.*

E: And you shifted your way of breathing—sometimes more on the right side, and then more on the left. So I knew that you did not know your exact physical orientation. Right now, move your chin down and touch your dress.

R: Since the termination of trance she has been saying "I don't know" more and more. I wonder if you were aware of having this effect on her. [The "I-don't-knows" are placed in italics for the convenience of the reader.]

E: Yes, you get them to say "I don't know" by telling them they don't know and asking questions they cannot answer. They get a set for "I don't know."

R: Why is that of value?

E: We develop an "I don't know" set to facilitate hypnotic amnesia. It is a request for the subject *not* to know, but she does not consciously hear the request as such. It is not desirable to say, "You will forget that." They would come back with, "Why should I forget it?" But you can say, "You may not remember it, you may not know it." That gives permission, but it is not a command—nor is it a demand. It is a mere observation, but the focus words are spoken.

R: You can facilitate trance as well as amnesia by breaking up the knowing and orienting aspects of consciousness.

E: Yes, I seem to bifurcate the individual into the conscious and unconscious. When I say something, I may say it to the conscious or I may say it to the unconscious. I change the locus of my voice; I tilt my head to one side to speak to the conscious and another side to speak to the unconscious.

R: When the subject is in trance?

E: When inducing trance as well as while the subject is in trance.

R: You use a different head location in speaking to the conscious and unconscious,

and people gradually become conditioned to that.

E: Yes, without knowing it—because it is so subtle they don't notice it. At most it might be taken to be a mannerism of the therapist. A subject could watch you hypnotize someone else and just think you've got a certain mannerism of turning your head from side to side. This observing subject then does not know why he is suddenly becoming sleepy, but he begins to sense hypnotic effects. It is the things I said to the other person's unconscious that makes the observing subject sleepy, because it gets right to his unconscious, too. You see, communication is not just words, it isn't just ideas. It is vocal stimulation, auditory stimulation, and it is apparently leading somewhere (e.g., dangling phrases, repetition, and then a complete sentence), causing the patient to reach out.

R: Those dangling phrases, for example, would lodge in the patient's unconscious, would they not?

E: Yes, because *there is no meaning that can be given to them by the conscious mind to close the door, to close the chapter on them.* You can use shaggy dog stories; they are a marvelous technique. The person does know that you will come to an end of that damn story.

R: He wants that damn ending!

E: Yes, he wants it! Even if the ending is in him going to sleep. There is a desperate desire for an end, a closure. And maybe the closure is "Close your eyes." I have used shaggy dog stories as a trance-induction technique.

Trance Ratification on an Unconscious Level: Distractions and Amnesia

Z: Now you want me to move it down normally. [She does so.]

R: She shows here that she is sensitive to the difference between her trance and normal head movements.

E: Only she doesn't know she told you that. She shows by the difference in behavior that there *is* another category; there is a horse of a different color, which is trance.

R: You do this very indirectly without getting her conscious mind to openly acknowledge that this proves she was in trance. Why? Why not take the advantage—tell her this is a proof of trance?

E: I'm getting away from her conscious acknowledgment. *I'm not going to let her conscious mind grab onto anything that she can dispute!* You move away from dispute.

R: I'd have felt frustrated at the end of this session because she did not feel she was really in trance. But you do not feel frustrated when a patient betrays evidence of trance and yet does not acknowledge it.

E: If there is evidence of trance, their unconscious knows it. I don't have to prove it! Too many operators try to save face. I take one look at you, and I know you are a man. Do I have to prove to you that you are a man? That is a sheer waste of time, and it arouses a patient's hostility.

R: By trying to give consciousness proofs of trance you only give it more ammunition to later fight against the idea of trance.

E: That's right.

R: How deep was this trance, by the way?

E: Light to medium. The fact that she made no response to the barking dog—you did

and I did, but she did not.

R: You are not bothered by distracting stimuli? E: No. The important thing is the trance. If the patients want to listen to traffic on the highway, fine. They are still within hearing distance of me. So I don't have to compete with my voice against those barking dogs, the sound of the traffic, the sirens that go by—they do not elicit a change in my voice level. You remember a siren better when the professor had to raise his voice than when he did not. There may be a commotion out in the hall, but you do not raise your voice or give any evidence of noticing the commotion. At the end of the lecture hour you ask the students individually, "Do you know what that commotion was outside the lecture room?" They respond, "What commotion?"

R: They have an amnesia for it because they had to attend all the more closely to you.

E: That's right. You did not give them a chance to see or respond or think about it, since they had to attend to you. The commotion only made it more imperative that they pay attention to you. That means they have to go through a process of shutting out that commotion. So you have produced an amnesia without ever having verbally suggesting it in any way. Your behavior to the commotion is a negative behavior.

R: It is an absence of behavior that leaves an amnesia. You did not let the outside commotion have any energy of attention, so it could not be impressed upon memory.

E: Yes, you have many opportunities to test that out when you are aware of it.

Depotentiating Conscious Sets with the Thumb-Dominance Question: Difficulties in Learning the Indirect Approach

E: Are you right-thumbed or left-thumbed?

Z: I'm right-handed somewhat, but *I don't know* about thumbs.

E: Put your hands above your head, and put them palm to palm, and then interlace your fingers. Bring your hands down. Now, you notice that your left thumb is on top. You are left-thumbed.

Z: Okay?

E: But I knew that because you were sitting in that position with your thumbs that way.

Z: It is the normal way I do it, but *I did not know* what defined right- and left-thumbed.

E: That's right. I know Dr. Rossi looked for it.

R: Yes, I did.

E: I'm training him in observation.

R: Yes, Dr. Erickson is carefully training me to watch. [Some friendly conversation takes place between Dr. Z and Dr. R as they become acquainted with one another, and so the session ends. During the closing remarks Erickson manages to mention casually that Dr. Z was about a half-hour off in her time estimations.]

E: I've shifted her here to an entirely different frame of reference far removed from trance, from amnesia, and it is interesting, too. She accepted orders previously, and now she is still in high gear for accepting orders. She is still receiving orders, and she is interested!

R: This question about whether one is right- or left-thumbed is the closest you get to a standard operating procedure. The patients' conscious minds usually do not know the answer, but their unconscious minds know—as evidenced by the interlocking of their hands and fingers without looking. Your silent implication is that their unconscious does know more than their consciousness, and their own behavior proves it. You don't

bother to belabor this implication by a discussion of it. The unconscious implication is more effective as a means of dethroning the hubris of consciousness.

E: Yes. I hope you are starting to get an idea of what hypnotic communication is.

R: Well, if I'm not getting it, it is because of my own limitations, and not due to any lack of effort on your part. It is a strain for me to shift gears from my psychoanalytic training, where I only learned to receive messages, to your approach of actively communicating with others on an indirect level. It is hard work learning to facilitate changes in patients' frames of reference, rather than simply dealing with the contents of their consciousness. You are constantly operating on an indirect level, where you help patients reframe the contents of their consciousness. Conventional therapists usually only deal with the contents of consciousness rather than the procedures for reframing those contents. They ask and answer questions in a perfectly straightforward manner on the object level, rather than engaging the patients on a metalevel in order to make more of their potentials available to them. The effectiveness of this approach is very much dependent on your subtlety. It would not work if the patient knew what you were doing.

In my initial efforts to use this approach I've come off rather badly because I was not natural with it. Patients immediately sensed that I was not answering their questions. I was, for some reason or other, proposing riddles, talking in metaphors, etc. Rather than reframing the contents of their consciousness, I only accomplished the reverse: They became alerted (and some alarmed), wondering what was up.

Postscript: Indirect Trance Learning to Rely on Unconscious Mechanisms

E: Dr. Z really did learn a sizable amount in this first session, even though it was not apparent to her at the time. A week or so later she casually remarked to Mrs. Erickson that for some unknown reason she was able to walk on the street more easily—walking down the street was different in some way. It was easier!

R: She had learned to rely on unconscious mechanisms more. She learned to let go of conscious controlling. So you got through to her in this session after all!

E: I got through! She was so pleased to have a totally new experience of walking on the street.

R: She really learned to let go. Now, you did not know in what way she was going to experience her new hypnotic learning, but you knew *something* would happen.

E: I wanted her to learn to use her unconscious. I did not know where or how, and I did not try to tell her where or how.

R: You let her unconscious figure out its own way.

E: And she was so surprised that she wanted to share it with us. She also remarked that that chair in which she sat was somehow different.

R: Actually, her body was responding differently to it, with more spontaneity. As I recall, she did have a fairly rigid way of holding herself, but that is all beginning to soften now.

E: That's right, she was experiencing sitting and walking more in the sighted way.

R: She now has more of a casual spontaneity, relying more upon unconscious mechanisms rather than consciously directing every movement. She did not know that is what she was coming for, but that is what she was getting. This is an excellent example of *indirect trance learning:* The occurrence of optimal learning in trance, whereby the hypnotherapist loosens the inhibiting influence of the patient's overly rigid conscious sets, which then leaves the creative unconscious free to change behavior in its own way and in areas that are most appropriate for the patient at that time.

SECTION III

Ideomotor Signaling in Hypnotic Induction and Therapy

A. IDEOMOTOR MOVEMENTS AND SIGNALING IN HISTORICAL PERSPECTIVE

The mystery of ideomotor movements and signaling has been discovered, forgotten, and rediscovered in many forms throughout human history. That the mind could signal answers or responses that were apparently outside the control of consciousness has always been a mystery. Being a mystery, it has usually been associated with the occult, magic, or those with "special powers" in relation to the gods. We cannot write a complete history of ideomotor movements and signaling because the necessary scholarship has not yet been done in this field. However, we can outline three salient periods of this history.

PHASE ONE: The Ancient and Medieval Period of Prophecy Divination and, magic
PHASE TWO: Chevreul and the Ideomotor Movement: Theories of Hypnosis in the 1800s
PHASE THREE: Clinical Investigations of Ideomotor Signaling in the 1900s

PHASE ONE: The Ancient and Medieval Period of Prophecy, Divination, and Magic

If we consider all the historical forms in which apparently purposeful movement and behavior were carried out without normal awareness, we would find ourselves with an inventory of most of the classical forms of hypnotic behavior. These are the so-called automatisms—apparently purposeful behavior that is carried out without normal awareness. Since ancient times phenomena such as somnambulism (sleepwalking), visions (visual and auditory hallucinations), prophecy and "speaking in tongues" (automatic speech), spirit writing (automatic writing), possession (multiple personality), mystical rituals, and dance (automatic body movements) have been regarded with fascination. Frequently they have been associated with healing on the physical as well as the spiritual plane. Some force, agency, or knowledge outside of man's usual range of awareness was found to have therapeutic value when all the regular channels of conscious behavior were found wanting. These approaches to healing were well developed in ancient times before the birth of Christ. The Papyrus Ebers, written 1500 B.C., describe magical incantations and rituals that placed patients in altered states for healing. The Egyptian sleep temples of Isis and Serapis as well as the sleep temples dedicated to Asclepius and Apollo in Greece about 400 B.C. utilized somnambulistic states to realize healing.

In the Middle Ages the "healing touch" was used as a method of faith healing when the physical medicine could offer no help. Albertus Magnus (12067-1280), Paracelsus (14937-1541), and Robert Fludd (1574-1637) utilized incantations, faith, and magnetism to effect cures. The common denominator of all these approaches, however, was recognized by numerous authors throughout the Middle Ages to be the *imagination* (Ludwig, 1964). Today we can recognize *ideomotor and ideosensory responses* as being the basis of these effects of imagination: An idea can give rise to motor (behavioral) and sensory responses to which it is associated. The idea of moving a part of the body actually gives rise to unrecognized but measurable motor responses in that part of the body; the idea of falling can activate anxiety responses of the autonomic nervous system; the word *lemon* easily conjures up an image and sensory responses in most people.

Physicians, priests, and prophets who possessed the necessary self-conviction regarding their ability to act as channels for divine or metaphysical forces were able to activate this conviction within their patients. In turn, the patients' unconscious processes

were frequently able to find and facilitate the necessary internal symbolic and ideodynamic processes to effect a cure. The rational left-hemispheric mind did not understand how such cures came about. We would say today that the cures were mediated by unconscious processes of the right hemisphere that have a close relation to bodily and psychosomatic processes. The imagistic, mythopoetical, symbolic, astrological, nonrational, and seemingly fantastical belief systems that become associated with these unconscious cures appear totally erroneous to our modern scientific mentality. It is just possible, however, that these early symbolic systems are reflections or projections of nonrational forms of right-hemispheric mentation that effect psychodynamic transformations that can result in genuine cures. Jung's studies of alchemy and the early gnostic and mystical systems seem to be the only modern, systematic investigations that take this possibility seriously (see Jung, *Collected Works,* Vols. 8, 9, 12, 13, 14, 18).

PHASE TWO: Chevreul and the Ideomotor Movement Theories of Hypnosis in the 1800s

The first phase, wherein ideomotor and ideosensory responses were taken as a manifestation of "special powers," began in ancient times and ended only tentatively in 1854, when Chevreul published his experimental critique of the exploratory pendulum and divination devices. In this critique he provided a correct interpretation of ideomotor movements as minute muscle responses set in motion by the unrecognized thoughts of the subject. We say that this first phase "ended only tentatively" because even today, of course, many people still hold an essentially magical view of these movements whether their source be from a special spiritual inspiration or an all-knowing and infallible "unconscious." From the time of Chevreul on, however, educated workers have understood that the mechanisms of ideomotor and ideosensory responses reside within the subject, though unrecognized because the responses are autonomous in their functioning.

This second period of our history of ideomotor movements is the classical period of mesmerism and early hypnosis in the 1800s. The work of Chevreul prepared the Zeitgeist for clinical investigators like Braid and Bernheim, who recognized that the essential nature of trance and suggestion could be explained as ideomotor and ideosensory action. Bernheim's formulation (1886/1957) is as follows (italics are ours).

> The one thing certain is, that a peculiar *aptitude for transforming the idea received into an act* exists in hypnotized subjects who are susceptible to suggestion. In the normal condition, every formulated idea is questioned by the mind. After being perceived by the cortical centres, the impression extends to the cells of the adjacent convolutions; their peculiar activity is excited; the diverse faculties generated by the gray substance of the brain come into play; the impression is elaborated, registered, and analyzed, by means of a complex mental process, which ends in its acceptation or neutralization; if there is cause, the mind vetoes it. In the hypnotized subject, on the contrary, the transformation of thought into action, sensation, movement, or vision is so quickly and so actively accomplished, that the intellectual inhibition has not time to act. When the mind interposes, it is already an accomplished fact, which is often *registered with surprise,* and which is confirmed by the fact that it proves to be real, and no intervention can hamper it further. If I say to the hypnotized subject, "Your hand remains closed," the brain carries out the idea as soon as it is formulated. A reflex is immediately transmitted from the cortical centre, where this idea induced by the auditory nerve is perceived, to the motor centre, corresponding to the central origin of the flexion. There is, then, *exaltation of the ideomotor reflex excitability, which effects the unconscious transformation of the thought into movement, unknown to the will.*
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> The same thing occurs when I say to the hypnotized subject, "You have a tickling sensation in your nose." The thought induced through hearing is reflected upon the centre of olfactory sensibility, *where it awakens the sensitive memory-image of the nasal itching, as former impressions have created it and left it imprinted and latent. This memory sensation thus resuscitated, may be intense enough to cause the reflex act of sneezing.(*This passage contains the essence of the senior author's utilization theory of hypnotic suggestion*)* There is also, then, *exaltation of the ideo-sensorial reflex excitability, which effects the unconscious transformation of the thought into sensation, or into a sensory image.*

In the same way the visual, acoustic, and gustatory images succeed the suggested idea. . . .

The mechanism of suggestion in general, may then be summed up in the following formula: *increase of the reflex ideo-motor, ideo-sensitive, and ideo-sensorial excitability. . . .* The ideo-reflex excitability is increased in the brain, so that any idea received is immediately transformed into an act, without the controlling portion of the brain, the higher centres, being able to prevent the transformation (1957, pp. 137-139).

In his *De la Baquette Divinatorie* (1854) Chevreul documented many forms of ideomotor phenomena, but it is difficult to say where they all originated. It is said, for instance, that in the Black Forest of Germany, during the Middle Ages, it was traditional to detect the sex of a child in utero by having the expectant mother hold her wedding ring suspended on a string over her abdomen. An apparently spontaneous movement in one direction indicated one sex, while a movement in another direction indicated the opposite sex. This, of course, was a precursor of what we today know as the Chevreul pendulum.

Alexander Dowie was an itinerant preacher in the colonial days of America who would enter the major saloon of a town and offer to detect thieves and murders. He would have all present place their hands palm down on the bar. He would mention a recent local crime and then exhort them to the effect that the guilty one would not be able to keep his index finger flat on the bar. Or perhaps it would be the thumb or the little finger that would give away the guilty person. This procedure easily qualifies as the neatest early low-cost lie-detection device on record and, of course, is a precursor of the finger-signaling approaches we use today.

The "thought-reading" games of Victorian England, which are even today a part of the stock and trade of magicians and "psychics," also fit our category of ideomotor signaling. The "psychics" claim that they can read minds. One might ask all those present in a room to decide on an object to be concentrated upon. He then enters the room and selects one of those present to act as his guide. The "psychic" gently grasps the guide's wrist and lets himself be led about the room. By being sensitive to the involuntary ideomotor movement of the guide's wrist, hand, and arm, the "psychic" soon is able to establish the area of the object of his search. By weaving back and forth with the guide's involuntary micromovements (unrecognizable to the guide or any others present) as his detector, the "psychic" is soon able to make an accurate guess about the object. He claims to have read the thoughts of the group; actually, he read the ideomotor movements of his guide.

Ideomotor movements, of course, are responsible for such phenomena as the Ouija board. The operator's unconscious or partially conscious wishes are transmitted by unrecognizable ideomotor movements from the fingertips that are gently placed on the board's surface to the movable pointer that spells out a message by pointing to different letters or words written on the board. In a more arcane way the fall of yarrow sticks or the flip of coins are also ideomotor components; together with the process of psychological projection, they facilitate the use of ancient oracles such as the I Ching.

Such procedures have survived for hundreds and even thousands of years precisely because they can, under proper circumstances, facilitate the evocation of interesting and valuable ideas—Ideas that are unconscious or only partially understood, but which can be projected by such procedures into full conscious understanding. The problem with such procedures is that the responses obtained are sometimes accepted uncritically as some sort of ultimate "truth"—whether from God, the occult powers, or the modern notion of the creative unconscious. Ideomotor responses are in fact simply another response system of the individual. There is no a priori reason for regarding ideomotor responses as more valid than any other response system (such as logical thinking, intuition, feelings, dreaming, etc.). In many individuals, however, ideomotor responses can provide information that is "surprising" to that individual's consciousness. This simply means that the "surprising information" was within the individual's system but not fully recognized or considered by consciousness. The surprising ideomotor responses, therefore, provide individuals with access to sources of information within themselves that they were unaware of or blocking out for one reason or another. The ideomotor responses are not necessarily more valid than other response systems, but they represent another source of information that can lead some

individuals to make a more educated choice on some important matter because they now have a more complete inventory of information from their systems.

Ideomotor signaling, then, cannot be used as the only source of information for important decisions. It is simply one of many sources of information that can contribute to a decision. When the individual *does not know,* however, or when the individual's *consciousness is confused,* ideomotor responses can make a more important contribution. When rational thinking, intuition, feelings, etc. all fail an individual, then ideomotor signaling may be the only clear and incisive source of information for decision-making. But even under these circumstances information from ideomotor responses should be checked and balanced by the common sense and overall understanding that a therapist has of the individual being questioned.

Just as rational thinking, intuition, feeling, dreaming, etc., may each have unique sources of information for response, so ideomotor signaling may come from sources within the individual that are not tapped by any other response system. We do not at present know exactly what these sources are, just as we obviously do not know all the sources contributing to other response systems (rational thinking, etc.). Because of the high probability that ideomotor responses have unique sources of information within the individual, however, it is important that we continue to explore them and develop new procedures for receiving them more sensitively and accurately and with adequate means of validating them.

PHASE THREE: Experimental and Clinical Investigations of Ideomotor Movements and Signaling in the 1900s

The ideomotor and ideosensory formulations of trance and suggestion of the 1800s carried over into the 1900s and provided the basis for much modern experimental work. The senior author began his studies of hypnotic phenomena as an undergraduate in 1923, working in Hull's laboratory at the University of Wisconsin (Erickson, (1964b). These studies helped initiate a program of research that eventuated in the publication of Hull's important book, *Hypnosis and Suggestibility—An Experimental Approach* (1933). That effort was to investigate hypnotic phenomena experimentally with the developing methods of experimental psychology and to integrate the concepts of hypnosis with those of basic learning theory and behaviorism. For example, ideomotor movements actually provided much of the foundation of behaviorism when it was postulated that subvocal or "implicate speech" was actually the motor basis of thought (Watson, 1919). Weitzenhoffer (1953) has reviewed the experimental work on ideomotor movements and hypnosis of this period. A portion of his summary is as follows:

> The psychophysiological basis of suggestibility is *ideomotor action,* itself a form of conditioning.
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> The physiological bases of hypersuggestibility are *(a) neuromotor enhancement* (homoaction), and *(b) abstract conditioning* (generalization or heteroaction).
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> The psychophysiological basis of the hypnotic alteration of awareness is a combined selective inhibition and excitation of various cerebral regions leading to a dissociation of awareness *from* all stimuli except the voice of the hypnotist, unless otherwise specified by suggestions.
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> Through hypersuggestibility and dissociation of awareness, the words of the hypnotist acquire the value of actual stimulus objects. His voice becomes an extension, so to speak, of the subject's psychic processes. This opens the way to a large variety of perceptual alterations (p. 259).

It will be recognized that these views are remarkably similar to those expressed by Bernheim almost 100 years ago. The terminology has changed slightly, but the essential understanding of ideomotor movements as the basis of hypnotic phenomena is the same. Ideomotor *movements* were intensively investigated because of their importance to the basic theories of behavior and hypnosis. But ideomotor *signaling,* which is of such great significance for modern clinical work, was not investigated by, or apparently even known to, the academic and laboratory workers of the early 1900s.

The senior author reports that his earliest awareness of ideomotor signaling developed

when he was a boy on the farm. A cat's tail would swish back and forth slowly and broadly when the cat was playing but would then make a series of quick, short jerks when the animal became serious. A moment before the cat pounced on an unfortunate mouse, it would stop movement altogether, cataleptically poised in totally fixed concentration. Erickson also noticed that the same sort of thing happened with fish such as pike: the normal, rhythmical beat of their gill fins would suddenly cease a moment before plucking a morsel. The ideomotor signals of the animal world seem almost too common and numerous to mention—the point of a good hunting dog, the gesture of a primate, etc.

These ideomotor signals range from the purely reflexive and unconscious—as is undoubtedly the case with those of fish and cats mentioned— to those with "conscious intent," such as the gestures of primates, who can even learn the value of tokens, gesture-speech, and perhaps more when trained in the laboratory.

The evolution of the senior author's development of ideomotor signaling from automatic writing to hand levitation and then ideomotor signaling proper can be traced in his paper, "Historical Note on the Hand Levitation and Other Ideomotor Techniques" (Erickson, 1961). Relevant portions of this paper will be quoted in our later section on facilitating ideomotor signaling, which can serve as an introduction to current work. This paper indicates that by 1938 the senior author had a firm grasp of the dynamics of *head* and *hand* signaling and used them both experimentally and clinically. The earliest written record of such ideomotor signaling in our possession consists of transcripts made in 1945 of Erickson's "Informal Meetings with Medical Students," which took place at the Wayne County Hospital in Eloise, Michigan. Portions of these transcripts will be presented in our later section on the utilization of ideomotor signaling.

The earliest written record of the use of ideomotor *finger* signaling in our possession is the transcripts of the 1952 and 1953 seminars in hypnosis held in Los Angeles, where Erickson, LeCron, and Bordeaux, among others, were instructors. On these occasions LeCron introduced his use of finger signaling to determine when anesthesia had taken effect (1952 seminar) and to detect psychological traumas (1953 seminar). He then published his views as "A Hypnotic Technique for Uncovering Unconscious Material" (LeCron, 1954).

B. RECOGNIZING SPONTANEOUS IDEOMOTOR SIGNALING

We have reviewed how the senior author's early observations of naturalistic ideomotor signaling provided a foundation for his later development of head and hand signaling in hypnotic work. His observations of animals as a boy on the farm led to the formation of a mental set for detecting nonverbal forms of signaling behavior in his early experimental subjects in Hull's laboratory, in his students sitting in a classroom, and finally in his patients in therapy. If we now outline the general literature on nonverbal forms of communication, it is only for the purpose of facilitating readers' study of these phenomena as a way of training their perception of the natural and spontaneous forms of ideomotor movements and signaling that are taking place in all human interactions. As readers train themselves to look for these nonverbal signals in daily living, they will develop the appropriate mental set for understanding them in experimental clinical situations.

In everyday life we can observe a rich panorama of nonverbal signs that accompany any conversation or transaction. Many of these signs have been studied in the form of the new science of "kinesis" by Birdwhistell (1952, 1971). These range from apparently reflexive movements to meta-acts whereby one uses gestures and body behavior to qualify, comment on, or change one's verbal meanings (Bateson, 1972, 1979). The vast literature that has developed around the concept of "body language" (Fast, 1970; Goffman, 1971) in recent years actually has its roots in Darwin's early study, *The Expression of Emotions in Man and Animals* (1872/1955). The hypnotherapist can study this literature to learn more about the different response systems that signal important forms of communication from patients. From this perspective it will be seen that the traditional form of verbal communication that has played such a major role in psychotherapy is actually only the tip of the iceberg. All the forms

of body language can be understood as systems of ideomotor signaling. These signaling systems come from sources other than those involved in traditional verbal communication and thus provide new sources of information about the total system of the patient.

In everyday life behavior is rich in many forms of ideomotor signaling. Some of the more obvious forms of ideomotor signaling that can be recognized and utilized in the clinical situation are as follows.

A. In everyday life head-nodding and -shaking frequently proceeds in an automatic and entirely unconscious manner. A newlywed is surprised to discover that her husband, still only half awake, is agreeably nodding and shaking his head in an imaginary conversation as he shaves in the morning. A salesman watches his customer carefully: when the customer unconsciously nods his head Yes, however slight it may be, the salesman continues with his line; when the customer shakes his head No, the salesman quickly changes his spiel. Every speaker looks to those in his audience who nod in agreement. The wise politician accepts questions only from those seen nodding in agreement.

B. From the early days of grammar school onward, the lifting of a hand and its associated movements of the face and body have been ingrained as a signal of Yes or of wanting to respond or ask a question. As we get older, these movements become more abbreviated and automatic in their functioning. When getting ready to speak, people lift their heads, wet their lips, incline the body forward, focus their gaze, etc. The parent, teacher, or leader of panel discussions readily recognizes these signals and acknowledges the would-be speaker. Most lovers can recognize at a glance whether the object of their desire is about to say Yes, No, or Maybe.

C. Ideomotor signaling plays an important role in sports. It is to great advantage if a batter can spot ahead of time some ideomotor signal from the pitcher indicating what kind of a pitch he will make. Much advantage in any competitive sport can be gained by learning to "read" the body movements of the opposing team as a signal of their future play.

D. In everyday life we automatically move our bodies the way we want things to go, even if there is no hope that our movements can actually help. Thus a passenger in a car will put his foot on an imaginary brake, bowlers will tilt their body the way the ball should go, and spectators at a boxing event will make incipient punches with their own clenched hands.

E. The senior author believes that, on a number of occasions when watching the preliminaries of sporting events, he was able to predict who would win and lose by observing the unconscious ideomotor signaling behavior of the athletes as they entered the field and prepared for the contest. The potential winners were those who appeared to have their own inner focus and sense of self-direction; the potential losers were those who appeared to fall in step behind the winner(s) or in some way to follow the lead of others during the preliminary warm-up exercises.

C. FACILITATING IDEOMOTOR SIGNALING

The senior author's review of his gradual discovery of ideomotor signaling provides a fine introduction for learning how to facilitate it in the clinical situation (Erickson, 1961):

"During that summer of 1923, among other things, the writer became interested in automatic writing, first secured from subjects in a trance state and subsequently by posthypnotic suggestion. This gave rise to the possibility of using suggestions conducive to automatic writing as an indirect technique of trance induction for naive subjects. Although successful, it proved to be too slow and laborious an induction technique in most instances. It was modified by suggesting to the subject that, instead of writing, the pencil point would merely move up and down on the paper, or from side to side. The vertical or horizontal lines thus secured were later found to be an excellent approach to the teaching of automatic writing to difficult subjects.

"Almost from the first trial it was recognized that the pencil and paper were superfluous and that the ideomotor activity was the primary consideration. Accordingly, the writer, using his younger sister Bertha as a subject for the first time, induced a somnambulistic trance by a simple hand-levitation technique. Thereafter many variations of this original technique were

devised until it became apparent that the effectiveness of many supposedly different techniques of trance induction derived only from a basic use of ideomotor activity, rather than from variations of procedure, as is sometimes naively believed and reported. Perhaps of all the many variations of ideomotor techniques of induction that may be devised, the more generally useful are (1) simple, direct hand-levitation, because of the possibility of visual participation, and (2) the slightly more complex rhythmical hand levitation, in which visual and memory participation frequently lead to the ideosensory response of auditory hallucinations of music and the development of a somnambulistic trance. . . .

"At the time of this work, there was no recognition by the writer of kinesthetic memories and images as a trance-induction technique, but it led to a systematic and profitable investigation of the possibility of using any sensory modality as a basic process in inducing hypnotic trances. . . .

"Approximately 15 years after these earlier studies on ideomotor techniques had been reported to the seminar group at the University of Wisconsin, another study was begun. This was initiated by the observation that, especially at lectures on controversial topics, there are those in the audience who will unconsciously slowly nod or shake their heads in agreement or disagreement with the lecturer. This observation was further enhanced by noting that certain patients, while explaining their problems, will unwittingly nod or shake their heads contradictorily to their actual verbalizations. These informative manifestations suggested the possibility of utilizing this type of ideomotor activity as an hypnotic technique, particularly for resistant or difficult subjects, although it can also be used readily on naive subjects.

"The actual technique is relatively simple. The explanation is offered to the subject that an affirmative or a negative answer can be given by a simple nod or shake of the head. Also, it is explained that thinking can be done separately and independently by both the conscious and unconscious mind, but that such thinking need not necessarily be in agreement. This is followed by asking some question phrased to require an answer independent of what the subject may be thinking consciously. Such a question is, 'Does your unconscious mind think you will learn to go into a trance?' After being asked this type of question, the subject is told to await patiently and passively the answering head movement which will constitute the answer of the 'unconscious mind.' A rapid or forceful response signifies a 'conscious mind' reply. A slow, gentle head movement, sometimes not perceived by the subject, constitutes a direct communication from the 'unconscious mind.' With the response catalepsy develops and a trance state ensues rapidly.

"Or, as a simple variation, one can suggest that the levitation of one hand signifies the answer 'yes,' the levitation of the other, 'no,' the levitation of both, 'I don't know' and then ask the above or a comparable question. The development of a trance state is concurrent with the development of levitation, regardless of the significance of the reply.

"These techniques are of particular value with patients who want hypnosis, who could benefit from it, but who resist any formal or overt effort at trance induction and who need to have their obstructive resistances bypassed. The essential consideration in the use of ideomotor techniques lies not in their elaborateness or novelty but simply in the initiation of motor activity, either real or hallucinated, as a means of fixating and focusing the subject's attention upon inner experiential learnings and capabilities." (pp. 196-199)

The senior author believes that for such ideomotor signaling to be truly autonomous and unconscious, patients should be in trance or distracted in one way or another so they will not have an opportunity to observe their own movements. Because of this he frequently prefers to look for automatic head-nodding or -shaking where patients are least likely to observe themselves. It is surprising how often patients will nod or shake their heads to contradict their own verbal statements even without any formal instruction about ideomotor signaling. Frequently it is a *very slow and slight but persistent head-nodding or -shaking* that distinguishes the movements as coming from an unconscious level. These slow, abbreviated movements are to be distinguished from *larger and more rapid* head movements, which are more consciously used as a way of emphasizing what is being said verbally.

The senior author prefers to utilize a patient's own natural means of ideomotor signaling whenever possible. Whatever natural and automatic movements a patient makes in ordinary

conversation can be studied for their metacommunicative value. Besides the more obvious head and hand movements, eye-blinking (slow or rapid), body-shifting, leg movements, arm position (e.g., crossed over one another as a "defense"), lip-wetting, swallowing, and facial cues, such as frowning and tensions around the mouth and jaw, can be studied for their commentary on what is being said verbally.

LeCron's corresponding use of finger signaling and the Chevreul pendulum is described by him as follows (LeCron, 1954):

> The hypnotized patient can be told that questions are to be asked and that the unconscious can reply to them by lifting or wiggling the right forefinger to indicate a "yes" answer, the left forefinger for a "no" answer. (If the patient is left-handed, this should preferably be reversed.) If a question is asked to which the answer is not known by the unconscious mind, the right thumb is to be lifted. If the question is one which the unconscious does not wish to answer, the left thumb is to be moved. This last is very important as it will usually eliminate resistances which might prevent any response otherwise. . . .
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> In addition to the suggested finger responses, conscious finger movements made to falsify and conceal can be made known to the therapist by means of some unconscious movement. This can be accomplished by suggesting that one hand, perhaps the right, will lift if at any time a false answer is given by the fingers (or verbally). It should be stated that such a hand movement will occur without the patient being aware of its being made.
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> An interesting variation of this questioning technique is the use of Chevreul's pendulum, using a light ring or other object tied to an eight- to ten-inch thread. The thread is to be held between the thumb and forefinger with the pendulum dangling, the arm either fully extended or with the elbow resting on the knee or arm of the chair. Replies by movements of the pendulum can even be obtained in the waking state, though it is better if a trance is employed. Two out of three people, or even more, will respond in the waking state. The variation is advantageous because hypnosis is unnecessary. Therapists not familiar with hypnosis will find they can employ it very successfully.
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> There are four possible movements of the pendulum. These are a circle clockwise or counterclockwise, a swing back and forth across the body, and a swing at right angles away from the body. It is best to permit the unconscious mind of the patient to select the movements it will use in answering according to its own choice. This is done merely by asking the unconscious to choose one of the four movements for "yes," then another for "no," a third for "I don't know," and the remaining one can then signify "I don't want to answer." (pp. 76-79)

Other details of the use of the Chevreul pendulum can be found in Weitzenhoffer (1957). It is rare to find anyone who cannot use the Chevreul pendulum successfully. When there is difficulty, it is usually because the pendulum's movements are not entirely clear in any one response pattern. Research indicates that it is important for the subject to see the swing of the pendulum to get a clearly defined response pattern. This suggests that the Chevreul pendulum finds its sources of response closer to consciousness than head, hand, or finger signaling, where awareness is not important for a clear definition of response.

The Chevreul pendulum and finger signaling do not require any formal induction of trance. In fact, the focused attention they require is itself a means of inducing trance. Even with new subjects, finger signaling usually proceeds easily after a few moments of concentration. However, a certain degree of learning and rehearsal is usually necessary. The movements that appear are usually slow and hesitant initially. Frequently the finger trembles slightly, and sometimes it moves curiously to one side, toward the middle finger. These movements can be taken as a criterion of the genuine autonomy of the response. Fingers that move up quickly with seeming conscious purpose should be questioned by the therapist. Subjects are enjoined to take their time and allow the fingers to move up by themselves. Occasionally, however, a subject will be found who is so highly responsive that the fingers do in fact pop up quickly in startlingly large movements.

When movements do not appear after a few moments, the therapist may notice that there is nonetheless some trembling or twitching on the back of the hand. This should be pointed out to the subject, who is enjoined to relax and learn to let the finger go. Sometimes the subject may have to "help" the finger lift by moving it voluntarily the first few times, when it feels as if it wants to move up by itself. In their learning of finger signaling, subjects often first feel an ideosensory response in the finger that "wants to" lift. These ideosensory responses can be encouraged as an initial stage of learning finger movements.

A curious but by no means uncommon occurrence in finger signaling is when the other

fingers that have not been given a response significance (yes, no, etc.) move in response to a question. What can such responses mean? Obviously a response other than the designated possibilities (yes, no, etc.) is being expressed. Cheek and LeCron (1968) have reported that such responses may mean perhaps or maybe, or that the question is not understood, or that it cannot be answered positively or negatively. Frequently it means the question is ambiguous and must be rephrased in such a manner that double meanings or literalisms are avoided. Sometimes the subject will have a hunch about what this extra, idiosyncratic response means. Subjects have reported that such responses sometimes coincide with an important shift in their feelings or thoughts. It is therefore valuable for the therapist to seek out the meaning of such responses. If the subject has no ideas, further ideomotor questioning may help uncover their meaning. Frequently such extra responses will have a persistent and consistent meaning for certain individuals; they may function as a signal for deepening trance, the onset of a dream, an important memory, a related thought or insight not being uncovered by the therapist, etc. The spontaneous appearance of such individual response systems—as surprising to the subject as to the therapist—are another indication of the genuinely autonomous aspect of ideomotor signaling.

Once a form of ideomotor signaling has been established, the observant therapist will notice that ideomotor responses sometimes begin to function spontaneously on other occasions, even when they have not been asked for. Later in the interview or in later interviews patients may not even realize that they are giving the therapist ideomotor responses along with verbal interaction. There is thus a *generalization of ideomotor signaling* that takes place just as naturally as any other form of learning. Patients will sometimes report with some amusement that they found ideomotor signaling taking place unexpectedly when they were daydreaming, reading, listening to a lecture or music, driving their car, falling asleep, etc. That is, spontaneous ideomotor signaling tends to take place on those occasions when people experience throughout the day those short periods of self-absorption that we have called the "common everyday trance."

D. FACILITATING IDEOSENSORY SIGNALING

Ideosensory responses constitute a unique signaling system that can be utilized in interesting ways. They can appear in any part of the body and can be experienced in a number of different forms—warmth, coolness, pressure, tingling, prickliness, itch, etc. Ideosensory signaling can be used by the patient for self-knowledge, but by its very nature this signaling does not communicate to the therapist. Thus, ideomotor signaling can be of distinct advantage when patients want to explore something privately or when they are not yet ready to communicate to the therapist. When ideosensory responses occur in place of ideomotor signaling, however, the therapist can interpret this to the patients and encourage them to continue their inner exploration in a private manner. Patients will later be able to make their own choices about how to communicate this material to the therapist.

Ideosensory signaling can thus be understood as middle station in the communication process. Ideosensory responses may be the first, primitive somatic signals coming from an unconscious level. Once recognized, they help the individual become aware of something that is in the process of reaching consciousness. These signals help individuals recognize that something important is happening even if they don't know exactly what. Thus, the person should pause for a moment and be receptive to new feeling or cognitive processes that require attention. From this point of view it can be seen how ideosensory signaling merges into the province of emotions, on the one hand, and psychosomatic response, on the other. All the somatic indications of anxiety, for example, can be taken as forms of ideosensory signaling. Blushing is a paradoxical ideosensory response that may signal to others even before the self.

E. UTILIZING IDEOMOTOR SIGNALING

Ideomotor signaling is without doubt the most useful indicator of trance experience that

has ever been developed. It is very easy to establish in practically everyone, and it can be applied to exploring practically any circumstance of interest to patient and therapist. Here we will simply outline the range of its applications.

1. Inducing Trance

Simply requesting ideomotor signaling of any sort requires the subject to fixate and focus attention in a manner that is trance-inducing. The beginning therapist can find no better way of learning to recognize the subtle indications of trance development—body immobility; the relaxation of facial muscles, giving an "ironed-out" or flaccid look to the face; a fixed gaze; retardation of respiration, pulse, and certain reflexes like blinking and swallowing; literalism; comfort; etc.—than by calmly studying subjects requested to allow ideomotor or ideosensory signaling of one sort or another to take place. If no other form of formal trance induction has been used, the therapist will note that many of the signs of awakening from trance tend to occur as soon as the period of ideomotor signaling has ended. Thus, most subjects will tend to reestablish their *generalized reality orientation* by body movements that provide the kinesthetic feedback associated with the awake state. They will tend to readjust their posture, flex and clinch their fingers, stretch, refocus their gaze, look about, adjust their legs, and so on. Subjects may then report having spontaneously experienced any one of a number of the classical hypnotic phenomena (amnesia, regression, analgesia, time distortion, dream states, sensory perceptual changes, etc.) in a more-or-less attenuated form.

2. Trance Deepening

With subjects who are receptive and properly prepared for exploring trance or inner experience, it is but a short step from ideomotor signaling to a state of deeper trance. The therapist can simply ask if the subject would like to go more deeply into a comfortable state of relaxation or inner absorption. If a positive signal is received, the therapist tells the subject to continue going more deeply until the unconscious is satisfied with the state of comfort and to give a positive signal when that state is reached. The therapist can then utilize any of the other classical approaches to deepening trance (hand levitation, eye closure, a ride down an escalator, heaviness or warmth of limbs, etc.) and use ideomotor signaling to monitor the effectiveness of each procedure for deepening.

In the past few years the junior author has adapted a form of hand signaling for trance induction and deepening that is well suited for therapists learning to use the hypnotic modality and indirect suggestion as well as for their patients who are experiencing hypnosis for the first time. The special value of this "moving hands" approach is that it allows the patient's own unconscious to play an important part in determining trance depth as well as signaling what is being experienced. Since this approach lends itself so easily to practically any contingency the beginning hypnotherapist may encounter, we will detail some of the ways it can be used in the following section.

3. A Double Bind Induction with the "Moving Hands" Approach to Ideomotor Signaling

The junior author originally adapted the hypnotic experience of "moving hands" (Weitzenhoffer, 1957) for creating a double bind approach to hypnotic induction because a great deal of research had already established that this phenomenon was very easy to experience. When it is evoked by direct suggestion as one of the items of the *Stanford Hypnotic Susceptibility Scale,* for example, it is "passed" by 70% of the subjects. Moreover, the observable aspects of how it is accomplished have diagnostic value regarding the quality of the trance that is being established. Hilgard (1965) has described some of his observations as follows: "It is characteristic of the more susceptible subject to move his hands with a slow and somewhat jerky movement. The response may be rapid or extreme; for example, the hands may move apart until the arms are stretched out on either side of the

body. The less susceptible subject often shows considerable delay before the arms start to move, or a movement is arrested after a very short distance. These quantitative aspects are of course subject to study; even without study the experienced hypnotist soon detects aspects of the movement related to an established trance state." (p. 104)

In the following we will present a generalized paradigm of the junior author's approach to facilitating the experience of many classical hypnotic phenomena via the use of indirect suggestion carefully monitored by ideomotor signaling to enable the therapist to tune into the patient's experience at all times.

Truisms Leading to Hypnotic Induction Via an Ideomotor Form of the Double Bind

R: Place your hands like so with the palms facing each other about eight inches apart. [The therapist demonstrates with his hands held about a foot or so in front of his face. Arms and elbows should not be touching anything so the hands and arms can be freely mobile.] Now we know the human body has a magnetic field. I don't know if you really will be experiencing that magnetic field between your hands, or whether your feeling will come from your imagination—but let yourself be sensitive to that magnetic force you will begin to sense between the palms of your hands—as if you have magnetic hands.

> R: Everyone has experienced the curious phenomenon of magnetism. Being a "curious" and invisible force that works mysteriously by itself, the metaphor of magnetism is associated with all sorts of ideodynamic processes that may evoke autonomous unconscious forces within the subject. This is a use of *indirect ideodynamic focusing:* an indirect form of suggestion that utilizes not the semantic or cognitive meaning of words, but rather their associated, concrete, ideodynamic values.
>
> While the subject's conscious mind (left-hemispheric rational processes) is a bit confused, fixated, and focused on the curious cognitive concept of "magnetic hands," the subject's unconscious (right-hemispheric ideodynamic processes) is automatically evoking all sorts of concretistic *body experiences* associated with the words "magnetic" and "hands."
>
> In general, many of the subject's life experiences with autonomous unconscious forces tend to be activated and placed on stand-by, ready for expression; in particular, many life experiences with automatic unconscious movement of the hands are primed for expression. The subject is unaware of all the unconscious, ideodynamic forces that have been set in motion because the conscious mind is still puzzling over what could be meant by "magnetic hands.
>
> Everything the therapist said is true, but what does it all mean? This obvious inner question is itself another indirect hypnotic form that binds the subject's consciousness to the induction process and arouses *expectation.*

Implication and the Negative Building Expectation

R: But don't let those hands move *yet!* Just let yourself experience the forces between them. [Pause]

> R: The unconscious requires time for the full experience of many ideomotor and ideosensory phenomena. In asking the subject to delay any actual hand movement and then pausing, the therapist is allowing time for these ideodynamic processes to maximize themselves. But notice that we have subtly introduced another indirect hypnotic form: *implication.* By saying, "But don't let those hands move *yet!"* we are implying that they will move. The senior author has emphasized that implication is something the listener must construct within himself. The therapist does not directly tell

the subject to move his hands, but the implication indirectly evokes the necessary ideodynamic processes within the subject that will move the hands in an autonomous manner. The hands are now primed to move, if only the subject will let them move.

In saying "don't let those hands move" we have interspersed a negative that may indirectly discharge any resistance the subject has about following the therapist's suggestion. Ambivalence is characteristic of all hypnotic work; the subject wants help and wants to follow suggestions, but of course there are doubts and fears about following any fool doctor. For many reasons the subject both wants and does not want the hypnotic phenomena to work. If the therapist continually insists that the phenomena will take place, naturally the subject is polarized and burdened into carrying out the opposite possibility that the hypnosis will not work. By expressing the negative "don't let those hands move," the therapist takes over this negative possibility so that it need no longer reside within the subject, and he need no longer act it out. The subject is thus left with nothing else but his curious positive *expectation* about when the movement will be permitted. It is no longer a question of will there be movement. The only question is, if not yet, then when?

Nonverbal Expectation and Preliminary Oscillations: Displacing and Discharging Resistance

R: In this pregnant pause the therapist simply watches the subject's hands with avid interest and expectation. This *nonverbal expectation* is another indirect hypnotic form that tends to evoke responses automatically within the subject. But the therapist cannot fake this avid interest and expectation because the subject's unconscious will sense it and be put off by it. The therapist is able to manifest genuine expectation because he knows that in fact unconscious ideodynamic processes have been set in motion, and he is indeed curious about how they will become manifest. He knows that acute and careful observation is necessary for the successful art of hypnosis so he eagerly watches the subject's hands for the first manifestations of movement.

When the patient sees the therapist's genuine interest, he too usually *focuses and fixates* his gaze on his hands. If not, the therapist makes a slight nonverbal head movement in the direction of the subject's hands to direct his gaze there. If the subject still does not focus his gaze on his hands, the therapist points at the hands to direct the subject's gaze nonverbally. The nonverbal direction tends to potentiate right-hemispheric processing while allowing left-hemispheric words to remain in relative quiescence.

With the subject's gaze now focused on his own hands, both he and the therapist can enjoy a few moments of expectation and careful observation. How will the subject's individuality process and manifest the autonomous forces that have been set in motion? No two subjects or sessions are alike. Each subject experiences it a bit differently each time. When the therapist notices the first slight micromovements, he sighs contentedly and comments on the movements however they begin to take place.

Reinforcing Ideomotor Movements: Creating a Therapeutic Milieu

R: That's right, letting that happen. Some fingers move a bit by themselves and that's OK, but don't let the hands move very much yet. Just experiencing, letting it happen by itself.

R: In commenting on the minute, tremulous movements that can usually be seen by this time the therapist is, of course, reinforcing them. In feeling and nonverbally manifesting satisfaction the therapist is modeling and indirectly reinforcing satisfaction and contentment within the subject for experiencing autonomous movements that in

most other contexts might seem strange and frightening. In being able to experience such an unusual and potentially frightening phenomenon with contentment, without quite being aware of it the subject is being conditioned to experience and express other repressed and potentially frightening material that may be of therapeutic value later on when it can be easily and safely elicited. The therapist is thus creating a safe milieu for future therapeutic experience.

The sentence, "Just experiencing, letting it happen by itself," is a subtle *indirect compound suggestion.* The first part, "Just experiencing," is, of course, a truism. How could the subject deny he is experiencing? Since he must agree that he is experiencing, the first phrase of the compound suggestion establishes a "yes set" for the acceptance of what follows, "letting it happen by itself." There are at least two levels of meaning confused in this phrase that funnel into facilitating autonomous ideomotor movement of the hands. On one level, the experience is going on by itself; all experiencing has an autonomous quality. On another level, the therapist is also directly, but subtly and permissively, telling the subject to let the hands move by themselves. Even if the subject is consciously aware of only one level of meaning, the ideodynamic principle of mental functioning indicates that all levels and possible associations will be activated even if they are not overtly manifest. When many levels of meaning and association are focused in one direction, however, an autonomous movement does tend to take place.

Introducing the Double Bind for Ideomotor Signaling

R: We know a magnetic force can pull things together or push them apart, and it's the same with the unconscious. When it wants to say "yes" it pulls people together; when it wants to say "no" it pushes people or things apart. So we can use that hand movement to ask your unconscious an important question. If your unconscious wants to say yes, you will feel those hands pulled together. If your unconscious wants to say no, you will feel those hands being pushed apart. You simply let your unconscious move those hands either way. And what will that question be? [Pause]

R: The double bind is that whichever answer is given, yes or no, an ideomotor response will become manifest, and autonomous ideomotor movements are by definition a form of hypnotic response. The subject is usually so fascinated with the incipient movements he is experiencing and the possibility of his unconscious answering a question that he does not recognize the double bind. Even when the subject does recognize the nature of the double bind and comments humorously about it (usually fellow professionals who have studied the double bind and know of its applications in hypnosis), the ideomotor experience continues. Sometimes a skeptical subject will be so unbelieving that he will consciously stop the movement, clinch his hands a bit as if to wake them up and reposition them to test the phenomenon again.

The Double Bind Question

R: What is the question that the unconscious is getting ready to answer with a yes by moving the hands together, or a no by pushing them apart? [Pause] The question is, "Will it be okay for the unconscious to allow you to experience a comfortable therapeutic trance?" [Pause] That's right. Allowing the hands to come together for yes, apart for no.

R: The hands usually do begin moving slowly together at this point, sometimes with that slightly jerky movement so characteristic of unconscious movements. The subject frequently smiles at this movement; it is a pleasant surprise to experience it.

Eye Closure via Contingent Suggestions

R: That's right. And as those hands continue moving very slowly together you can wonder what is happening to your eyelids. Are they blinking? Are they getting ready to close comfortably as those hands continue moving together? [Pause] Will they close before those hands touch?

R: Associating eye closure with the ongoing hand movement is an indirect form of *contingent suggestion:* we hitchhike a new suggestion to an ongoing pattern of behavior so that the yes of the ongoing behavior carries the new along with it. We introduce the new suggestion in the form of a question so that the subject's own internal dynamics can be responsible for the eye closure. The phrasing of the suggestions in question form is always associated to whatever behavior the subject is actually manifesting. If the subject does blink the therapist comments, "That's right, it does seem to be happening, doesn't it? And how soon will those eyes actually close?"

If the eyes do not close at this point, or if the hands actually move apart or not at all, it means we are encountering resistance. This resistance can be explored and utilized somewhat as follows.

Displacing and Discharging Resistance: Many Contingencies, Many Opportunities for Hypnotic Response

R: That's right, those hands are actually moving apart, meaning the unconscious would rather not go into a therapeutic trance just yet. And that's because consciously or unconsciously there is some difficulty with it. So those hands can continue to express that difficulty by very slowly moving apart. And as they continue moving apart, does the reason for that difficulty come into your conscious mind? Does the unconscious require some time to work things out before trance can take place? [Pause]

Let's just watch those hands. Can the unconscious deal adequately with that problem right now without even telling me about it? And start moving those hands together when it has dealt with the problem? [Pause]

Can the unconscious stop that movement for a moment as it deals with that issue? Will it keep your eyes open, or will it allow your eyes to close in order to focus more intensely and adequately on resolving that problem? [Pause]

Does the unconscious want you to speak about what you are experiencing even as you continue to experience it? How easily can you let yourself talk while that continues?

R: The above are only a few of the possible ways of exploring and resolving whatever is behind the negative ideomotor signal of the hands moving apart. The therapist deals with the so-called resistance by (1) continually commenting on how it is being manifested and by (2) associating the resistant behavior with another hypnotic suggestion designed to deal with and possibly resolve the resistance via a series of questions that are answered by (3) yet another ideomotor response. As long as some movement is taking place the hypnotic modality is being manifest and the therapist can enjoy the process of exploring the patient's patterns of responsiveness. In the very rare case of no hand movement at all the therapist can proceed somewhat as follows.

Converting No Response into Catalepsy

R: And what is happening to those hands? Are they really not moving? How long can you hold them rigidly there with no movement at all? That's right, try as hard as you

can not to let them move at all. The body is usually always in a state of constant movement even if we don't notice it, but in the hypnotic state we can get paradoxical responses—the opposite of what we ask for—and the body can become completely immobile and still sometimes for quite some time. Or one part of the body can become quiet while another part of the body experiences the movement. What will happen in your case?

R: Thus no movement can be converted into a passive form of catalepsy with the subject staring wide-eyed at his hands and not moving at all. While so transfixed, the therapist can go on with further indirect suggestions about how the unconscious can continue to work on its problems very intensely within as the body remains completely quiet and immobile—just as in a dream or in a deep state of concentration.

Time Distortion and Awakening: A Subtle Posthypnotic Suggestion

R: And the unconscious can continue working on that problem in that special trance time when every moment in trance can be equivalent to hours, days, or even years of ordinary clock time. [Pause] And the interesting thing is that the conscious mind may or may not really understand just what is happening if the unconscious needs to keep it private. You can remain just as you are until the unconscious completes that unit of work and you'll know it's finished when you have that urge to move and stretch and come fully awake again.

R: What has happened here? The original lack of ideomotor movement has been converted into a trance experience wherein the subject deals effectively with whatever resistance there was to oppose the ideomotor movement. It could even be that there was no active resistance at all. The subject may simply have no talent for ideomotor movement. In this case the passive catalepsy is the more ideal way of permitting trance experience to take place.

How do we know that trance has in fact taken place? The very quietness and immobility of the body frequently with a flattened facial expression are the basic signs of trance. Perhaps the eyes blink and eventually close as permission is granted to remain immobile. At certain moments the observant hypnotherapist may notice that the pupils of the eyes dilate with interest and recognition that something is happening.

Another obvious indicator of trance is that the subject will usually follow the subtle posthypnotic suggestion to "move and stretch" as he comes awake. Sometimes the therapist can reinforce this posthypnotic suggestion by stretching and moving about himself. On awakening the subject may be rather blank and essentially amnesic about what was experienced. This of course is yet another indication of a genuine trance experience and the therapist should not press the subject to talk about it. The situation is that an interesting hypnotic experience has just taken place which lays the foundation for future trances. The next time the therapist and subject meet the experience of this first trance can be brought up again as an ideodynamic approach to initiating the next trance.

If on awakening the subject does want to talk about the experience, the therapist can carefully collect the phenomenonological data regarding the subject's experience, and then utilize it to facilitate the next trance experience which can take place immediately or later.

But let us return now to the more typical situation where the subject responds positively to the original double bind question by allowing the hands to move together indicating that a comfortable therapeutic trance is being experienced. There are innumerable directions that suggestion can take once the hands are moving slowly together. Here are a few that are typically explored by the junior author because of the valuable information they provide about the subject's response abilities.

Demonstrating Conflict Between the Conscious and the Unconscious

R: That's right. And as those hands continue slowly moving together indicating that the unconscious is moving you more and more into a comfortable state, you may wonder what would happen if you try to oppose it with your conscious will. What if you took some time out just for a moment and tried to oppose that force? Is it possible for your conscious mind to oppose that unconscious force? [Pause]

R: The pause gives the subject a conscious opportunity to counter the magnetic force. It is interesting and informative to note how the subject uses this opportunity. If the hands continue moving together without interruption even as the subject makes a somewhat hopeless facial grimace, or perhaps a wee smile, it may mean that he is so possessed by the ideomotor movement that he cannot oppose it; this is possibly a right-hemispheric type of individual who has a special talent for hypnotic suggestion and may be able to experience most of the classical hypnotic phenomena with ease.

With another subject, the hands may continue moving together without interruption and with no facial cues of an opposing effort being made. This may be an individual who is so comfortable with the ongoing experience that he would rather not bother to make any effort to oppose it. This subject may also be ready to experience most of the classical hypnotic phenomena but he may be particularly successful with those that permit him to remain passive rather than active: ideomotor inhibition, ideosensory responses, and imaginative processes; successful suggestion may be best phrased in a manner that allows him to remain passive and simply receive from his own unconscious or the therapist rather than suggestions that require an active engagement of some effort.

Yet another subject will pounce upon the opportunity with relief and eagerness to test the strength of the conscious will against the ideomotor movement. The therapist will now observe all sorts of testing behavior: Most of the time there is an oscillation between the obviously conscious pulling of the hands apart and then a pause as they slowly begin moving together again autonomously; infrequently a subject will pull his hands apart, drop them, and become apparently awake thus ending the experience for the moment. This subject should then be questioned to determine if there are any serious objections to further trance experience.

All these diverse and informative ways of opposing the ideomotor movement have one common denominator: It is invariably disappointing to the subject when he finds he can, in fact, stop the ideomotor movement. Subjects usually say later that they were sorry to sense that the "magic" or "trance" was gone for a moment; they did not want their ordinary conscious mind to interfere with the interesting potentials of the unconscious. It's not as comfortable when the conscious mind imposes its will.

In this disappointment reaction the junior author sees further evidence for the special state theory of hypnosis: trance does involve a special state of consciousness or being that most subjects can distinguish as different from ordinary everyday consciousness, even when they have difficulty in verbalizing the difference. This shift from the hypnotic to the ordinary modality may be either (1) the perceived phenomenological shift from right- (or minor) hemispheric dominance to left- (or major) hemispheric dominance, (2) a shift from the dominance of the parasympathetic system to that of the sympathetic, or, (3) perhaps an actual shift in the relative utilization of different neurotransmitters, endorphines, or other psychobiological systems. Whatever the underlying biological source of this perceived phenomenological shift, it can help people to recognize an altered state and be used to introduce a valuable bit of self-understanding somewhat as follows.

Recognizing Altered States: Posthypnotic Suggestion Facilitating Therapeutic Modes of Being

R: That's right, it is a bit disappointing to force yourself out of that comfortable state where things happen by themselves. It's rather disconcerting because it always does feel better to let the unconscious do the things it knows how to do best, by letting it work without interference from the conscious mind. You're now experiencing that difference and learning how to allow the unconscious to do things. Letting the unconscious move those hands again either together or apart. It really doesn't matter, the only important thing is that we allow that creative part of the unconscious to determine just what it will be. And it's nice to know that just as you allow those hands to move again you can use this new sensitivity throughout the day to occasionally tune into yourself when the unconscious wants you to take a few minutes out, to rest, and let it do the important things that will help you in more ways than you can consciously realize. Tuning into the body carefully throughout the day and letting the unconscious have the time and energy it needs to deal with those problems that are so important to you.

R: We know that in fact the body is on a ninety-minute cycle throughout the day and night (Hiatt & Kripke, 1975). Every ninety minutes while asleep we go through a dream cycle. And every ninety minutes while awake we go through a period of parasympathetic dominance when we actually do need to take a break from work and left-hemispheric thinking. Every ninety minutes throughout our waking hours we do get a bit hungry and are prone to fantasy. This, of course, is the ideal time to go into self-hypnosis, giving our unconscious the permission to do everything necessary to facilitate our lives while we give our conscious intentionality a rest for a while. The junior author is currently exploring the clinical hypothesis that many states of *unease* and psychosomatic *disease* are the result of the stress that arises when consciousness does not allow this natural ninety minute cycle to operate. Anxiety, mental blocking, errors and fatigue tend to occur when the conscious directed thinking of the dominant hemisphere attempts to usurp the balancing and compensating functions of the minor hemisphere as they naturally take place throughout this cycle.

To associate a posthypnotic suggestion of sensitivity to this cycle, then, is to *tie a posthypnotic suggestion to a behavioral inevitability.* That tends to reinforce the suggestion while utilizing and facilitating a natural life process.

Exploring Hypnotic Potentials: Body Immobility and Anesthesia

R: And as those hands continue coming together you can tune into what else is happening. Are those hands getting a bit stiff and wooden? Is there a pair of thick, soft magnetic gloves on those hands so that they don't feel anything? So thick that the padding of those gloves stops the hands so they can't get closer than an inch or two together? [Pause]

R: If the subject responds and the hands do in fact stop an inch or two apart (assuming the subject's eyes are open at this point; or, if the eyes are closed phrasing the suggestion so that it becomes contingent on the eyes opening to witness this blocking, stiffness, and numbness of the hands), the therapist has an excellent basis for now wondering aloud just how stiff and numb those hands have become so that the subject can experience a glove anesthesia. The anesthesia can be tested later when the hands are allowed to drift to the lap and not feel anything. For many subjects, of course, it will be impossible to feel anything because by remaining consistent to the glove suggestion their hands will not quite touch their lap because the thick magnetic gloves will interfere. Along with anesthesia, or in place of it, one could also explore ideosensory responses.

Ideosensory Responses

R: And as that continues you can tune into the sensations on your face. We all know the warmth we sometimes feel on the face and parts of the body when flush with emotion. And you may not know exactly why but your unconscious knows how to feel that warmth. Can you feel that warmth now? [Pause] And as you feel that warmth, will those hands drift apart to let me know, or will your head slowly begin to nod yes? [Pause] Or will your head shake no all by itself?

R: There are innumerable ways of evoking ideosensory responses but certain principles always help: (1) mentioning a life history of situations when the body could have experienced the sensation (the flush of emotion, the coolness of the wind) tends to initiate an inner search on an unconscious level that primes the sensations to be experienced; (2) using the pause to allow adequate time for the response; (3) setting up a behavioral ideomotor signal to let the therapist know when the response has been experienced. These principles are, in fact, basic for facilitating any hypnotic phenomenon in the permissive manner. At this point the therapist can introduce and explore whatever range of hypnotic responses he feels is necessary to facilitate future work.

Trance Deepening and Preparation for Further Therapeutic Work

R: That's right. And if the unconscious is now ready to allow that trance to deepen, for the comfort to deepen just as in going to sleep, you will feel those hands and arms getting a little bit heavy—and then a bit heavier. [Pause as therapist looks for the slight bobbing motions that signal the greater weight that is being experienced.] And as those hands continue drifting lower that comfort deepens more. But those hands won't come to rest on your lap until the unconscious is really ready to rest and then learn other hypnotic skills that can be useful for your purposes.

R: At this point the subject is usually ready for further work. The junior author now typically introduces ideomotor finger signaling that can be used to monitor the course of whatever procedures there are to follow.

4. Measuring Trance Depth

The concept of trance depth has been a controversial matter in the history of hypnosis. Our modern *utilization theory* would define depth as the state of concentration or absorption in relevant associations and mental processes that allows the subject to experience a particular phenomenon of interest. "Depth" may thus be understood as readiness to respond in a *particular* way rather than as a *generalized* readiness to experience any hypnotic phenomena. The notion of a generalized readiness to respond with a graduated scale of trance depth correlated with the various hypnotic phenomena (from easiest to experience in a light trance to those phenomena requiring deeper trance) is well established, however, and offers a practical guide. Tart (1972) has reviewed many self-report scales of hypnotic depth which suggest that subjects can be trained to give accurate verbal responses about their current depth of trance. It is found that depth varies continuously, so that it is of value to monitor it when doing important trance work. Individual differences between what is actually experienced at the various stages of "depth" are so great, however, that no universal scale exists that can be used with all subjects at this time.

The senior author has used finger signaling as an individual index that is gradually developed for each particular subject. With patients' hands resting comfortably by their sides, out of their line of vision, Erickson will suggest that the digits of the hands can signal the depth of trance by moving a bit all by themselves. The use of the thumb is excluded because the senior author believes there is more consciousness associated with thumb movement

than with other finger movements. He uses the impersonal term *digits* because it has less conscious associative strength than terms like *forefinger, index finger, ring finger,* and *little finger.* The same digit on either hand can designate trance depth. This tends to bypass learned associative patterns specific to one hand or the other, but there are great individual differences in this matter. Some patients will use the hands interchangeably; others are very consistent in using either the left or right hand.

In working out an index of trance depth, the first digit (however the patient interprets "first digit") can be used to indicate the lightest stage of trance, while the other digits can indicate depth on a scale somewhat as follows:

First digit (0-25%): Light trance wherein relaxation, comfort, ideosensory, and ideomotor signaling is possible.

Second digit (25-50%): A comfortable state of receptivity to inner experience wherein feelings, thoughts, daydreams, colors, etc., flow autonomously. An agreeable receptivity to the therapist's suggestions so that familiar trance phenomena can be experienced easily, with the subjective experience of their taking place automatically when the therapist suggests them (e.g., hand levitation, heaviness, warmth, sensory-perceptual alterations, etc.).

Third digit (50-75%): A state of established receptivity where the subject has "passed" all familiar indicators of trance experience and feels capable of exploring new trance phenomena or unfamiliar areas of personal dynamics (uncovering memories, partial age regression, etc.). Trance events take place autonomously, though the ego may observe them and may or may not recall them upon awakening. Subjects are frequently enthusiastic upon awakening because they feel their trance was deeper or more therapeutic than usual, and they spontaneously experienced other hypnotic phenomena not even suggested by the therapist. They have a deep sense of the autonomous or dissociated nature of their experience.

Fourth digit (75-100%): Subjects report that they lost consciousness at times. They were either asleep, dreaming, far away, or "out" somehow. They cannot recall hearing the therapist's voice, even though they responded appropriately, though slowly, to it. They cannot explain or recall much of their experience.

Some people may experience the plenary trance, which is relatively rare and usually requires several hours for induction. It is a state akin to suspended animation, with greatly retarded respiration and pulse, requiring an extended period of time (30 minutes or more) to recover the generalized reality orientation.

5. Replacing Challenges

Perhaps the greatest value of ideomotor signaling for modern hypnosis is that it permits the therapist to do away with the authoritarian "challenges" of yesteryear ("you cannot open your eyes, unclasp your hands," etc.), which were a somewhat traumatic method of gauging trance depth and a most disheartening way of relating to patients. Ideomotor signaling permits the patient's own system to indicate when it is ready to respond and what help it requires to make an adequate response. This permits a closer rapport and more enlightening cooperation to develop between patient and therapist. Ideomotor signaling opens up the subject's trance experience so that the clinician and the researcher have an adequate tool for exploring the nature of any altered state of consciousness.

6. An Indicator of Response Readiness

The shift from the older authoritarian approach to the more modern permissive approach pioneered by Erickson is nowhere more evident than in the use of questions to subjects regarding their readiness to experience a particular response. The senior author continually offers subjects a series of truisms regarding their ability and motivation for experiencing different phenomena. Even when he believes a subject is ready for a particular experience, he will first ask a question about it to activate the proper associations and response potentials within the subject. Questions and ideomotor responses are thus a way of priming

an individual to make certain responses.

An example of the senior author's recognition of a spontaneous and automatic head-nod at the appropriate moment made by a person attending his 1945 "Informal Meetings with Medical Students" illustrates how he utilizes unconscious ideomotor signaling as an indicator of a person's readiness to experience trance.(Taken from unpublished stenographic records of Erickson's "Informal Meetings with Medical Students," 1945)

E: Actually, there isn't a volunteer here tonight. I have been looking the group over very carefully and there isn't a volunteer. ... By the way, does anyone know who nodded his head just then?

LeJ: It seems I did. I had already said I would try to go into a trance, and then the fact that you said you didn't see a volunteer in the group seemed significant and it seemed it must have been me. ... I didn't know it. It might have been because I was rocking the chair.

LeJ's head-nod came in response to the senior author's verbal remarks about searching for a volunteer. Erickson might have (1) arbitrarily picked out a volunteer or (2) asked for a volunteer. But he might have picked a person who was not ready, and even if a subject volunteered, it may have been only a response from the conscious level. By spotting an ideomotor signal, the senior author was fairly certain of finding a subject who was ready on a deeper level.

LeJ's introspective remarks are instructive. He had previously said (outside the immediate group situation) that he would try to go into a trance. That is, he was ready to make a response to trance induction. He needed Erickson's verbal remarks about the need for a volunteer as a stimulus to trip off the automatic head-nod, however. Having made the head-nod, LeJ admits that he did not know he was making it (he had no forethought of nodding his head), and he even tries to rationalize his way out of it by suggesting his head nodded because he was rocking his chair. On a conscious level LeJ was thus ambivalent; he said he would like to try trance, yet he tries to rationalize his way out of it. This ambivalence is highly characteristic of patients, who have problems precisely because they are poised between conflicting forces within themselves. Erickson's verbal remarks and questions allowed an ideomotor response to take place as a way of tipping the ambivalence into a constructive direction.

Other investigators such as Le Cron began to use ideomotor signaling in a more consciously directed form. In the 1952 Los Angeles Seminar on Hypnosis, taught in association with Erickson, Le Cron described his beginning use of ideomotor signaling as follows (taken from L. LeCron's unpublished tape transcriptions of the 1952 Los Angeles Seminar on Hypnosis.) :

> In inducing anesthesia, you do not know when your suggestions are taking effect until you test the anesthesia and the subject says he feels nothing. I avoid the use of the word "pain," saying "discomfort" instead. The word "pain" is a negative suggestion—the word itself. I make a suggestion that when anesthesia has become complete or almost complete that a designated finger will twitch. When it does, you can take it that you have at least a good partial anesthesia. That finger twitch is an indication of acceptance by the subject. When he feels the finger twitch, his thought is "well, the hand must be anesthetized."

This approach is certainly applicable in evaluating the patient's readiness to experience other phenomena as well as anesthesia. What if the patient's ideomotor responses indicate that he is not ready to experience the desired response? This is an indication that the patient's understanding, motivation, or internal readiness is not yet sufficiently developed to sustain the required response. The patient can then be questioned about the source of the difficulty. The therapist then helps the patient resolve these problems with understanding and motivation, then provides the appropriate associations that will enable the patient to approach the required response with more security and internal preparedness. The therapist mentions all the past and partial experiences the patient has had in making the response automatically, as a part of everyday life experience. These associations encourage the

patient on a conscious level while (1) providing the unconscious with appropriate cues about how the response may be made and (2) actually activating the relevant response sets that can facilitate the appropriate behavioral response. Examples of this procedure will be provided throughout the following chapters.

6. Uncovering Unconscious Material

Ideomotor signaling can be used as a procedure for uncovering unconscious material in a much shorter time than the traditional psychoanalytic approaches. An early illustration was provided by Erickson in his "Informal Meetings with Medical Students" (1945). Upon recognizing the presence of covert hostility in Mrs. W, Erickson proceeded to use both ideomotor signaling and automatic writing to help her recognize it. This example is particularly instructive because he begins by working with two subjects, both of whom make an identical response on a conscious verbal level indicating that they do not want to say anything unpleasant. Ideomotor signaling supports Miss H's verbal statement but does not support Mrs. W's. Erickson then proceeds to utilize *ideosensory* signaling (when Mrs. W's hand "feels a little light"), which then merges into a genuine *ideomotor* signal a few moments later, thus helping Mrs. W. Recognize her ambivalence.

E: Let's put it to a test. Suppose you put your hand in this position. If unconsciously you would like to say something unpleasant about him, your right hand will lift up. If you have nothing unpleasant to say—if there is no need to say something unpleasant—the left hand will lift up. Which hand will you bet on?

Mrs. W: My left one. [No hand lifting]

Miss H: My left one. [Left hand lifts up]

E: Nothing unpleasant. Is there anything unpleasant you would like to say about anybody here?

Mrs. W: No.

E: Does your right hand feel different?

Mrs. W: My right hand feels a little light, but does that mean I want to say something unpleasant to somebody?

E: Does it?

Mrs. W: I can't think of anything.

E: If you would like to, let's see your right hand lift up.

Mrs. W: [Right hand lifting] It did, though. You're going to get me into trouble.

E: Do you know what it is?

Mrs. W: No.

E: There's no awareness or conscious state. There is a movement of the hand. Something occurred within her to make her realize that there must be something unpleasant. I haven't persuaded her or directed her, one way or the other. I have just created the situation and raised the question, and she found her right rising, and she is aware of the face, "Yes, If I am to believe my hand, I want to say something unpleasant, but I can't think of anything."

Mrs. W: It's all Greek to me. My hand lifted, and I was trying to keep it down.

E: Would you like to have the fun of finding out what it is you want to say?

Mrs. W: I can't imagine want it is.

E: I can tell you very easily and quickly how to find out.

Mrs. W: Go back to sleep again?

E: No, no. Suppose you pick up the pencil, and your hand is going to write somebody's name.

In the process of doing automatic writing the name of the person she wants to say something unpleasant to finally pops into Mrs. W's mind. This is highly characteristic of the ideomotor-response approach to uncovering unconscious material. There is an interplay between *entirely autonomous ideomotor responses,* which come from sources outside the patient's awareness, and *conscious recognitions* (thoughts, feelings, etc.), which become available suddenly. It is as if the therapist's persistent questions activate many patterns of association and sources of response within the patient. The patient's responses may then come by way of ideomotor signaling alone, through a combination of ideomotor signaling with conscious recognition (which may come just *before, during,* or *after* the ideomotor response is made), or by conscious recognition and verbal report alone.

A question naturally arises regarding the validity and reliability of ideomotor signaling in these applications. All of these applications of ideomotor signaling to date have been developed in clinical work and have depended upon the clinician's skill in detecting valid from invalid results. No systematic studies of the validity and reliability of ideomotor signaling have ever been done under standardized laboratory conditions with proper controls and statistical analyses. Erickson admits that the results are only as valid as is the clinician's capacity to understand the total situation. He discusses this as follows (edited from audio recordings made with the junior author during the 1970s):

"What is the validity of ideomotor signaling? A great deal has been said about asking the unconscious to lift the right hand if the answer is Yes and to lift the left hand if the answer is No, to seek further information from the patient's unconscious as an entity that can give reliable information. The question is asked, how valid is that? It is only as valid as is your capacity to understand the situation that you are dealing with.

"A patient came into my office and said that she had a tremendous complex over the fact that she had had seven affairs over a period of several years. She very willingly gave me the names, dates and places, and situations of each of those seven affairs. The patient was so communicative and so free, so direct in describing all of those things, describing her feelings. But having some psychiatric experience, I wondered what she would tell me in the trance state.

"In the trance state she gave me literally the same account of the same seven affairs with minor corrections. I mentioned the possibility of her unconscious giving answers: Yes with the right hand or with the right index finger and No with the left hand or with the left index finger just as one would nod the head Yes or shake the head No. I gave this as a simple incidental explanation, not telling her to do that but just to mention that it was one of the things that could be done presumably by some other patient. In the trance state, when she finished relating the first affair, she said, 'My first affair was in 19xy,' but her left hand said No. I made a mental note of that. Then I think it was the fourth affair she introduced by saying, 'My next affair,' and her hand again said No.

"Ideomotor movements contradicted her words three times: Once her hand said No, once it was her finger that said No, and once it was her head saying No. But she didn't notice any one of those movements. She was as unaware as could be. Later I found out that her first affair didn't occur at age 17, as she said. It occurred at the time of puberty, when she became very aggressive and undertook to seduce an older man, but had tremendous guilt reactions and a complete repression of it. That was her first affair which she had forgotten. She had forgotten who the sixth one was also. Another repression. She gave that information only through ideomotor signaling. And yet I could ask her, 'Did you give me an account of all your affairs?' and she would answer verbally, 'Yes.' Well, she had given me an account of all her affairs, but only those that she was aware of consciously. She did not at all mind knowing that it was an incomplete account when I later suggested that to her. She was willing to learn about the affairs first disclosed via ideomotor signaling that were repressed from consciousness.

"So when you deal with patients, you ought to bear that in mind. You cannot force them, but you can get them to disclose more completely when you provide an ideomotor outlet for responses that are not available to consciousness. I certainly didn't try to force that woman to tell me about the missing accounts until she got ready to. She was tremendously surprised when she found out about those repressed affairs later in therapy."

LeCron (1954, 1965) has utilized ideomotor signaling to uncover early memories of light trance states. He outlines his approach to questions in his early 1954 paper as follows:

> Questioning should usually be carried out on a permissive rather than a commanding basis. Cooperation at unconscious levels will probably ensue if this is adhered to, for resistance may be provoked if there is an attempt to force information.
>
> With practice and ingenuity in asking questions a great amount of valuable material may quickly be obtained. For instance, if a trauma is involved, the exact day when it occurred can be ascertained by a bracketing method of questioning. A query may be made as to whether the event happened before the patient was 15 years old. If the reply is "yes," the next question could be "was it before you were 10 years old?" If the answer is "no," the date was then between 10 and 15 years of age. The year can then be ascertained and further questioning can even locate the exact day, though it is seldom necessary to establish the time so closely.
>
> Having learned the age or date, the patient can be instructed to regress to the time of the experience. The regression need not be of the revivification type, the subject merely relating the experience as though reliving it but recognizing also that he is in the present. Such a regression can be with all five senses functioning as the incident is relived—seeing, hearing, etc.—and with abreaction and discharge of emotion.
>
> In this way information can be obtained as to almost anything involved in the patient's difficulty or neurosis. It is, of course, infinitely more rapid than the usual method of free association. Questions can even be diagnostic—"Are there psychological or emotional causes for this symptom?" And sometimes it will be found valuable also to ask questions as to prognosis.
>
> To the patient it is most impressive to have this information come from within himself. The nonvolitional movement of the fingers demonstrates to him most effectively a direct action of the unconscious mind. Not infrequently a patient will remark that a "no" answer was expected when the fingers actually responded with "yes." This serves as an excellent indication both to the patient and therapist as to the validity of the replies. Sometimes a subject may try experimentally to prevent the fingers from moving. Perhaps he can do so, but frequently they will move in spite of such an effort.
>
> Of course the wise therapist will take all replies with a grain of salt and will show, however, that it is exceptional for a false reply to be given, though of course it is possible. Even with deeply repressed material the answers usually are accurate and perhaps easily obtained. This is not always true if the repression is great or if the material is too emotionally charged, but the method seems to break down repressions. Avoidance of answering a question by the signal with the left thumb [I don't want to answer] is an indication of danger. Carefully handled, objections may be overcome with reassurance and discussion, or a suggestion may be given that the subject will be able to summon ego strength enough to bring out the material at a later session. Questions may here bring out the reasons for the avoidance of an answer and also if there is danger to the patient as to being overwhelmed.
>
> Care should be taken in the wording of questions so that they do not suggest either an affirmative or negative answer. The operator can mention at the beginning of the questioning that he does not know the correct answers and that the patient probably does not consciously know them, but that his unconscious mind does know and is able to reply with the correct answers, (pp. 76-78)

Cheek and LeCron (1968) have systematized many paradigms for questioning patients to obtain ideomotor signaling to uncover sources of psychological trauma and psychosomatic illness. Cheek, in particular, has developed a number of ingenious ideomotor procedures for uncovering unconscious material. These include the removal of subconscious resistance to hypnosis (Cheek, 1960), the unconscious perception of meaningful sounds during surgical anesthesia (Cheek, 1959, 1966), the significance of dreams initiating premature labor (Cheek, 1969b), and communication with the critically ill (Cheek, 1969a). In an important paper, "Sequential Head and Shoulder Movements Appearing with Age Regression in Hypnosis to Birth" (1974), he has made interesting observations on ideomotor responses that take place on unconscious levels. His papers represent truly pioneering efforts on the part of a clinician and therapist. His work points the way toward much systematic research that needs to take place under controlled laboratory conditions in order to establish the validity

and reliability of ideomotor responses and signaling.

F. SUMMARY

The useful clinical art of ideomotor signaling has evolved out of an extensive and ancient history of automatism. While automatisms were regarded as mysterious, God-inspired, or magical in ancient and medieval times, we understand them today as an interesting manifestation of response systems outside the usual range of awareness. These ideomotor and ideosensory responses are now understood to be the fundamental building blocks of the automatisms that gave rise to the classical trance phenomena and the establishment of hypnosis in the 19th century. New forms of ideomotor signaling have been explored during the past few decades, primarily by clinicians interested in uncovering unconscious material and facilitating hypnotic responsiveness. These modern forms of ideomotor signaling, developed by Erickson, LeCron, and Cheek, are providing *permissive* clinical approaches to understanding and facilitating hypnotic and therapeutic responses that are replacing the older *authoritarian* forms of command and "challenges." Systematic and controlled laboratory investigation is still required to establish the validity and reliability of ideomotor responsiveness and signaling.

G. EXERCISES IN IDEOMOTOR SIGNALING

1. Ideomotor Signaling and the Indirect Forms of Suggestion

The use of ideomotor in conjunction with the indirect forms of hypnotic suggestion (Erickson & Rossi, 1979) provides the therapist with a creative array of approaches to facilitating hypnotic phenomena and working with unconscious material. In his 1960 paper on the removal of resistance to hypnosis, for example, Cheek provided an excellent illustration of the use of the Chevreul pendulum with questions and the implied directive to help a subject recover a traumatic memory. The subject, Dr. R. (not the same Dr. R. of this volume), had an unusual reaction to his first experience with the Chevreul pendulum and apparently froze with fear. Following is an excerpt from Cheek's account; the italics are ours, indicating where Cheek utilized a series of two implied directives in successive sentences to evoke the critical material.

Dr. R grasped his pendulum more tightly. Beads of perspiration appeared on his forehead. His face and hands turned an ashy-gray color. I asked him to open his eyes and let the pendulum answer some questions. I asked him:

Q: Have you ever felt like this before?

A: Yes.

Q: Was this before you were 20 years old?

A: Yes.

Q: Before you were 15?

A: No.

Q: Does your subconscious mind now know what that was?

A: Yes.

Q: Let your eyes close now, and *if your inner mind will let you know what the experience is it will pull your fingers apart. As the pendulum falls to the table, the noise will bring that memory up to a conscious level where you can talk about it.*

I remained silent for about 20 seconds. As his fingers released the chain, he appeared disturbed. A split second later, as the plastic ball of the pendulum struck the table, he lifted his left hand to the side of his head, opened his eyes and said: "I know now. I was in gymnasium exercises and I was the top man in one of those pyramids. The man below stumbled, and I landed on the side of my head on the cement floor."

There seemed to be no further comment. I asked him to pick up the pendulum and answer this question:

Q: Do you now think you can enter hypnosis comfortably, and be free of the reaction you had a little while ago?

A: Yes. (p. 106)

The reader can now explore how each of the indirect hypnotic forms can be used with ideomotor signaling to effect significant therapeutic responses.

2. A Basic Paradigm for Ideomotor Signaling

In recent years the cybernetic hypothesis that conceptualizes *information* flowing along a *feedback loop* as the basic unit of learning and behavior has provided interesting models of psychological functioning. Of these, the *Test-Operate-Test-Exit* (TOTE) Model (Miller, Galanter, & Pribram, 1960; Pribram, 1971) provides a useful paradigm for experimental and clinical work with ideomotor signaling. This paradigm outlines the use of a series of *test* questions and psychological *operations* that can eventuate in the solution of a given psychological problem.

After establishing ideomotor signaling via head, hand, or finger responses, a five-state TOTE paradigm that theoretically could be used to investigate and resolve most psychological problem runs as follows: The *tests* are usually a series of questions or instructions that the therapist addresses to the subject, while the *operations* are the inner psychological processes the subject must undergo to give an ideomotor response. This paradigm is actually a generalization of the lines of investigation developed by Cheek and LeCron (1968). In the following outline the "no," "I don't know," or "not willing to answer" responses all indicate a need for further inquiry at that level to resolve whatever difficulty the patient is experiencing.

1. TEST: Is there a psychological or emotional reason for your problem? OPERATE: Inner review on an ideomotor level (with or without conscious awareness), giving rise to an ideomotor response:

"YES" "No" ➧ TEST: Further inquiries

2. TEST: Series of age-bracketing questions and/or a request to reorient to time the problem began.
OPERATE: Inner review on an ideomotor level, giving rise to an
ideomotor response:

"YES" "No" ➧ TEST: Further inquiries

3. TEST: Is it okay for consciousness to know it? OPERATE: Ideomotor response:

"Yes" "No" ➧ TEST: Further inquiries

4. TEST: Discuss the source of your problem.

OPERATE: "No" ➧ Unsatisfactory verbal discussion TEST: Further

Inquiries
'Yes": A satisfactory discussion

5- TEST: Is it now okay to give up the problem?
OPERATE: Inner review of the problem on many levels summarized in an ideomotor response.
"Yes" "No" TEST: Questions about other sources of problem or when problem can be given up.

EXIT: Posthypnotic suggestions supporting resolution of the problem.

The first test question regarding a psychological or emotional reason for the patient's problem initiates the operation of an inner review on an ideomotor level. Such inner reviews always tend to deepen trance; consciousness is fixated and focused within, while an autonomous or semiautonomous process is allowed to make an ideomotor movement. If a Yes signal comes forth, the therapist can go on to the second test question. If a No response is obtained, then further inquiries are indicated. It may well be that the problem does not have a psychological or emotional basis. It may be that the patient does not accept the words

psychological or *emotional* and that the question needs to be rephrased in terms acceptable to the patient's understanding.

A No response at this initial level could also indicate transference problems. The therapist may need to question patients about their willingness to let the therapist help them, and so on. At this level "I don't know" may mean that the patient needs more education regarding the nature of psychological or psychosomatic problems. "Not willing to answer" may mean that there are important secondary gains associated with the problem that need to be investigated. People use their signaling system in their own unique ways, however, so the therapist must closely study each person's style and personal system of meanings. In any case this first question initiates a process of inner review regarding the nature of the problem. This activates many associative processes that may be utilized to identify sources and potential solutions to the problem.

The second test question is actually a series of bracketing queries to localize the source of the problem in time. Erickson has always emphasized that hypnotic responses take time. This series of bracketing queries provides time for a series of inner reviews. In addition trance is usually deepened whenever we have a serial task (Erickson, 1964b). Frequently the sources of the problem will pop into the patient's mind as soon as the bracketing queries are initiated. It is well to continue an entire series of questions, however, to provide the patient's associative process with an opportunity for a more thorough review than the patient probably has ever done before. Other sources of the problem may be uncovered and valuable connections made between different age levels.

Having located the time when the problem began, the therapist then asks if it is okay for the consciousness to know it. In truth the therapist does not always know where the patient's consciousness is. It may be present, quietly watching the ideomotor responses, or it may be far on, relating to other matters and entirely unaware of what ideomotor responses are being made. There may be a total, partial, or complete lack of dissociation between the ideomotor level of responding and the cognitive system of awareness. When there is no dissociation, the patient's consciousness is theoretically aware of the significance of a particular ideomotor response. Even when this is the case, however, there is every likelihood that there are associations available at the ideomotor level that are not shared with consciousness. Because of this we ask whether these associations can be shared with the patient's consciousness. A Yes response usually means that the inquiry can proceed, but there is still no assurance that all the relevant associations will be shared with consciousness at this time. Many reviews (sometimes dozens) of the same ideomotor process relating to a problem may be required before certain associations reach consciousness.

An "I don't know" or "unwilling to answer" response at this level requires further inquiries regarding why a dissociation (or unconsciousness) needs to be maintained. The conventional view of most forms of therapy requires that the unconscious be made conscious. Erickson, however, has pioneered the view that many if not most neurotic problems can be handled more adequately at an unconscious rather than a conscious level. A No response at this level could mean that consciousness is not necessary to resolve a problem. A line of inquiry can be used to test this possibility (can the unconscious solve this problem without your conscious mind knowing anything more about it?). This possibility gives rise to the fascinating prospect of problems being resolved at an ideomotor or unconscious level without either patient or therapist knowing the what, how, or why of it. Much research is needed to explore this possibility. It may be that certain patients and certain problems are more effectively resolved without the intervention of consciousness.

In the typical course of inquiry test question #4 invites the patient to talk about the material stirred up by the questions thus far. What is or is not a satisfactory discussion of the problem depends on something more than the therapist's preconceptions and theoretical views. Ultimately the only criterion of a satisfactory discussion of a problem is the pragmatic one of whether or not it leads to a Yes response to test question #5, regarding the patient's willingness and actual ability to give up the problem. There is a wide range of possible responses when patients are invited to talk about their problems at this level. There is the usual uncertainty about the degree of dissociation that may be present. Patients may talk

with seeming normality, yet be in a somnambulistic state so that an amnesia would be present for everything said when they awaken later. Usually, however, the dissociation is only light or partial; the patients speak and may undergo a catharsis more freely than when awake, but they retain a fairly complete memory of the discussion when awakened later. This memory has actually been facilitated by any efforts to secure a Yes response to test question #3, regarding the appropriateness of consciousness knowing.

Test question #5, regarding the patient's willingness and ability to give up the problem, is the main objective of the entire proceeding. Again it is well to recognize that psychological processes continue to develop over time. Sometimes a patient will gain a clear insight about a problem and definite prospects for its immediate, confident resolution. Many "emotional" and "identity" issues can be resolved in this manner. Habit problems with ingrained patterns (smoking, nail-biting, overeating, etc.), however, may require more time. It is always valuable to have the patients "see" a date when the problem will be finally resolved. It is then valuable to have the patients pseudo-orient themselves in time future to that date. When the ideomotor responses indicate the patients are there, the therapist can have them review all the things they had to do to finally resolve the problem (Erickson, 1954). This provides patients with a series of tasks or steps their own system needs for problem resolution. In this manner, a patient's individuality has an opportunity to create its own patterns of problem solving. Patients are usually impressed when they realize that modern hypnotherapy thus facilitates their own creative abilities rather than attempting to impose some arbitrary solution from the outside.

The final stage is to EXIT from the therapeutic encounter with a few indirect posthypnotic suggestions to facilitate the solutions just found (and created!). The patient usually awakens spontaneously when the ideomotor situation is ended by the therapist simply adopting a conversational manner that requires responses of normal attention and behavior. The therapist can recognize the spontaneous awakening by the patient's reorientation to his body, etc. If the awakening is not obvious and spontaneous, then the therapist can request that the patient close his eyes, rest comfortably for a few moments, and then awaken completely, feeling refreshed.

3. The TOTE Model and Psychological Change

The TOTE Model was developed to account for central control of receptor mechanisms (which Sherrington's conception of the reflex arc cannot do). Central processes within the brain are continuously modifying sensory input from the environment. This central control is necessary for the organism's continuous adjustment between internal states and the outer environment. If this central control is important in integrating sensory and motor processes, consider how even more important it is in the psychological realm, where input from a social scene is continuously modified by the person's central control over that input—that is, the person's interpretation of that social scene. What we have termed "interpretation" or "bias" in clinical psychology is actually the person's "central control" over input. When the person's central control of "bias" is rigid—that is, not sufficiently or appropriately modifiable by changing external realities—we have psychological maladjustment. When the central control (bias, interpretation) changes appropriately as a function of real-life changes, we say the person is "well oriented to reality," "adjusted," or "growth-oriented."

The most significant factor involved in changing central processes or biases is the organism's motor interactions with the environment. Central control does not change unless the organism has a chance to modify itself by way of an actual interaction with external reality. A kitten needs to actually walk in order to organize its visual perceptions; being carried about in a special cart does not allow it to develop the requisite perceptual-motor coordination to move with grace and accuracy. Thus we can expect that modifying inappropriate central control of social situations (bias) will also require actual interaction with those social situations— simple interpretation or understanding of one's bias is not enough. One needs to interact or actively change one's responses to a social situation in order to change the bias or maladjustment.

4. Levels of Response in Ideomotor Signaling

It is evident from the preceding discussions that the sources or levels of response in ideomotor signaling remain a fascinating puzzle. Cheek and LeCron (1968) have indicated, "Deeply repressed information of a traumatic sort will be indicated first by physiological indications of distress, then by an ideomotor response, and finally by verbal reporting" (p. 161). The results of their clinical investigations thus indicate that there may be at least three sources or levels of response. Actual clinical experience suggests there may be even more. Some patients respond on an emotional level, feeling something but not knowing what it is. The emotional level is thus different (dissociated from) the cognitive level. Others have an intuitive level of response about knowing something, but again they cannot put it into words. Ideomotor signaling appears to be in rapport with these emotional and intuitive levels even when they cannot be verbalized. This is a line of research that is still open for systematic investigation. Is there in fact a hierarchy of sources or levels of response that passes through the various stages—physiological, ideomotor, emotional, cognitive, verbal, etc.—or is this simply a matter of individual differences? What approaches can be developed to explore the question experimentally?

AN AUDIO-VISUAL DEMONSTRATION OF IDEOMOTOR MOVEMENTS AND CATALEPSY: THE REVERSE SET TO FACILITATE HYPNOTIC INDUCTION

In 1958 the senior author gave Ernest Hilgard and Jay Haley a demonstration in hypnotic induction at Stanford University. A videotape or 16mm film of this demonstration is available from the publisher (Irvington Press, 551 Fifth Ave., New York, New York, 10017). Although both the visual and auditory qualities of this old record are poor, it is nonetheless the best visual record we have of the senior author's uses of a variety of nonverbal approaches to catalepsy and an unusually complex form of ideomotor signaling in trance induction during an exciting period of his work as a teacher. The analysis of this visual record in this section contains his commentaries on the puzzling use of a *reverse set* to confound the learned limitations of everyday thinking to facilitate the experience of mental flux, creativity, and therapeutic trance.

After being introduced to the subject, Ruth, Erickson made a few conversational remarks to initiate the idea of "automatic movement" to her and then began a hand levitation approach. As her hand approached her face, Erickson introduced another task: to discover the difference between her thinking and doing. In what follows we have a transcription of how Erickson proceeds to facilitate a dissociation between her thinking and her doing as a means of deepening trance and establishing a reverse set.

In this ingenious procedure Erickson arranges matters so that her *doing* (an initially voluntary head signaling that gradually becomes more and more involuntary) can be true or false. Circumstances are arranged, however, so that her *thinking* will always be true. Her thinking will be true even if she needs to go through a private mental maneuver of believing the reverse of what she does with her head signaling.

The outer movement of head-nodding or -shaking and the inner process of thinking are usually associated together in a body-mind pattern of agreement in everyday life. Here Erickson separates or dissociates them, so they now have a significance that is the reverse of each other. By having her head signal the reverse of what she obviously knows to be true, Erickson establishes a reverse set within her. She develops a set to think the reverse of what her head signals. The critical point comes when he has Ruth shake her head No to indicate she is not in trance; but the reverse set that has been activated within her reverses this so she must think, "I am in trance." Erickson thus arranges what she actually thinks by utilizing a mental mechanism (the reverse set) within her own mind.

This example is the clearest, verbatim illustration of the evocation and precise utilization of a mental mechanism for trance induction that the junior author is aware of. It has been

analyzed in this section in almost painful detail because it is so subtle a process that it can easily be lost or misunderstood. Difficult though it may be to grasp initially, we believe *this process of activating and utilizing mental mechanisms is actually the essence of the hypnotherapeutic process.* Erickson's 1948 paper "Hypnotic Psychotherapy" contains his original formulations of this approach of utilizing—rather than simply analyzing—mental mechanisms.

Introduction and Initial Learning Orientation to Hypnosis

Hilgard: Ruth, I want you to meet Dr. Erickson.

Ruth: How do you do, sir.

E: How do you do. Do you mind if I call you Ruth?

Ruth: No, I'd like to have you call me Ruth.

E: Please sit down. Does that light feel all right?

Ruth: Yes, it does.

E: I understand you've never been hypnotized?

Ruth: No, I haven't.

E: But that you are interested?

Ruth: Yes.

E: And I think that perhaps the best thing to do is to get right down to work. *How much are you willing to learn?*

Ruth: Well, I'm very willing. [Slight pause] I'm a little nervous, though. E: You're a little nervous? Ruth: Yes.

E: Well, really, I ought to be the one who's nervous, because I've got to do the work, and *all you have to do is let things happen, and they will happen.*

> R: Upon being introduced, Erickson uses his first remark to gain access to personal contact by requesting permission from Ruth to use her first name. Requesting her permission is not only polite, it immediately gives her an active role in determining how the proceedings will go. Erickson's first solicitous remark about the light (for the movie that is being made) continues this initial effort to enlist her approval and active participation. He then asks a question to ensure her interest in hypnosis, and then another, "How much are you willing to learn?" Thus the hypnotic situation is immediately defined as a learning process. This is especially appropriate in a university setting.
>
> In the next remarks about being nervous Erickson does a number of things: (1) acknowledges and reflects her feelings; (2) identifies with her nervousness and in a peculiarly concrete way may be relieving her of it by taking it on himself (the original meaning of transference in the rituals of early forms of healing was that the patient's disturbance or disease was transferred to the healer (shaman, witch doctor, or guru), who internalized the problem and dealt with it in his own system); (3) utilizes it to define hypnosis further as a situation where "all you have to do is let things happen, and they will happen." The ease and casualness with which all this is done contributes to its effectiveness. Casualness in a context of truisms and good rapport may be regarded as a most effective vehicle for the acceptance of suggestion.

Initial Assessment of Possible Trance

E: Uh, are you forgetting about the light?

Ruth: No, I'm not—am I supposed to look at it?

E: Oh, no.

Ruth: Oh.

E: You can forget about it, you know.

R: In this innocent questioning about the light, Erickson is boldly but indirectly assessing her response attentiveness and potential for hypnotic responsiveness. If she had given some indication that she had already forgotten the light in the intensity of her concentration on him (e.g., a slight startle as she reoriented to the light or a frank admission that she had indeed already forgotten it), Erickson would have had rapid evidence of her tendency toward somnambulism. She indicates to the contrary, however, that she is in fact aware of the light. She is a subject who likes to hang onto her generalized reality orientation. She does not like to admit altered states. It will not be easy to ratify her trance experience. This turns out to be true, as we shall see later; even after experiencing a number of classical hypnotic phenomena during this session, she tends to question them at the end. Nonetheless, Erickson ends the interchange at this point with the direct suggestion that she can forget the light. The casualness with which this suggestion is made, however, tends to make it indirect and acceptable without challenge. He then rapidly goes on to initiate a formal hypnotic induction by hand levitation.

Modeling Hand Levitation and the Conscious-Unconscious Double Bind

E: And I'm going to take hold of your hand in a moment or so. [Pause while E puts her hands on her thighs.] Now, as you watch your hands, they're resting there. And do you know about the feelings you have when you are feeding a baby and you want the baby to open its mouth, and you open yours instead of the baby? And did you ever put on the brakes when you were in the back seat of a car?

Ruth: Yes.

E: Well, I would like that same kind of automatic movement. Now look at my hands. You see very, very slowly, without it being a voluntary thing, my right hand can lift and it can lower, and the left hand can lift and lower. [E models this slow lifting and lowering with his own hands.] Now what I'd like to have you understand is this: that you have a conscious mind, and you know that and I know that, and you have an unconscious mind or a subconscious mind, and you know what I mean by that, do you not? [E is leaning forward in his chair toward her, engaging intense eye contact.] Now you could lift your right hand, or your left hand consciously, but your unconscious mind can lift one or the other of your hands. And I'd like you to look at your hands, *and I'm going to ask you a question and you do not know the answer to that question consciously, and you'll have to wait and see what the answer is. I'm going to ask you which hand is your unconscious mind going to lift up first? The right hand or the left, and you really don't know. But your unconscious knows.*

R: Erickson begins a hand-levitation approach by giving an everyday analogy of automatic movement that is especially appropriate for a young woman (feeding a baby). This analogy tends to initiate an unconscious search for those unconscious processes that can facilitate the automatic movement of her hands. Erickson models this automatic movement with his own hands and then uses the conscious-unconscious double bind to further facilitate the unconscious search for automatic movement (Erickson & Rossi, 1976, 1979).

Voice Locus Cue for Hand Levitation

E: That's right, and it's beginning to lift one of your hands. *Lifting, lifting, lifting,* [E slowly moves his body backward and his head upward as he says this] *lifting up,* and now watch it. That's right. Watch it lifting, lifting, lifting, up it conies, lifting higher. And watch it. Soon you'll notice it, and keep watching your hand and watching it. And if you wish, you can close your eyes and just feel your hand lifting higher and higher. That's right. Lifting still more. That's right, elbow will start bending and the hand will come up, that's right. Lifting, lifting, and now close your eyes and just feel it lifting, and it's lifting higher and higher.

R: As you intensely intone "lifting, lifting, lifting, lifting up" you move your body backward and your head upward. Your voice locus is moving upward in the same direction you want the hand to levitate.

E: Yes, that's an auditory cue that may facilitate hand levitation on an unconscious level. The patient doesn't know why the hand lifts.

R: In the next section you again use voice locus as a cue several times by lowering your head and deepening your voice when you tell her that her hand is coming down and she will "go way deep asleep."

Tactile Cues for Hand Levitation and Catalepsy: Amnesia for Tactile Cues: The First Apparent Awakening

E: *And I'm going to take hold of this hand. [E* signals the levitation of her left hand by lightly sliding his thumb on its underside.] And it's lifting)

lifting, lifting, lifting, that's right. And the other hand is lifting, lifting up. [E guides her right hand up with some lingering touches to signal that it is to remain up in a cataleptic position.] That's right. Now, I mentioned before that the hand could lift, and it could go down. And now I wonder if you know which hand is going to go down first? One or the other is going to go down, and down it conies. [Her right hand begins to come down slowly.] That's right, that's right, down it conies, down it comes, and coming down still more, still more, down it comes, down it comes. [E lowers his head as he says this.] And as it conies down, I want you to go deeper and deeper into the trance. I'd like to have you enjoy going deeper and deeper, and when your hand reaches your lap, you'll take a deep breath and go even deeper into the trance, because you're beginning to learn how now. That's right, coming to rest there. That's right. Now, take a deep breath and go way deep asleep. [E lowers his head and deepens his voice.] And now let it seem to you as if many minutes had passed. And I'd like you slowly to arouse and look at me and talk to me. [E lightly touches the underside of her still levitated left arm.] And slowly *rouse up* now, slowly rouse up, rouse up now. And open your eyes. [She opens her eyes and looks at E.] That's right. And you're beginning to learn to go into a trance. Do you realize that?

Ruth: I think so.

E: When I tell her, "I'm going to take hold of this hand," I actually just lightly touch her right wrist with my hand, giving slightly more pressure with my thumb on the underside of it. My touch indicates that I'm going to lift her arm, but I don't lift it! I just gently slide my thumb a bit up the underside of her wrist to indicate lifting, but she does most, if not all, the lifting. I try to give continuous cues for lifting until she takes over and does all the lifting.

R: This is a way of initiating a kind of semiautomatic hand movement that seems to take place without the patient realizing it is a step toward fully autonomous hand movements. As you ask her to "rouse up," you gently touch the underside of her left

wrist as a nonverbal cue that that arm is to remain levitated even after she awakens.

E: Yes, if you do this at exactly the right moment between trance and awakening, the patient will awaken and stare with curiosity at that arm in a cataleptic position.

R: The patient tends to be amnesic for the tactile cue that was just given in the trance state?

E: Either the patient is amnesic or she has lost the tactile cue altogether, because it was given between the trance and the awake state and actually belongs to neither.

Assessing Trance Experience: Sensory and Perceptual Distortions

E: You think so. And how does your hand feel?

R: Um—a little—heavy.

E: A little heavy; and can you see your hand plainly?

Ruth: The one in my lap, yes.

E: And this one?

Ruth: Yes.

R: You apparently awaken her, but her left arm remains levitated, and she reports that her hand is heavy. This suggests that she is still experiencing trance effects. Your questions are to assess just what sensory and perceptual distortions may be spontaneously present at this point. Your unusual questions can evoke unusual responses in the unusual situation of a trance induction.

Implied Directives for Automatic Movements and Trance Deepening: Sensitizing for Minimal Cues

E: Now watch that hand as it gets closer and closer to your face. That's right. That's right. And I would like to have you pay full attention to the sensations of the movement of your arm, the bending of your elbow, and the way that hand is getting closer and closer to your face. And very shortly it is going to touch your face, but *it's not going to touch your face until you are ready to take a deep breath and to close your eyes and go way deep, sound asleep.* That's right, almost ready, almost ready. That's right, that's right, and it's moving, moving. That's right, and you're waiting for it to touch your face and getting ready to take that deep breath. Getting ready to go way deep, sound asleep in a deep trance. Almost touching now, that's right, almost touching now, and yet *it isn't going to touch until you are ready to take that deep breath and your eyes will close.* That's right, getting closer and closer and closer. That's it, elbow bending more, fingers move up to touch your chin. That's right, that's it. Almost there, almost there, and now your head starts bending forward. That's right, and you'll take a deep breath and go way deep asleep. That's right. [E arranges the fingers of her right hand into a cataleptic position.] Go way deep, and now slowly [E gives her left arm a signal touch to go down.] this arm will come down to rest on the arm of the chair. That's right. Slowly and then just a bit more rapidly. And now your right arm is going to start lifting up, and the elbow will start bending. That's it, and the left arm is coming down, [E waves his hand to motion her right arm down.] more and more. That's it. And your right elbow is bending, and your wrist is lifting up. That's right, lifting, lifting, lifting, lifting, lifting. [E is giving the underside of her right hand light touches to signal lifting.] That's it. Lifting, lifting, lifting, lifting, lifting, lifting, lifting. That's it. Elbow bending, and this arm is straightening more and more.

R: You're reinducing deeper trance by focusing and fixing her attention on the

sensations of movement in her arm, etc. This kind of unusual task tends to depotentiate her usual conscious sets so that she more readily accepts your implied directive not to let the hand touch her face until she is ready to close her eyes and, in effect, go into a deep trance. You gave her many directive touches in this section both to speed up the procedure and to increasingly sensitize her to the minimal cues you're giving her as well as the minimal cues from her own inner processes that are usually ignored in the everyday awake state.

Paradoxical Challenges to Facilitate Hypnotic Responsiveness: Implication and Hand Gestures as Nonverbal Cues for Right-Hemispheric Involvement

E: And now, Ruth, I would like to have you discover something more. I'd like to have you slowly, very very slowly open your eyes and look at your right hand and then look at your left hand. That's right. And notice the difference in the movements. That's right. And now I want you to try, just try to stop the downward movement [E makes a broad sweeping gesture downward, as if directing the left hand downward.] of the left hand. That's right, that's right, and down it comes. And now I want you to notice that you can't stop it from lifting up. [E now makes a slow upward movement to direct her left hand upward.] Watch it. Now watch the right hand lifting up toward your face, and try hard to stop it, but up it conies, up it comes, up it conies, and keep watching that. Up it comes.

R: Are you using challenges here to deepen trance when you ask her to try to stop the downward and upward movements?

E: You can't try to stop a downward movement unless there *is* a downward movement. The patient thinks I'm challenging her to stop something. She doesn't see the implication for downward movement to continue.

R: A patient could be hesitating on a downward movement; you apparently challenge her to stop it. She doesn't realize that this challenge actually implies there is movement and facilitates that movement.

E: Yes, because you have to have a thing in reality to be able to stop it. I reinforce the reality of the movement with my own hand movements that direct her nonverbally. By this time she has been conditioned to follow my nonverbal cues, so she finds that she cannot stop the lifting or lowering of her arms.

R: So the paradoxical challenge to stop a hypnotic behavior that is on the brink of taking place is actually a way of facilitating and strengthening it. You then reinforce the movements with your nonverbal hand gestures. The patient's right hemisphere is probably picking up these cues and processing them automatically, so that she follows your hand gestures even though her left hemisphere may be puzzled, since it only hears your verbal challenge to do the opposite. This opposition may be reinforcing the more autonomous processes of the right hemisphere, which we associate with hypnotic behavior, and depotentiating the verbal controls of the left hemisphere, which we associate with the normal generalized reality orientation.

E: Yes, and you can tell the patient, "Try hard to stay awake." R: You thereby set in motion a process to go to sleep.

E: Yes, and she knows she's been trying to stay awake! It's been a difficult job to stay awake. Therefore by implication, it's easy to lapse into sleep or trance.

Multiple Tasks to Depotentiate Conscious Sets and Facilitate Following Behavior

E: And I'd like to have you watch, look at my finger now. [E points upward with his left hand for Ruth to focus on. With his right hand he slowly moves her left hand to her face. While doing this, he points his left hand down, so that Ruth's eyes gradually close as he lowers his hand toward the floor.]

***And I want you to notice something that happens to you.* Take a deep breath, close your eyes. That's right. And all the time you are beginning to feel that you are learning more and more. [E touches the underside of the fingers of her right hand to signal an upward movement.] And it's moving up toward your face, and as soon as your right hand touches your face, you'll take another deep breath and go deeper asleep. The closer your right hand gets to your face, the more your left hand will move away from it. [E signals a downward movement with a light touch on her left arm.] And up goes the right hand. That's right. Up it goes, and the left hand is moving away. A little bit faster, and a little bit faster, that's it, and faster yet, and still faster, and still faster, and faster and faster, that's it. And now, while your hands are busy doing that, Ruth, I'd like to have you open your eyes and look at me. And now I want to teach you something of importance, as soon as your right hand touches your face. And it'll start moving away, and so we'll have that alternate movement. [E demonstrates by alternating his hands up and down.] Do you understand? And Ruth, I want you to discover something else. It is rather hard for you to guide your hand. [E guides her right hand toward her face.] That's it.**

R: You continue your learning frame of reference, continually enjoining her "to notice something that happens to you." You are hereby reinforcing her hypnotic attitude of passive expectation; her conscious intentionality is to do nothing except witness unusual sensations, perceptions, movements, or whatever manifestations there may be of autonomous or unconscious processes. You reinforce her movements with nonverbal touch signals, and you give her multiple tasks that so absorb the conscious attention of her left hemisphere that the way is open for the more autonomous processes of the right hemisphere to manifest themselves (Watzlawick, 1978).

Dissociating Thinking and Doing

E: I want you to discover *the difference between your thinking and your doing.* And that is this: You know how to nod your head, [E models head nodding.] and you know how to shake your head. [E models head shaking.] And you know your first name is Ruth, and you know that you are a woman, and you know that you are sitting down, and I know all those things too.

R: Your initial statement about discovering "the difference between your thinking and your doing" sounds matter-of-fact and rational, but it is a task that is outside her habitual ideational patterns. Thus, it is a new and rather odd frame of reference that tends to depotentiate her usual conscious sets so that unconscious searches and processes are initiated. This reinforces and deepens the hypnotic modality.

You then state a series of truisms that establish both a strong yes set and the first stage of a reverse set that you are carefully developing.

Paradoxical Confusion from Ostensible Clarification

E: And no matter *what I say or you say* or anybody else says, *it won't change your name,* will it? And it won't change the fact that you are a woman. And it won't change the fact that you are sitting down.

R: Here you are apparently clarifying the difference between doing ("what I say or you say") and thinking ("it won't change your name") in a convincing way so that the above yes set is maintained and reinforced. But in actual fact your statements are so different

from the ordinary frames of reference of everyday life that what is ostensibly clarifying is in reality precipitating a paradoxical confusion that further depotentiates her left hemisphere's ability to maintain its own orientation. This is especially true since she is already in a fairly passive, receptive mode where she is not particularly disposed to do much active analysis of your abstractions. Further, even the highly abstract nature of the dissociation you are establishing is hidden behind your casual manner and the apparent obviousness and concreteness of the phrases you use—"you are a woman" and "you are sitting down." Anyone could hear and accept the obviousness of these concrete statements even if they were half unconscious. So naturally she accepts them without realizing everything else she is accepting along with them—especially the hidden implications that come in the next section.

E: [Laughing heartily] You found me out! [The senior author and the junior author have been working on the reverse set for about five years. Only now, and after a dozen revisions, does R catch on to this particular bit of paradox. E was just waiting and wondering when it would finally dawn on R.]

R: Did you actually plan this confusion while apparently clarifying?

E: Yes, of course, many times! [Breaks up in renewed laughter]

Hidden Implication for the Reverse Set

E: But I can say anything, and you can think anything. *It doesn't necessarily interfere with facts.*

R: These statements further illustrate and reinforce the difference between doing (what we say) and thinking ("it doesn't necessarily interfere with facts"). The apparently gratuitous use of *necessarily,* however, does set up the hidden implication that what we do may after all influence what we think. This, as we shall see, is the critical implication that later allows the reverse set to operate effectively.

Exercising a Yes Set

E: Now I'm going to ask you, is your first name Ruth? [Ruth nods Yes.] That's right. Are you a woman?

Ruth: Yes.

E: You just nod your head or shake your head in answer. Are you a woman? [Ruth nods Yes.] Are you sitting down? [Ruth nods Yes.]

R: You now exercise a yes set wherein Ruth establishes a habit of responding behaviorally (a head nod meaning yes) in a positive way to the questions. What she does and thinks are the same; both are true.

Dissociating and Reversing Thinking

E: AH right, now I'm going to ask you some other questions, and you will nod your head in answer. Is your name Ann? [Ruth shakes head No.] And you will nod your head in answer. [E models, nodding Yes.] Is your name Ann? [Ruth nods Yes.]

R: This is the first dissociation and reversal between her doing (nodding her head Yes) and her thinking (she thinks No, since obviously she knows her name is not Ann). Is this also a confusion technique?

E: Yes. I also sometimes tell irrelevant stories and make non sequitur remarks to induce confusion. [Erickson now illustrates a number of childhood games that amuse

by inducing paradox and confusion.]

Reinforcing the Reverse Set

E: That's right. Because your thinking can be different than movement of the muscles in your neck. Are you standing up? [Ruth nods Yes.]

R: This response reinforces the same dissociation and reversal between thinking and doing begun in the above section. Her head nods Yes, while her conscious thinking, if she is consciously thinking, must obviously be the reverse.

E: That's right. And are you a boy? [Ruth nods Yes] That's right.

R: Again the same dissociation. By this time a reverse set has been established; a set for acting out a dissociation between doing and thinking. It is a reverse set because what she thinks is the reverse of what she does; she now tends to nod Yes when her thinking is No.

Reversing the Reverse Set: The Onset of Confusion

E: And now I want you to shake your head No. [E models head shaking.] Your name isn't Ruth, is it? [E shakes No; Ruth shakes No.]

R: Another dissociation is established similar to the above but with a reversal of the reverse set in doing and thinking: Her doing (shaking her head No) is now false, while her thinking is true (her name really is Ruth!). If the reader is now beginning to struggle against becoming confused, imagine the difficulty Ruth is beginning to have!

E: And *you* aren't a woman, are you? [Ruth shakes head No.]

R: Again the same dissociation between the falseness of her doing and the truth of her thinking.

E: And you aren't sitting down, are you? [Ruth shakes head No.]

R: The same dissociation establishes another reverse set: doing what is false while thinking the reverse, which is true. It is the complementary reverse set of the first that was established. She is now trained both in doing what is false while thinking what is true, and doing what is true while thinking falsely. The net results tend to be a well-established reverse set between thinking and doing; she will now tend always to think the opposite of what she does, and vice versa.

The Reverse Set Establishes That She Is in Trance

E: And you aren't in trance, are you? [Ruth shakes head No.]

R: This is the utilization of the hidden implication described earlier and the firmly established reverse set; since she shakes her head No, she must think the reverse, "Yes, I'm in a trance." Thus, the reverse set establishes within her own thinking that she is in a trance. At least that's the first implication of her head shaking No. It would be too difficult to immediately switch the reverse set that has been so long established. She could switch it if she had a moment to reflect and decide, "Well, no, I'm really not in trance." But you don't give her time to make this inner adjustment, even if she felt disposed to it.

The situation is now as follows: Since she is in fact closely following you in her outer behavior, she is evidencing what you call "response attentiveness." That is, she is in trance whether she knows it or not. Even if she had a tendency toward inner resistance so that she would deny consciously acknowledging trance, this resistance tends to be

bypassed because of her confusion and your careful engineering of the reverse set—which now prompts the inner, conscious acknowledgment that she is in trance.

Adding Contradiction to the Reverse Set: Depotentiating Conscious Sets

E: And you aren't answering me, are you? [Ruth shakes head No.] And you're not going to answer me, are you? [Ruth shakes head No.] That's right. And you can hear everything I say, can you not? [Ruth shakes head No.] And you won't hear anything I say to you, will you? [Ruth shakes head No.]

R: You now quickly shift to another question that reinforces the reverse set in a very obvious way, so that she cannot disagree with it. She continues with the same form of the reverse set as the above, which implies she is thinking (if she is consciously thinking at this point) that she is in trance. This reverse set is reinforced four times, but notice that the last two are contradictory. Since she makes the same response to these contradictory statements, she is obviously confused to the point where she is simply responding by a rote following of whatever response Erickson sets in motion. Her conscious sets and self-direction are depotentiated to the point where left-hemispheric rationality has been depotentiated.

Deepening Trance: Breaking the Reverse Set

E: All right, and you can close your eyes.

R: You suddenly switch from questions to a definite statement about something she can do.

E: You can close your eyes, can you not?

R: This is another change. You ask a positive question about something she really can control. She does not shake her head. The previous reverse set is broken.

E: And you're closing them, are you not? [Ruth closes her eyes.] That's right. And you can enjoy sleeping more and more deeply all the time. And you really are, aren't you? [E nods his head continuously.] That's right. And you really are—and just keep right on sleeping, deeper and deeper in the trance.

R: You now positively reinforce eye closure and deepening trance.

Implied Directive to Deepen Trance

E: And to let me know that you are, your right hand is going to come to rest on your lap.

R: This implied directive is used to signal, motivate, and reinforce deepening trance.

E: And in some way you're *beginning* to know that you're sleeping in a deeper and deeper trance. [Ruth's right hand slowly moves down to her lap.]

R: You emphasize *beginning* because the subject can hardly argue with that; it is experienced by the subject as true no matter how her conscious attitudes may be evaluating the situation.

E: And I'm going to talk, and you don't even need to listen to me.

R: A dissociation is encouraged between the conscious and unconscious by not needing to listen.

E: And you really don't, because you are very, very busy, going deeper and deeper in

the trance as your hand comes closer to your lap. And as it comes to rest in your lap, and *as it continues to rest in your lap, you're going to be very, very busy sleeping deeper and sounder and more profoundly in the trance state, as your hand comes to rest more and more completely.*

R: This section ends with the simple contingent suggestion that as her hand continues to rest in her lap, she will be going deeper into trance. Since her hand is resting there, it would be hard to resist the suggestion that she is going deeper into trance. She would have to move her hand to deny the suggestion.

Ideomotor Signaling of Dissociation and Daydreaming

E: That's right, and that's what your hand is doing, and it is doing it very, very well. And the wrist is coming to rest, and the whole arm is going to feel relaxed and comfortable. And I can talk to the others. I can say anything to them, but you don't need to listen, and your head can shake No, that it won't listen. And it can shake No. [Ruth's head shakes No.] That's so you can go deeper and deeper and your hand can rest on your thigh. And perhaps the other hand would like to rest on the arm of the chair, and I don't know, but your hand will find out. That's right, and the elbow can straighten out. But of course it would be all right if I took hold of your wrist and lowered your hand, because that would feel all right. [E manually signals a lowering of her left hand.] That's right. And as you go deeper and deeper in the trance, it feels so restful and so very comfortable. And I'd like to have you enjoy all the learnings you are achieving. I'd like to have you enjoy that feeling of relaxation, that feeling as if you were all alone and relaxing comfortably by yourself. And you're getting that feeling. And I would like to have you enjoy the way that your head can nod in answer to questions. And it can, can't it? [Ruth's head nods slightly.] And I'd like to have you discover how easy it is, and you will discover how easy it is to feel yourself all alone, sitting in a chair all by yourself and feeling yourself at home, in an easy chair, just daydreaming, aimlessly, purposelessly, just daydreaming comfortably all alone. [E is nodding his head Yes throughout this section.] Nobody else around, and a very, very pleasant daydream. And as you daydream, you will nod your head, and as you enjoy it more, your head will nod a little bit more extensively. That's right. And a little bit more. And nodding more freely. That's right, still more freely. Nodding, nodding still more freely. [Ruth gradually nods her head very slightly.]

R: You continue your learning context, always associating it with enjoyment about achieving. You give her the internal tasks of dissociating herself to her home and daydreaming. You then give her the ideomotor signal of nodding her head to let you know when these internal tasks are accomplished. You have to do quite a bit of prodding to get that head movement. It could be that you're rushing a bit because of the time limitations in making a movie of this situation.

Assessing and Deepening Trance: The Second Apparent Awakening: Assessing the Possibility of Negative Hallucinations

E: All right, now rouse up. That's right. [Ruth opens her eyes.] That's right. And how much did you forget about the people that were here?

Ruth: Well, I didn't think of them.

E: You didn't think of them. And can you answer my next question? And I wonder if you can answer it? I wonder if you can answer it?

R: You assess the depth of trance by questioning her about amnesia and possible negative hallucinations about the other members of the group. Her answer is of a neutral sort consistent with trance experience, but it does not give any admission of deep trance experience.

Pantomime Suggestion for Further Dissociation

E: Is your name Ruth?

Ruth: Yes.

E: And now I wonder if you can nod your head? Is your name Ruth? [Ruth nods her head slightly.] All right. And this time I wonder what you'll discover. Is your name Ruth? [Ruth begins to nod her head continuously.] And keep nodding your head and see what happens. Is your name Ruth? [E begins to shake his head No, but Ruth nods Yes.] Is your name Ruth? That's right. And now it is going to shake more and more No, isn't it? And it is shaking from side to side—you can't stop. That's right. [Ruth still nodding Yes.] More and more from side to side, more and more from side to side, more and more from side to side. More and more. [Ruth continues nodding, so E makes exaggerated movements with his whole body shaking No.] And the nodding stops and the sidewise movement begins. [Ruth begins shaking her head No.] That's right, that's right, that's right, that's right, that's right, that's right, that's right, that's right, from side to side, from side to side. [E is still shaking his whole body from side to side.] And now I want you to feel comfortable and at ease, and I want you to feel rested and comfortable. And you will, will you not? [E now starts to nod broadly.] And you will, will you not? And you will, will you not? And you will, will you not? [Ruth still shakes No.] And you will, will you not? That's right. Slowly you will. That's right. Slowly you will. That's right. And now it begins, doesn't it? Up and down, more and more. [Ruth gradually converts her head-shaking to -nodding.] That's right, that's right, that's right. Up and down, and I want you to feel rested and comfortable and relaxed, and I want you to feel as if you had been resting for hours, and feeling so comfortable.

> R: You continue sensitizing her to following your nonverbal head-nodding and -shaking. She seems confused at this point and becomes more and more dependent on following your behavior. Apparently you are dissociating her more and more so that she follows your behavior whether what you are saying is correct or not.

Third Apparent Awakening and a Double Bind Question

E: And I'd like to have you rouse up. And you'll rouse up as your hand lifts and lifts and lifts, [E signals a lifting of her left hand with touches.] and rousing up, your eyes are opening. That's it. Wake up feeling fine. Wake up. [She opens her eyes, but her left hand remains cataleptically suspended.] *You think you're awake, don't you?* Are you really?

Ruth: [Laughs] *I'm not sure.*

E: Now you know the answer. You closed your eyes, didn't you? And you couldn't help that, could you? Are you awake?

Ruth: Um-hmm.

E: What did you think about that? Now, I'll ask you again, are you awake? [Ruth nods Yes, but then closes her eyes.] *Would you like to awaken? Would you like to awaken?* [Ruth opens her eyes.]

Ruth: *No.*

> R: Like the others, this third awakening is only apparent, since her hand remains cataleptically suspended. The double bind question, "You think you're awake, don't you?" provides enough confusion so that her left hemisphere answers that she is not sure. When you repeatedly ask if she wants to awaken, she finally answers, "No," meaning she is still in trance and does not want to awaken—even though she does

manage to open her eyes.

Fourth Apparent Awakening with a Double Bind Question and Ideomotor Questioning to Assess and Ratify Trance Experience

E: [Laughs] You wouldn't? But you know all good things come to an end sometime. So close your eyes and take a deep breath and wake up wide awake, wake up, wake up, wide awake. Hi! How are you?

Ruth: I'm sleepy.

E: [Laughs] You're sleepy? You mean I've got to awaken you again? Well, I'll tell you the world's worst joke if I need to in order to awaken you, and if that doesn't, I'll tell you the world's second worst joke. Is that sufficient threat?

Ruth: I feel all right now.

E: [Laughs] You rested?

Ruth: Uh-hmm, very.

E: *Did you know you were a good hypnotic subject?*

Ruth: Not exactly—well—um—yes.

E: Um-hmm. Would you like to ask your unconscious the question? Now, if the right hand goes up, that means Yes. If the left hand goes up, that means No. Are you a good hypnotic subject? [Pause as her right hand goes up.] Of course. I wonder if you've noticed what's happened to this hand. And did you know you're back in a trance? And did you see the perfectly beautiful answer there?

R: You make a more serious effort to awaken her with the taking of a deep breath, your typical "Hi," and a question to evoke her conscious evaluation of her feelings. Since she is still tending to remain in trance, you utilize the situation to ratify her conscious acknowledgment of her trance experience. You do this in your typical fashion of asking a double bind question, "Did you know you were a good hypnotic subject?" Since she seems doubtful in her reply, you ratify trance further with an ideomotor questioning approach that tends to convince her, since her right hand does go up in an apparently autonomous manner.

Arrested Awareness to Ratify Trance

E: And now you've got that very, very nicely arrested awareness. [To Ernest Hilgard and Jay Haley off-stage] And you see she's very, very much out of contact with the total situation. There's a loss of the blink reflex, there's a loss of the swallowing reflex. As I mention these things, she may or may not reestablish them. But you see, I awakened her, she didn't want to awaken. I forced the issue. I shook hands with her. This way, which was out of order—and she is really going to go into a trance. And now what she's doing is the other thing, and carrying it out so very nicely, and this is going to come, and we are going to get that very nice continued maintenance of the trance state. Now, I doubt very much if she isn't much aware of the range of movement or the range of activity, and she is decidedly interested in her own experience at the present time. [To Ruth] Was I talking to anybody, Ruth? Were you listening?

Ruth: Sometimes.

R: Your description of the trance indicators she is experiencing is a way of further ratification of trance. You give this information to her in a slightly indirect way by telling it to the professional observers who are present. Speaking to them makes it more authoritative for her, since they are, after all, professional. Speaking to others about her

is also a way of depersonalizing her and thus further reinforcing trance experience. Her response of "sometimes" is typical of the light to medium stages of trance, where the subject's conscious awareness or attending to the outside situation tends to fade in and out.

Doubt and Not Knowing to Ratify Trance

E: Sometimes. It wasn't really important for you to listen, was it? You're really enjoying watching your hands, isn't that right? *And actually you've forgotten where your hands are, you can just watch them,* And you really don't know how far up they move, how far down they move, isn't that right? And Ruth, now you can understand how unimportant everything else is and how important is your own experience as you continue in the trance. That's the important thing, what's happening within you and your own learnings.

R: Doubt and not knowing about her awareness and memory is implied with the subtle compound suggestion, "And actually you've forgotten where your hands are, you can just watch them." Notice how the second half of this sentence, "you can just watch them," is a simple statement of what she can do; she probably receives it with an implicit inner response of "Yes, I can watch them." This immediate Yes also tends to reinforce the associated suggestion about forgetting where her hands are. This doubt and not knowing about her own experience ratifies to her now reoriented habitual conscious sets that she has, in fact, been experiencing trance.

Fourth Awakening: Time Distortion to Ratify Trance

E: Would you like to awaken now?

Ruth: I don't know.

E: Well, suppose you look at your hands and see which one of them moves up. Would you like to awaken now? All right, so you can close your eyes and take a deep breath and let it seem to you as if you had been resting for hours and hours, as if you had been in bed for eight long, comfortable, and restful hours. And I would like to have you really rest that way and then rouse up and feel so rested and so comfortable, and willing to discuss things with this group. Will you do that? Will you do that? That's right. All right, now, slowly your hand comes to rest in your lap, and when it reaches your lap, take a deep breath and open your eyes and become wide awake. [Long pause] Lowering still more, that's right, still more. As soon as it touches your lap, take a deep breath and wake up wide awake and feeling rested, refreshed, and energetic. [Ruth makes a deep breath sound.] Wake up. Hi!

Ruth: [First, she makes an indistinct mumble or small laugh.] Hi. [Both Ruth and E laugh]

E: Well, do you mind if I change seats? You won't mind if I sit down here. Now what is the rest of the program?

Hilgard: We have a meeting in another place at 4:15.

E: Do you feel completely rested?

Ruth: Yes, I feel like more. [The group laughs heartily]

E: Do you know you are a very delightful subject to work with?

Ruth: Yes?

E: And sometime I hope Dr. Hilgard has you, or Dr. Weitzenhoffer has you—sit in and observe some other subject because you are capable of very extensive

somnambulistic behavior. You have a tendency to—what should you call it?—utilize time in the way that I am particularly interested in. You show the phenomenon of time distortion. Did it seem to you that you were in a trance as long as you have been?

Ruth: No, I don't really—how long have I been?

E: Well, how long do you think?

Ruth: Well, it really seems just a few minutes.

E: That's right, it seems like a few minutes. Actually it was much longer than that. How long was it, Jay?

J: About an hour.

Ruth: Really?

J: About 50 minutes, anyhow.

E: About 50 minutes.

Ruth: Oh, that's amazing.

E: Now I bring that out because all of her hand movements tell you that she—that she is distorting time in a rather significant fashion, and if she were to watch some somnambulist do a number of things, in the tempo of the ordinary waking state, then you could have her learn that, and have her in addition show you her own spontaneous development of distorted time. Just getting technical. Now I'm supposed to go somewhere else in a few minutes. Anything you'd like to ask me?

> R: You're feeling it's time for the session to end, so you make a more determined effort to awaken her. You even change your chair in order to change the situation a bit and thus break associative connections with trance experience. You ratify trance directly by allowing her to assess the time distortion she experienced and indirectly by talking to the observers about her hand movements that were different in trance.

An Ideomotor Ratification of Amnesia and Dissociation

Ruth: Well, why wasn't I allowed to put my head back and really—I mean I wanted to—lay down and just fall asleep? I mean, and not hear anything. Do you always hear—I always hear you.

E: That's right. Some people say I'm not bad to listen to.

Ruth: No, you're very nice to listen to—but *I felt that I was in a trance, and yet I felt I wasn't.*

E: Uh-hmm. And yet you know you were, and yet you felt you weren't, and wanted to lean back. You know your picture was being taken.

Ruth: Oh, I forgot about that.

E: [General laughter] Do you mean to say that in your movie—

Ruth: —I'd rather have slept—

E: —debut, you forgot all about that? What else did you forget about?

Ruth: Oh, I don't know.

E: Didn't you forget about the presence of the audience? . . .

Ruth: Yes.

E: —more than once?

Ruth: I mean I'd—I just didn't care whether they were there or not.

E: And tell me, did it seem to you as if for awhile there you were at home?

Ruth: I could have been. I mean, I was comfortable enough to have been.

E: Yes, but could you have had a feeling there for a little while that you were actually sitting in a chair or lying on a couch at home?

Ruth: No, I don't believe so. ,

E: You don't believe so. Do you mind if we find out? Ruth: No.

E: Put your hands in your lap. Now, right hand lifting means Yes; left hand means No. Did you at some time during this afternoon's trance or trances feel yourself, sense yourself, at home in your own home? [Pause as right hand lifts] Lifting, lifting, and maybe as your hand lifts, you will have a conscious awareness of just where you were in that feeling. And so close your eyes and take a deep breath and lower your hand to your lap. Another deep breath and wake up, wide awake and feeling rested. Wake up, wake up. Hi. [Laughter]

> R: You get into a bit of trouble here as you attempt to further ratify trance by having her acknowledge amnesia for the movie-making and the presence of the audience, along with a possible dissociation of place from the laboratory to her home. It would not be wise to end her first hypnotic experience with the doubt she expresses about these hypnotic experiences. You thus feel impelled to further ratify her experience with yet another ideomotor signaling. Fortunately the right hand lifts, giving a positive ratification, and you immediately awaken her on that positive note.

Doubt and Humor to Ratify Trance

E: Oh, you remember where you were in your sensation you're feeling?

Ruth: No, I just thought of—thought of being in the study. I didn't—I wasn't there, I don't remember being there. Just the thought passed through my mind.

E: Uh-hummm. [Laughter] Ruth: Oh, they're all scientists. E: Well, that's why the afternoon seemed so—brief-

Ruth: Oh, I—

E: —went home, it seems! Well, I suppose I've got to terminate this, and I want to thank you very, very much for your help. I've appreciated it greatly. Thank you.

> R: Ruth gives some small acknowledgment of at least having a thought of being dissociated to the study in her home. It is in fact common for subjects to dissociate themselves to a comfortable home environment when they are in trance. That is why suggesting such a dissociation can be a good approach to deepening trance. But Ruth apparently did not dissociate in just this way on this occasion. It might have been better to ask a more general question about dissociation such as, "Was there a time during trance when you seemed to be somewhere else?" To this question Ruth might have given valuable information on just where she tends to dissociate herself. This information could then be used for deepening her next hypnotic trance.

EXERCISES AND SELF-DEVELOPMENT REQUIRED IN LEARNING ERICKSON'S APPROACHES

The preceding analysis of the reverse set is without question the most detailed approach to evoking a specific mental mechanism that we have ever presented. Learning how to evoke and utilize such mental sets could bring the process of trance induction and hypnotherapy to new levels of effectiveness. The exercises in this section are designed to help the

professional reader gradually develop some facility in using this approach.

Many of Erickson's original papers in *The Hypnotic Investigation of Psychodynamic Processes* (Vol. 3 of *The Collected Papers of Milton H. Erickson on Hypnosis,* 1980) contain the basic background reading required. This is particularly true of the section, "Mental Mechanisms," where, in a number of papers written between 1939 and 1944, Erickson illustrates how he makes the transition from the typical psychoanalytic approach of analyzing to utilizing mental mechanisms. Not till several years later, in his highly innovative paper, "Hypnotic Psychotherapy" (1948), did he actually demonstrate how the utilization of mental mechanisms can be employed in a radically new kind of hypnotherapy. A patient and deep study of his paper will provide the reader with the essence of Erickson's utilization approach. The reader will find an ingenious utilization of the psychodynamic mechanisms of projection, amnesia, repression, and resistance, among others.

The greatest danger in reading some of these early papers by Erickson is that they make the work seem rather glib and easy, so that the reader feels foolish and frustrated if the techniques cannot be immediately and successfully duplicated. But these early papers do not specify the many years of patient study and effort Erickson went through in his late teens and early twenties, learning to develop his own psychological, sensory, and kinesthetic perceptions. His efforts were motivated by highly personal reasons as he sought in lonely desperation to teach himself to recover from the crippling effects of polio—despite the fact that his condition was assessed as hopeless by his doctors (see "The Autohypnotic Experiences of Milton H. Erickson," Erickson & Rossi, 1977).

In these early case presentations Erickson usually did not specify the many hours of diligent effort he spent studying and evaluating a patient's problem before proceeding with what then seemed like a quick and brilliant cure. Often Erickson would see a patient for a session or two and then ask him/her to return after a few weeks. He would then spend the time pondering what he knew about the person and how he could utilize that knowledge effectively to facilitate a cure that then seemed dramatic and surprising, but was actually based on many hours of careful and often tedious planning.

The first major requirement in learning to use Erickson's approaches would thus appear to be facilitating the personal development and clinical sensitivity of the hypnotherapist. Many of the exercises in our former volumes (Erickson, Rossi, & Rossi, 1976; Erickson & Rossi, 1979) were designed for this purpose. The second basic requirement is taking the time to undertake careful clinical studies of individual patients to determine what their dominant or preferred mental mechanisms are, and how these mechanisms can be engaged in the hypnotic process. The hypnotic work could then be organized in a systematic manner as follows:

1. How can a particular patient's own mental mechanisms and habitual associative processes be utilized to create a method of hypnotic induction that is uniquely suitable for that patient?
2. How can the patient's own mental mechanisms and associative processes be utilized to facilitate an experience of all the classical hypnotic phenomena?
3. Now, utilize this background of hypnotic training to help the patient find a uniquely suitable resolution of the presenting problem.

Although this three-stage paradigm is highly characteristic of the senior author's exploratory approach to clinical problems (Erickson & Rossi, 1979), he has long maintained that each case is unique, and he recognizes the essentially experimental nature of each clinical endeavor. But while each case has this exploratory and experimental aspect, the three-stage paradigm does provide a methodological outline of a therapeutic approach that could enable clinicians to describe and publish their work in this area on a comparable basis.

SECTION IV:

The Experiential Learning of Trance by the Skeptical Mind

Dr. Q was a young psychiatrist interested in having a hypnotic experience with Erickson. He was just passing through Phoenix and decided to call. He agreed to allow Dr. Rossi to tape the sessions for possible publication. After an agreeable half-hour in which a mutual feeling of trust and rapport was developed, Dr. Q expressed some of his difficulties and doubts about hypnosis and his wish to have Erickson facilitate his personal experience of trance. This took place in two sessions extending over two days. Of particular significance in these sessions was the emphasis on Dr. Q's experiential learning. Erickson reiterates his belief that the best way to learn trance is by experiencing it. Erickson said of Dr. Q, as he said of so many other professionals he has trained, "Now here is a trained man, skeptical! I had to meet him at that level. I had to give my suggestions in a way that would meet his needs for scientific understanding. I had to phrase what I said in ways that would appeal to his unconscious mind . . . ways he would not be able to analyze."

In this first session Dr. Q entered the beginning stages of the experiential learning of trance through catalepsy and "not doing." The experiential approach so well demonstrated in the session has important implications about Erickson's views of the nature of therapeutic trance. Trance can be most broadly defined as a state or period of intense inner absorption. The concept of trance depth is highly relative. Erickson likes to point out that a trance can be both deep and light at the same time. It can be deep in the sense that a person is so absorbed that he or she does not notice irrelevant stimuli like the traffic outside or a surgical tray dropped a few feet away. The trance is light in the sense that important and relevant stimuli like the therapist's voice are easily received.

There are some subjects, however, who have special requirements for the nature of the trance they are willing to experience. They object to the experience of trance as a kind of sleep or withdrawal from outer reality. They don't like to close their eyes or rely on automatic responses like hand levitation. Many modern subjects want to know what is going on at all times. In such cases Erickson ratifies trance by a careful questioning that heightens the subjects' awareness of any minimal alterations of their usual everyday mode of experiencing. A subject and observer might not believe a trance was experienced, but Erickson accepts *any* unusual pattern of subjective experience or responsiveness as an indication of at least the beginning stages of learning to experience trance. This is sometimes disappointing to subjects of our post-psychedelic era, who expect to experience striking alterations of awareness in trance. Striking alterations are certainly experienced in some subjects (see Chapter 9 of Erickson & Rossi, 1979), but the more basic problem for the skeptical and rational mind of our day is for the hypnotherapist and patient first to learn to recognize the minimal manifestations of altered states wherein therapeutic processes may be facilitated. This first session ends with Erickson giving Dr. Q some "rehearsal" in learning to experience the reentry into trance by following a posthypnotic cue before he can recognize what is happening.

SESSION ONE: The Experiential Learning of Minimal Manifestations of Trance

Receptivity and Reinforcement in Compound Suggestions

E: Look at that spot there. Put your hands on your thighs. Now you do not need to talk. You do not need to make a single movement of head and hands. Just look at one spot, and I'm going to talk to you.

E: Dr. Q expressed so much skepticism and disbelief about trance. He had made his own inability to understand. Instead of suggesting something to him, I gave him simple statements with which to deal that did not seem to have much real significance. "Look at that spot there. Put your hands on your thighs. Now you do not need to talk." What he is not realizing is that in that simple way I am taking over the control of the total situation. I haven't offered anything with which he can take issue.

R: With these few simple directions you have indirectly established an acceptance set for a quiet, receptive mode of being. You don't tell him to be quiet and receptive; rather, you structure his behavior so he naturally will be.

E: That's right. "Just look at one spot, and I'm going to talk to you." There is no possible way of disputing either one of those. It is a compound statement: You do that and I do this. If he accepts my statement of what I'm going to do, he has to accept my statement to him of what he is to do. Only he does not know that.

R: This compound statement, "Just look at one spot, and I'm going to talk to you" gives two suggestions tied together with the conjunction, "and." The second suggestion that you have control over (talking) reinforces the first (he is to look at one spot).

E: Yes, it emphasizes my control in a way not recognizable in the ordinary conscious state.

The Indirect Use of Language: Depotentiating Conscious Sets and Channeling Resistance with a Casual Negative

E: But you don't need to listen.

R: Why do you begin here by telling him he doesn't need to listen?

E: It depotentiates consciousness and thereby potentiates the unconscious functioning. If there is any rebellion in his soul, it can now be centered in doing exactly what I told him: He *doesn't* need to listen. I'm taking control of any rebellion by telling him how to rebel.

R: If he is experiencing resistances, you gather them up with your negative *don't* and channel them into a resistive response *(not* listening) that can facilitate the hypnotic process (since "not doing" facilitates the parasympathetic mode of receptivity rather than self-directed activity). This is an example of your indirect use of language. You do not tell him he should not listen! That would require an active effort to cooperate. Your casual approach of merely mentioning that he doesn't need to listen has an indirect purpose that is entirely different: in this case to depotentiate his conscious sets and channel resistance into a constructive channel.

Depotentiating Left-Hemispheric Conscious Sets: Mind-Wandering and Truisms

E: You can let your mind wander because I'm going to mention to you something that happened when you first went to school. When you went to school, you were confronted with the *problem* of letters and numerals.

R: Letting the mind wander also depotentiates the conscious self-direction of left-hemispheric functioning in favor of right-hemispheric access to the personal and experiential.

E: Dr. Q and I are strangers, you know. How can I mention something that happened to him when he first went to school?

R: That is a question in his mind immediately.

E: Immediately! He is going to search his mind, and that is where I want him to be. But even you reading this could not see what I was doing! It is so indirect.

Now, what "problem" was there? He has really got to search. He has to determine that there was a problem. There is no way for him to turn away from this problem because it is true; it's a truism. Everyone has had a problem in the initial stages of learning.

R: You first lull his self-direction by permitting mind-wandering, and then indirectly nudge it into certain directions—in this case an early learning set—with a series of truisms that continue into the next section.

Intriguing Questions to Yo-yo Consciousness to Initiate Inner Search and Therapeutic Trance

E: To you at that time learning the letter "A" seemed to be an impossible task. And *how did you* tell a "B" from a "P"?

E: In response to my question he's probably thinking, "Why?" What is hard about the letter "B"? It has various shapes, sizes, even colors. Script and block printing. All kinds of forms. I've got another truism there that is within his experience. You can see how he's being played back and forth, up and down, being yo-yo'd, you might say. "How did you" is a question that gets him inside his own thoughts.

R: Your questions are taking him away from outer reality and putting him on an inner search.

E: Without telling him that! And he can't avoid what I'm saying because it is an intriguing thing.

R: By yo-yoing him back and forth between your intriguing statements and questions, you lift him out of his usual and habitual frames of reference and put him on an inner search that we have described as an essential aspect of the microdynamics of trance (Erickson, Rossi, & Rossi, 1976; Erickson & Rossi, 1979). Intriguing statements and the yo-yoing process, as you call it, are indirect or metapsychological uses of language to secure attention and initiate that intense focus of inner search and automatic unconscious processes that we define as therapeutic trance.

Utilizing Internal Reinforcement to Facilitate an Acceptance Set

E: A "Q" from an "O"?

E: A "Q," you know, is hard for every kid. An "O" is easy. So I give him the hard thing first, and then he accepts the "O" because that is easy.

R: So you have reinforced "Q" by putting an easy "O" after it. This is how you reinforce with a subtle truism right within the same sentence. You are utilizing his own already built-in internal patterns of reinforcement to continue his acceptance of what you are saying. This is another illustration of your indirect approach: When you feel one suggestion may be difficult to accept, you immediately reinforce it with another related suggestion that is easier, more acceptable, or more motivating. The second, easier suggestion also leaves him with an acceptance set for what follows.

Words Extending Unconscious Activity in Time: Posthypnotic Suggestions

E: *But eventually* you learned to form mental images. Mental images that you did not know at the time would stay with you for the rest of your life.

E: "But eventually"—how long is *eventually?*

R: Could be any length of time. It's fail-safe to say *eventually* because it is open-ended in time. Other words like *yet, until, when, sometime, henceforth,* etc., all have a time aspect that can continue unconscious activity from the past to the present and future. We know that some posthypnotic suggestions, for example, can continue over decades (Erickson & Rossi, 1979). It would be a fascinating research project to find some means of experimentally evaluating the extent to which different words and suggestions are effective in setting unconscious processes into activity over time.

E: That's right. I'm also preparing him for what takes place after this. That word *eventually* stretches from kindergarten to old age. With his training in psychology, he knows that very well.

R: That is the indirect use of a truism again: a safe statement that utilizes his own knowledge to reinforce what you are saying.

Focusing the Attention of the Modern, Rational Mind Inward with Intriguing Learning Experiences

E: You had to learn the numerals, and *how do you tell the difference between an upside-down nine and a right-side-up six?* It seemed impossible at first, and which way do you make the number three?

E: "How do you tell the difference between an upside-down nine and a right-side-up six?" Well, that is intriguing. So he is not going to be thinking about anything else. I am focusing his attention inward to his own experience.

R: That's what you are doing in presenting all these intriguing learning problems. It is not the particular content that you are interested in. It is the indirect *process* of focusing inward that is the important matter. A modern, rational mind like Dr. Q's is intrigued with learning, so you utilize this interest to focus him inward.

E: Early learning is a long, hard task, and all kids go through that.

R: So this approach is actually valid for most people who have gone through the educational process. You are focusing them on valid inner experiences you know they have had. They cannot dispute it. You move them away from external reality.

E: Very far away.

Hypnosis as Loss of Multiple Foci of Attention: Maintaining the Absorption of Trance: The Role of Poetry and Rhyme

E: But you formed mental images, and later you formed mental images of words, of *faces,* of *places,* of objects, of a great many mental images.

R: Thus far there is no question of an altered state of consciousness or trance; it is just a shift of his focus of awareness.

E: The shift of the focus of awareness.

R: Where now does the altered state of consciousness come in? Do we need the concept of an altered state of consciousness or is it just a shift in the focus of awareness that is involved? Maybe that is all hypnosis is: a shift in the focus of awareness.

E: *All hypnosis is, is a loss of the multiplicity of the foci of attention*.

R: I see. A loss of the multiplicity of the foci of attention. Is that the monoideism of

Braid? You really agree with that?

E: Except it isn't just a monoidea, but all the *multiple* foci of attention; the desk, the birds, the bus have all been eliminated.

R: Okay, now would you define this loss of multiple foci of attention as an altered state of consciousness, or is this just a game of words?

E: It's an altered state of consciousness in the same sense as you experience in everyday life when you are reading a book and your wife speaks to you and you make no immediate response. You are obviously experiencing some sort of altered state involving time distortion when 10 minutes later you answer, "Did you speak to me?"

R: That's the sense in which hypnosis is an altered state of consciousness; the same as that experience of absorption in reading an interesting book.

E: *It is a lack of response to irrelevant external stimuli*.

R: That's the altered state of consciousness that constitutes trance: deep absorption on a few foci of inner experience to the exclusion of outer stimuli.

E: And to use it for therapeutic purposes, it must be maintained.

R: Part of the art of the hypnotherapist is in maintaining that trance state.

E: Yes. You deal with that altered state in any way you wish, but you are keeping that altered state.

R: That's the purpose of many of your verbal suggestions to the patient—trance maintenance.

E: I never really made up my mind whether the rhyme of "faces" and "places" was important in maintaining trance. But all these words, faces, places, and objects—there are so many in his past. In anybody's past. And I'm really enlarging that altered state of consciousness to permit the entry of words, faces, places, and objects.

R: That interesting little book, *Hypnotic Poetry* (Snyder, 1930), certainly suggests the importance of rhyme and rhythm in trance. By adding these other words you are reaching into his memory banks; you are bringing other memories and associations into the realm of the trance focus, for whatever values they may have for maintaining the trance and laying down an associative network for therapeutic work.

E: Yes, and making it possible to enlarge that altered state. But it is all within him; nothing from his outer environmental situations is important while he is focusing within during this trance work.

Indirect Suggestion for Visual Hallucinations: Constructing Implications with Time

E: And the older you grew, the more easily you formed mental images.

E: Dr. Q doesn't know that is a suggestion: The older he grows, the more easily he forms mental images.

R: What's the suggestion here?

E: He will easily be able to do whatever I tell him with regard to visual images. That's the implied suggestion. It is awfully hard to see it.

R: This is another subtle use of time to construct an implication that could be preparation for hallucinatory experience later.

E: Yes, later.

Depotentiating Conscious Sets: Structured Amnesias

E: And you didn't realize it at the time, but you were forming mental images that would stay with you for the rest of your life. Now you don't really need to listen to me because your unconscious mind will hear me. You can let your conscious mind wander in any direction it wants to.

R: Why do you repeat that phrase about forming images that would stay "with you for the rest of your life" here? You said it earlier in a previous section (Words Extending Unconscious Activity in Time).

E: It's tying that previous section with this section.

R: Oh, so that all between them falls into a lacuna and will tend to become amnesic! It is a structured amnesia.

E: Yes, all that material will fall into a lacuna. I also said that about not needing to listen to me and letting your mind wander in an earlier section.

R: That again tends to structure an amnesia while also depotentiating his conscious sets.

Ratifying Trance: Inner Focus for the Experiential Learning of Trance

E: But your unconscious mind will pay attention, you will understand. And *you are drifting into a trance. You've altered your rhythm of breathing. Your pulse rate is changed.* I know that from past experience.

R: Are you giving him a direct suggestion by telling him he is drifting into trance?

E: No, that is a statement of fact based on the alterations in his breathing and pulse that I can actually observe. I did not say, "You've *drifted"* (past tense): I just observe, "you are drifting into a trance" (present tense).

R: You observe these changes that are actually taking place and comment on them so that his own inner experience can ratify that trance is really taking place. You don't suggest trance is taking place: You prove it!

E: Yes. He has to examine his rhythm of breathing. He is still within himself! He has to examine that rhythm of breathing in terms of drifting into a trance.

R: You're keeping the focus inside of him, and you are getting him to ratify his own trance through these experiential learnings.

The Role of the Conscious and Unconscious; Left- and Right-Hemispheric Focus in Therapeutic Trance

E: And you're trying so hard to understand instead of just experiencing.

E: This implies I'm going to say things to you that you will try hard to understand instead of just experiencing. It implies you're going to do more than just experience.

R: This I find difficult to understand! I thought you were trying to turn off the conscious mind in order to facilitate the unconscious and the experiential mind. When you ask him to "understand," it sounds like an appeal to do left-hemispheric conscious work.

E: You still don't grasp it! I've already turned off his conscious mind except to a minor degree. And I'm trying to make his unconscious mind understand: You've got a lot of work ahead of you in addition to just experiencing.

R: We could formulate this as a two-stage process of trance induction and utilization. In the first stage, *trance induction,* you depotentiate Dr. Q's currently dominant left-hemispheric conscious sets. This then facilitates the release of right-hemispheric unconscious processes, which contain the experiential learnings and repertory of response possibilities that will be used as the raw material for the hypnotherapeutic changes you will evoke. In the second stage, *trance utilization,* you reactivate left-hemispheric processes to now act upon ("reassociate, resynthesize"; see Erickson, 1948) the released right-hemispheric contents in order to reorganize them into hypnotherapeutic responses.

Depotentiating Conscious Sets While Engaging Unconscious Processes to do Constructive Work: Gentle Direct Suggestion for Unconscious Work

E: *You don't need to understand. All you need to do to drift along and feel relaxed and comfortable.* And I don't even need to talk to you because there is nothing that needs to be done. But you can rest comfortably while I speak to you, *your unconscious mind will hear me* and *do as I say, as I indicate.* [Pause]

R: You again depotentiate left-hemispheric conscious sets with not knowing ("You don't need to understand") and drifting along, relaxed and comfortable.

E: That enhances the trance state and implies that he is going to maintain the trance.

R: Maintaining the comfort and relaxation of trance means that nothing needs to be done by left-hemispheric consciousness. Then you clearly indicate that the unconscious will hear you and do as you say.

E: "Do as I say, as I indicate"—that's complete obedience.

R: What? You are giving a direct suggestion for obedience! E: But it is said so gently. It is so comprehensive.

R: And you're not telling the conscious ego to obey you; rather, you're gently nudging the unconscious to respond to verbal stimuli you're providing.

Dissociating Frames of Reference to Facilitate Hypnotic Phenomena: The Art of Reinforcing Suggestions

E: *And I can talk to you, to Dr. Rossi* all I wish. But you don't need to pay any attention to that. *You are busy with your unconscious mind,* looking at that mental image. *You just rest.* [Pause]

E: "And I can talk to you"—that's one frame of reference; ". . . to Dr. Rossi" is another frame of reference. I'm separating, dividing the situation.

R: That separation and division is an essence of the approach by which you effect dissociation and set the stage for experiencing most hypnotic phenomena. This dissociation is the important hypnotic phenomena, the important unconscious work you have been leading up to in the past few sections. You tell him, "You are busy with your unconscious mind." Let your conscious mind rest while your unconscious does the work of engaging its dissociative mechanisms.

E: That's right, there is nothing else. And it is said so gently and so acceptably.

R: You don't give him, a psychiatrist, a difficult left-hemispheric cognitive task by telling him to "dissociate" the conversation. Rather, you give him a concrete task of separating the talk to him and to me, Dr. Rossi. The right hemisphere can perform this concrete

sensory-perceptual task and thereby engage its dissociative mechanisms. You evoke unconscious processes not by informing him of what mechanisms to use but rather by giving him a task that will automatically evoke these mechanisms. This is one of your favorite indirect approaches: You give a suggestion or task, not because of any inherent interest in it, but rather to evoke those mental processes that are required to carry it out.

The placement of your final phrase, "You just rest," reinforces the statement just before it, "You are busy with your unconscious mind." You do that a lot, don't you? You use one phrase to reinforce another. That is an important aspect of the art of suggestion.

Rapport and Indirect Suggestion to an Audience via Voice Locus

E: Now, Dr. Rossi here is somebody who is trained in psychology. He has been oriented to place individual meaning or interpretations on everything according to his past teachers. *He does not know very much about* looking at or *experiencing reality.* He must experience reality in terms of what he has been taught and read.

R: *Huh?!* [Pause]

R: You caught me by surprise here; although you were apparently talking to Dr. Q, you were actually beaming important suggestions to me. I was so absorbed in watching Dr. Q that I was actually experiencing what you would call the common everyday trance. I finally wake up out of it with my "Huh?!" You also shifted your voice tone and its location to provide a clue to my unconscious even before my conscious mind realized what you were doing. In fact, I did not realize it until I began going over this transcript to prepare for these commentaries. This was a typical example of how you use indirect suggestion to turn over the associative processes of someone in the audience without their quite realizing it.

E: And that different locus of voice *is* important.

R: Even though the subject is not aware of it consciously.

E: At the same time I'm adding to the rapport by pulling him closer to me and excluding you from the situation from his point of view.

R: Why do you want to exclude me?

E: I thereby increase his areas of functioning in accord with what I say, what I indicate.

R: I'm irrelevant for that, so you exclude me to focus all his mental energies on himself. At the same time he also gets the implication that he must learn to experience more on his own and not be limited to just what he learned from books and his past teachers. This is one of those peculiar situations that's so hard to analyze: Dr. Q and I both received the same indirect communication, but in different ways—each from his own frames of reference.

E: Yes.

Catalepsy to Ratify Trance

E: *Now I'm going to touch your wrist.* [Erickson touches Dr. Q's wrist and very gently provides tactile cues to facilitate a lifting of his hand and arm of about six inches.] I'm going to touch your arm. I'm going to put it in this position. [Pause as Erickson arranges a somewhat awkward position of Dr. Q's wrist by positioning his hand at an odd angle relative to the arm. The arm does not remain in the air but drifts down to Dr. Q's lap. One or two fingers touch his thigh, and the others remain poised and unmoving in the air. His hand is not really resting "normally" on his thigh, but appears

to remain cataleptically suspended with only the lightest touch on his thigh.]

E: "Now I'm going to touch your wrist." So what's the big deal? There is no big deal there at all. It is a safe procedure.

R: You are setting up a catalepsy in a very innocent way.

E: Very innocent—the odd angle is the important thing.

R: Why is the angle in which you place the hand so important?

E: In lifting the subject's arm, I'm not going to tell him I'm lifting it purposefully to achieve a certain goal. But I am lifting it to achieve a certain goal. When the goal is reached, I can see it, but he doesn't even know it. And so he is behaving in accord with the tactile stimuli I've given him.

R: What does that prove? Why are you engaged in that?

E: When you lift up a person's arm, they seldom leave it up in midair, do they?

R: No, not normally.

E: And when you put it in an odd angle, they are much more likely to correct that odd angle, are they not?

R: When you do this in trance, the subject just leaves it there. Is this then a test of the trance state? Is that why you are doing this?

E: I was doing it more to prove it to you so you could have visual proof.

R: So that catalepsy was to convince me. How about to convince the patient?

E: Sooner or later he will find out his arm is still there. And that is contrary to all his past experience. He will have to investigate it, and it will be very convincing to him.

Not Doing: Catalepsy is a Form of Mental Economy Utilizing the Parasympathetic Mode: Electrodynamic Potential as a Measure of an Altered Receptivity Expression Ratio: A Proposed Definition of Therapeutic Trance

E: And I'm not Instructing you to put it down. [Pause]

Dr. Q: Umm, that—

R: Why the "not," here? Why not simply say, "hold your hand up?"

E: Whatever he does has to be on his own responsibility.

R: So he will hold it up on his own responsibility because the implication of your remark is to hold it up.

E: No, his hand was already up. The only way he can get that hand down is for he himself to undertake that task as a separate, totally separate, totally individual task. It is much easier to allow that state of balanced tonicity to remain. He doesn't have to do anything!

R: I see, it is simply an economy of mental effort to leave the hand there rather than go through the labored decision process of whether or not he should put it down in this situation.

E: That is better than telling him, "Don't put it down."

R: Otherwise, after you lift his hand, he could put it down as part of the same act; the lifting and putting down would be one total act. But when you lift his hand and say, "I'm not instructing you to put it down," that means one act (lifting) is completed, and to put

it down would require another act on his part demanding a separate decision and expenditure of energy. Since he is in such a relaxed state of trance, it would simply be easier to let the hand remain there. You incisively do something (like lifting an arm) and then cut it off, limit it, so that he needs a lot of decision and energy to change it. It is harder to put it down than leave it. So there is an economy of effort in trance. Would you say in trance the parasympathetic system, the "relaxation" system of the body, is more dominant than the sympathetic?

E: Yes, it is.

R: That is why you place so much emphasis on "not doing" in trance: Not doing is natural when relaxed in the parasympathetic mode; doing things is more natural in the outgoing, high-energy output characteristic of the sympathetic system. I believe that is what the Burr-Ravitz device measures, by the way. When the Ravitz curve goes down, it means the patient is in a passive-receptive mode. I've conducted ordinary therapy sessions without the use of hypnosis while measuring a patient's electrodynamic potential (Ravitz, 1962), and when the patient is really absorbed in a moment of introspection or listening to me in a receptive manner, the potential goes down. When they are putting out energy to express, the potential goes up.

E: It is an altered state.

R: Altered in a direction of receptivity. In trance the normal alteration of receive and express is cut off in favor of continual reception. That reception can be from within—as when one is receptive to their own imagery, thoughts, feelings, sensations, and fantasy—or it can be receptive to something from the outside, like the therapist. The electrodynamic potential seems to remain low as long as one is not making the normal effort to respond actively.

E: And use the normal pattern of multiplicity of foci of attention.

R: That's right, the foci of attention have a restricted range in trance—the range being defined frequently by what the therapist suggests. This indicates that we could also define therapeutic trance as an alteration in the normal balance of receptivity and expression that is characteristic of an individual. Anything that shifts the individual to a higher receptivity/expression ratio would be a shift toward therapeutic trance. Research would be needed to determine how our proposed receptivity/expression ratio could be measured, and the degree to which it is similar to or different from some measure of the relative dominance of the parasympathetic system to the sympathetic: the parasympathetic/sympathetic ratio.

Catalepsy as Balanced Tonicity

[Dr. Q experiments very slowly for about two minutes, moving his arm a bit at the elbow and shoulder, but not the wrist and hand.]

E: *Now, nobody knows what any one person learns first.*

Dr. Q: Ummm.

R: What is he doing, moving his elbow and shoulder about that way?

E: He knows there is something different in that arm, and he is trying to find out what it is. He knows there has been a change.

R: And that change is balanced tonicity?

E: Yes.

R: That balanced tonicity, you believe, is a different physiological state?

E: Yes, that's right.

R: The balanced tonicity means there is an equal pull on the agonist and antagonist muscles, is that right?

E: That's right. All day long you keep your head in a state of balanced tonicity.

R: That is why we don't get tired holding up our head—it is balanced tonicity. If there was a pull on one side or the other, we would get tired.

E: That's right. In other parts of your body you are not accustomed to balanced tonicity.

R: Catalepsy is introducing balanced tonicity into another part of the body?

E: Yes, into another part of the body where it is an unfamiliar thing.

R: That is what Dr. Q is investigating.

E: But he can't understand it, nobody has ever explained to him what balanced tonicity is.

R: How did you introduce that balanced tonicity? Just by those subtle tactile cues to lift the hand?

E: No. He's in a trance state, where there is balanced tonicity. And then when 1 tell him "nobody knows what any one person learns first," I'm telling him that he is learning, but I'm telling it as a truism that he cannot dispute: We really don't know what any one person learns first.

"Wait and See" as an Early Learning Set: Evoking and Facilitating Response Potentials from Idiomatic Expressions with Multiple Meanings: The Essence of Hypnotherapeutic Work

E: Wait and see. [Pause] The only really important thing out of this—

E: "Wait and see"—what on earth does that mean? There is nothing to be seen. That is an idiomatic instruction to keep on learning.

R: Without saying, "Keep on learning," and possibly arousing resistance.

E: That's right! Just "wait and see." That is so enigmatic that it arouses expectation!

R: And when a person has waited in the past, they frequently have learned something new, so you are also setting into action and utilizing a learning set that has been relied on since childhood.

E: Yes, and it is also asking for passivity.

R: Yes, the passive-receptive type of learning is another implication. You do this repeatedly: You make a general statement; frequently it is a cliché or an idiomatic expression that has many meanings, many implications. You presume you are utilizing many if not all the meanings. The patient is certainly not aware of all of them at any given moment, but these multiple meanings are evoked at some level and then focused to facilitate response potentials that might not otherwise be possible for the patient. You first evoke a plethora of associative processes and then somehow focus on one or two that will be reinforced into overt behavior. This is the essence of your work as a hypnotherapist: to evoke and facilitate response potentials that the patient's own ego cannot quite manage yet.

The way you first evoke multiple associations and meanings is akin to Freud's idea of the multiple determination of symptoms from many different life experiences and lines of associations. With symptoms, however, we are the victim of these multiple paths of psychic determination that we cannot control. You presume to use the same principle to actually facilitate desirable behavioral responses.

E: The "this" in "The only really important thing out of this" is not defined, but it refers to the learning.

R: You don't always know what the hypnotic learning is, but you reinforce whatever it may be.

Principle of Paradoxical Intention: Memories for Inner Focusing

E: —is what I say to your unconscious mind, nothing else. Your conscious mind can tend to or attend to memories of anything. [Pause]

E: It "is what I say to your unconscious mind, nothing else." That means, Don't pay attention to the room, nothing else is important. I've excluded Dr. Rossi, the room, the floor, the sky. But I haven't told Dr. Q to disregard those things.

R: Right. If you actually mentioned those extraneous things, then by the principle of paradoxical intention he would be focused on them even though you told him not to.

E: "Attend to memories"—that is, not external realities. R: You are focusing on inner work again.

The Double Bind and Unconscious Mind as Alternative Metaphors

E: And now I'm going to give your unconscious mind some instruction. It isn't important whether or not your conscious mind listens to it. Your unconscious mind will hear it—

E: His unconscious is unreachable by him, but I can say anything I please.

R: So long as you address your remarks to Dr. Q's unconscious, you are using the conscious-unconscious double bind (Erickson & Rossi, 1979). He can only control his conscious mind, not his unconscious. Is this also a way of dissociating a person?

E: That's right. It also depotentiates conscious sets just as it does to add the phrase that it's not important whether the conscious mind listens.

R: Do you really believe that there is an unconscious mind that will hear you? Or is this all just a way of formulating a double bind?

E: I know his unconscious is listening. It has to. He's only a few feet away from me, my voice is loud enough. It will!

R: You actually operate on the assumption that any unconscious mind really exists and you can tell it what to do; others would view the unconscious only as a metaphor. My best understanding is that the double bind tends to depotentiate conscious, voluntary (intentional) control of the left hemisphere over the associative processes so that more involuntary response potentials of the right hemisphere will become manifest.

Casual Approach to Posthypnotic Suggestion

E: —and keep it in mind. From now on you can always go into trance by counting from one to 20, going into the trance 1/20th at each count. [Pause]

E: "And keep it in mind," but I didn't do it elaborately, "Now forever more you will remember!"

R: So casually put it does not arouse resistance.

E: Yes, I'm just making talk, that's all.

R: It seems to be an explanation describing how he can go into trance. But actually it is a posthypnotic suggestion?

E: Yes.

Time Distortion to Ratify Trance

E: Now I'm going to suggest that you awaken by counting silently, mentally, to yourself from 20 to one. And you can begin the count, now! [Pause for 50 seconds, and then Dr. Q begins to awaken.]

R: Why do you like to have people go into trance and come out at the count of 20?

E: Sometimes I use a stopwatch. It tells them they have had an altered experience. I can show it to them.

R: If they are far off in their estimate of how long it took them to awaken, it is a way of ratifying trance due to the time distortion.

Questions to Ratify Trance

E: *Are you fully awake?* [Dr. Q stomps on the floor and stretches a bit more.] Now the first part of the awakening was done by facial movements. Then the respiration alteration and the head and neck movements.

R: Um-hum.

E: And more facial movements and still further alteration of the respiration. You will note how rapidly. How long did it take you to awaken?

Dr. Q: About 35 seconds.

E: [To R] How long was it?

R: About 45, closer to 50. [Pause]

R: "Are you fully awake?" asked after he is moving and awakening ratifies the trance.

E: Yes, it really ratifies trance to his unconscious mind, and his conscious mind can think anything it pleases.

A Double Bind Inquiry to Ratify Trance

E: Do you know if you were in a trance?

Dr. Q: Felt like I was in a light trance.

E: What all occurred?

E: This seems to be just a simple inquiry, "Do you know if you were in a trance?" Whether the answer is Yes or No, it admits a trance: A Yes response admits a trance, but a No response also admits a trance! A No response means, "No, I didn't know I was in a trance."

R: If you said, "Did you know you were in a trance?" that would be an even clearer way.

E: But he can dispute it if you put it that way. The way I put it was just asking for information for myself, not for him.

R: What if he says, "No, I wasn't in a trance?"

E: Then I'd say, "That's fine, you really didn't know." I'm putting doubt in him, and I'm

speaking the truth—he really didn't know.

R: So your question was a double bind: Any answer he gives automatically ratifies trance. The double bind is effective in this situation because it's being used to depotentiate the limitations of his doubting and skeptical mind that does not know how to recognize the reality of his trance experience. Some level of awareness within him that does recognize the reality of the trance experience is thereby potentiated into awareness, so that it may be more possible for his conscious belief system to overcome its limiting bias and accept the reality of the altered state.

The double bind is effective in altering one's belief system only when it is used to confirm a truth that is known at some level but denied because of the biasing effect of the conscious mind's learned limitations. The double bind can facilitate the recognition of a truth only when it is confirmed by something within the subject. You probably could not get away with using it to foist something on a person if this inner confirmation is absent.

Outlining Amnesias

Dr. Q: Well, the most significant thing is that you touched my arm and said, "I'm not instructing you to put it down." I *felt badly* because I—my arm should have hung there in a trance, and it didn't.

E: Ask Dr. Rossi if that is a correct memory.

Dr. Q: Is that a correct memory?

R: I'd like to have you describe your experience in more detail. Did it hang there at all?

E: What he doesn't know here is that he is outlining his amnesias. He doesn't know it, and you didn't know it. He doesn't really know what his arm did. When he says he "felt badly," it means he felt bewildered. He didn't know what to understand. Something was altered, but he doesn't yet understand what.

Learning to Recognize Minimal Indications of an Altered State: Muscle Sense and Distraction

Dr. Q: It might have done this [touches his thigh very lightly with hand that is partly suspended in air]. I felt the pressure of my fingers against my leg. *I did feel my muscles try to carry out the suggestion,* but I don't feel that I did.

R: [To Dr. Q] I noticed that your hand dropped a little bit, but I felt it was a satisfactory catalepsy.

Dr. Q: I didn't.

E: [To Dr. Q] Did you notice that your skin was touching, your fingertips were on your leg? Were they?

Dr. Q: Fingertips were on my leg?

R: One or two were touching.

Dr. Q: Something like that. Like this. [Dr. Q correctly demonstrates.] And I think you [Dr. R] wrote something.

R: Yes.

E: All right. Let's take up the question of values. How important was Dr. Rossi's writing?

Dr. Q: *I think it distracted somewhat.*

E: Did it have any value for you at all?

Dr. Q: Well, I was receiving some attention, so I think I enjoyed that aspect of it.

R: Was it a partial response here when he says, "I did feel my muscles try to carry out the suggestion?"

E: [Erickson demonstrates by lowering Rossi's arm.] Did you feel your muscles? How do you feel your muscles?

R: I did not have any particular feeling in my muscles when you guided my arm. The very fact that he is feeling his muscles means that he is in an altered state. His foci of attention are concentrated on his muscles. When patients say something like that, you know they have been experiencing trance?

E: They have been experiencing an unusual feeling.

R: Now, someone like T. X. Barber (1969) might say that you have just shifted their focus of attention, but that does not mean there is a trance.

E: I haven't shifted the focus of attention—he has! He doesn't do that consciously. What did your writing distract? He is validating that something was there that your writing distracted him from. Only he doesn't know he's saying that.

R: From Dr. Q's point of view he was not experiencing enough of trance. This seems to be highly characteristic of many modern subjects in our post-psychedelic revolution who deeply covet an altered state. But from your point of view he is just a beginner whose first task is to learn to recognize and welcome any minimal alterations that take place, however slight. Even mental health professionals today think of hypnosis as a fast key to miracles. But the reality is that learning to experience an altered state of consciousness usually requires time, particularly for professionals because of their critical and skeptical attitudes. They first need to learn to recognize these very subtle cues that imply an alteration has taken place.

Questioning to Ratify Trance and Inform the Unconscious

E: You are receiving attention right now. Since I asked that question, how many cars have passed?

Dr. Q: I have no idea.

E: That's right. Of what importance was the passing of the cars while you were answering that question?

Dr. Q: Answering whether the cars passed or not?

E: Urn-hum. I know that they didn't have importance for you.

Dr. Q: No.

E: Dr. Rossi's writing had no value for you. ... All right, now I'm going to ask you to shift from that chair to that one.

R: What is your purpose in asking Dr. Q all these questions?

E: I'm using them to ratify the trance, and I'm directing his attention to various things. And I'm not telling him! I'm just asking for information. You ask for information about all the things you want him to be aware of unconsciously.

R: They seem to be innocent questions, but actually you are informing his unconscious?

E: Yes, to make known anything that happened.

An Hypnotic Demonstration for Indirect Trance Training

The senior author now demonstrates an hypnotic induction and trance with another, more experienced subject, as a learning experience for Dr. Q. Dr. Q believes there has been a role shift so that he, as a young psychiatrist, is now being trained to induce trance in others by watching a demonstration. The purpose of this procedure, of course, is that without being aware of it, his unconscious is receiving indirect suggestions for learning to experience trance personally.

After this demonstration and a discussion of it, Dr. Q talks about himself and his professional work. He describes his uncertainty and tenseness when working with groups. Erickson draws an analogy with going to the theater. One might or might not be interested in the play being presented, but there are certainly many interesting observations that can be made on the audience: One can distinguish those who can hear and those who cannot, the man or woman who came only because their spouse insisted, etc. "You can see a lot of things, but you enter the theater not knowing what you are going to discover there. There are plenty of alternatives in any situation. . . . When you attend a session of group therapy, what on earth are you going to see? That is what you go there for." The conversation then continued as follows.

Posthypnotic Suggestion initiating the Microdynamics of Trance Induction: Therapist's Behavior in Focusing Attention for Trance Induction: Interspersal Approach and Voice Dynamics

Dr. Q: There is a lot going on at all times.

E: Much more than you can see, and you have no time for anxiety.

Dr. Q: I think my anxiety is because I feel so blind in the situation where there is so much data coming at me that I can't understand it.

E: And everybody learns to count. *First they count up to one. Then they count up to two, and five, and 10 and 20.*

Dr. Q: Hummm. [Dr. Q blinks uncertainly and then closes his eyes. He begins to raise a hand toward his face, as if to scratch his nose, but the motion slows down, and his hand finally becomes motionless after it touches his nose and makes only a preliminary movement of scratching. His hand becomes cataleptically fixed in mid-scratch. His face relaxes, and he is obviously entering trance. Erickson pauses a moment or two, observing him intently, before continuing.]

E: He is following the posthypnotic suggestion given back in the last session.

R: Even though it did not seem like a posthypnotic suggestion when you told him he could reenter trance on a count of one to 20.

E: There was no way for him to identify it as a posthypnotic suggestion.

R: You said in the last session that he would go into a trance when he counted from one to 20, not when you, Dr. Erickson, counted. Yet you count here, and he goes into a trance. Why?

E: All right, now, see what you do. [Erickson now begins to count to 20 while staring with intense interest at R, who in turn feels a strong hypnotic effect and momentarily closes his eyes, obviously responding to it.] Do you follow? You have been counting with me.

R: Oh, I see! When you count, it automatically evokes a counting response in the patient, and that is his cue for entering trance.

E: Yes. You see, it doesn't fit in with anything. It was an interspersal technique.

R: The count from one to 20 was interspersed in the normal flow of conversation.

E: Yet it doesn't belong there, so he has to think, "What?" But he doesn't know.

R: The conscious mind is startled and doesn't know why. That startle leaves a gap in awareness and allows the unconscious to fill in.

E: Yes, because whenever your conscious mind does not understand, it says, "Wait a minute, that will come to me." What are you saying? In effect you are saying, "My unconscious will help me."

R: The typical microdynamics of trance induction come into play here: (1) Your remarks about counting do not fit the context of the conversation, so his *attention is immediately fixated;* (2) the conscious mind's *habitual sets are depotentiated* by the startle effect; (3) not knowing what it means initiates an *unconscious search* that (4) locates and *processes the posthypnotic suggestion* you gave him previously so that (5) he experiences the *hypnotic response* of reentering trance. I notice that you stared very intently and expectantly at him when you gave him the posthypnotic cue. Is that searching look of yours important?

E: I couldn't let him trivialize my counting as a meaningless utterance, so I looked at him as if I was really saying something.

R: That is a problem I've had with posthypnotic suggestion. I mention the cue, but since I did not have the patient's full attention, they just ignored it.

E: When you speak to a person, you let them know, "I'm speaking to *you!"* You can speak directly with your eyes or your voice or with a gesture. You have to have the person's attention. If you have been speaking casually and then use a very *soft* voice, you immediately get the person's attention.

R: So that is another built-in habitual mode of responding that you are utilizing. Simply by lowering your voice in initiating an induction, you fixate attention, and that already accomplishes the first step of trance.

E: Yes, that narrows the person's attention. I use a soft voice because that compels attention.

R: So, when initiating a posthypnotic cue, you first try to fixate attention so that it is not running on and on in its own association patterns. You focus attention so the rest of the system is momentarily open and receptive. The unconscious can then respond.

Awakening to Ratify Trance

E: *And now* you can begin to count backward from 20 to one. [Pause for about 30 seconds, after which Dr. Q moves and apparently awakens.] I only wanted to surprise Dr. Rossi.

R: I was still listening to your stories!

E: "And now" implies that he has accomplished the trance. From that accomplishment he can proceed to the next, which is counting backward.

R: You thereby quickly ratify his accomplishment of trance.

Reentering Trance Without Awareness

Dr. Q: Yeah. It was so out of context, what you said, that it just had to have a different meaning.

E: And you didn't know what I was saying, but your unconscious mind did.

Dr. Q: I had a conscious awareness, too. I think I had both.

E: You had some awareness consciously after your eyes closed and your mobility disappeared.

Dr. Q: I remember—I feel embarrassed arguing with you.

E: You see, I watched your eyelids, and if Dr. Rossi wasn't taken by surprise, he could have noted the glazing of your eyes when I said "10." I actually began at five.

R: Your counting was so "out of context" that it resulted in Dr. Q's attention being momentarily fixated; his consciousness did not know what it was, but it had to have a meaning, so his unconscious supplied a meaning by having him enter trance.

E: Without his consciousness knowing! After he goes into trance and comes out, he is saying, "Yes, it was out of context, what you said, but it just had to have a different meaning."

R: The conscious awareness of the significance of your words as cues for trance comes after he has entered and come out of trance. So the subject enters trance without conscious awareness of what is happening.

Another Subtle and Indirect Trance Induction

E: Now, if you've read that report on Susie (in Erickson, Haley, & Weakland, 1959), I told her she could go into a trance when I counted to 20 in various ways. I swatted a fly and talked about other things, how children came *cheaper by the dozen and so on till "20"* which was the cue for Susie to enter trance. [Pause as Dr. Q apparently enters trance again.] Now, why weren't you [Dr. R] watching his eyelids?

R: I guess I'm the poorest student you ever had.

R: Why does he enter trance again here?

E: You missed the fact that I counted from one to 20 again with that "cheaper by the dozen" story about how Susie entered trance.

R: Oh! I missed that completely! I thought you were just telling one of your stories again! You used the same cue of counting from one to 20 in a different context to put him into trance again without either of us realizing how you did it! You mentioned a "dozen and so on till 20" as a subtle way of counting from one to 20.

Studying the Patient's Frame of Reference

E: He [Dr. Q] obviously wants to learn. [Pause for about two to three minutes as Dr. Q apparently goes progressively deeper into trance.] And you can take your own time in awakening.

R: Here you are reinforcing the trance by giving approval for his wanting to learn.

E: But he did not hear it as an obvious approval. It was an objective observation to you which he heard. And there is no higher approval than that. You see, that was so casual. His unconscious knew how to respond, but you could read over the transcript and still not know what was happening. Why don't you use your unconscious mind?

R: I'm trying to!

E: You were placing *your* meanings on my words. But what was *my* meaning?

R: I've got to start practicing that: looking at other people's frames of reference; the meaning that their words have for them, not for me. The therapist has to avoid placing his own meanings on the patient's words. This is so important because therapists often

distort patients' words by reinterpreting them from the therapist's own theoretical frames of reference (Freudian, Jungian, etc.), rather than the patient's.

Unconscious Communication Rather than Prestige

E: When you [Dr. R] see that happening, it takes away all the magic and all the prestige. He knew unconsciously how to respond.

R: The unconscious can respond out of the logical context of conscious understanding.

E: Yes, and that is how you should look upon human behavior. [To Dr. Q] You didn't go into trance because you were bored with me. You did not go into that trance to get away from the environment. You went into the trance because you had been programmed with a certain awareness. Now, you can awaken now. [Dr. Q awakens.]

R: In other words, it is not prestige and magic that counts; understanding and communicating with the unconscious is what counts!

E: Yes, the unconscious can respond out of the logical context of unconscious understanding.

Indirect and Unrecognized Posthypnotic Suggestion in Trance Induction

R: Although we have dealt with the subject before (Erickson & Rossi, 1979), I'd like to learn more about your indirect approaches to posthypnotic suggestion. In your major paper on posthypnotic behavior (Erickson & Erickson, 1941) you say the following:

Once the initial trance has been induced and limited to strictly passive sleeping behavior, with only the additional item of an acceptable posthypnotic suggestion given in such fashion that its execution can fit into the natural course of ordinary waking events, there is then an opportunity to elicit the posthypnotic performance with its concomitant spontaneous trance. Proper interference (with the posthypnotic performance) can then serve to arrest the subject in the trance state. (p. 12.)

Can you give me further illustrations of "an acceptable post-hypnotic suggestion . . . that can fit into the natural course of ordinary waking events?"

E: When I used to smoke, I'd *first* put a cigarette out and *then* induce a trance.

R: So putting a cigarette out became a conditioned cue for entering trance.

E: Later on in the interview, after they had been awakened and engaged in discussion, I'd light up a cigarette and then *very slowly* reach over to put it out, talking *slowly.*

R: Is that a way of fixing their attention when you do it very slowly? The very slow gesture arrests attention, initiates an inner search for its meaning, and allows the unconscious to express itself.

E: But it fits in with ordinary behavior and is *not recognized* as a posthypnotic suggestion to reenter trance.

R: Yes, it's only a slight modification of ordinary behavior. As they see that hand moving slowly, before they can figure out why it is moving slowly—

E: They are in a trance!

R: So when they come out of trance, they have no real understanding of why they went into a trance.

E: They say, "I don't know what happened. I awakened from a trance and we were talking, and you lit a cigarette or I was about to reach for one. But I guess I never did."

R: When their eyes close, do you let them rest in trance for a while, or do you start working with the trance immediately? Do you wait for signs that they have reached a proper depth or whatever?

E: I say, "All right, I think you're really deep enough now. That tells them, *"Be deep enough!"* That does the rest of it.

Nonverbal Trance Induction as a Conditioned Response

R: Tell me another approach you've used.

E: [Erickson illustrates silently by adjusting his telephone.] In other words, any little acceptable thing can become a subtle cue.

R: You can set up a conditioned response by doing something, any inconsequential thing just before you induce trance. Their consciousness does not associate it with the trance induction that follows since it is such a casual thing, but it nonetheless serves as a conditioned cue for their unconscious.

E: [Erickson illustrates another pretrance cue by moving his chair up half an inch closer.]

R: I thought I could provide such a cue by lowering the light in the room must before trance induction, but that is too obvious a thing.

E: That *is* too obvious!

R: Since it is so obvious, the conscious mind can immediately set up barriers to trance work. These barriers are not so much a resistance against hypnosis per se. I suspect the so-called resistance is a naturally built-in mechanism by which the conscious mind is always protecting itself against being overwhelmed by the unconscious. It is this natural barrier that your indirect approaches are designed to cope with. So far, you've illustrated nonverbal cues. Is there something particularly valuable about nonverbal movement cues?

E: That way you don't have to interrupt what you are saying. You can say something just before the movement cue and during the cue—that is what they remember in the waking state as the last thing you said. There are so many little things that you can do. [Erickson demonstrates by turning a cube with pictures of his family.] I'm apparently thinking.

R: You appear to be quietly, meditatively thinking as you turn the cube in the clockwise direction.

E: Then, when the patient is in trance with eyes open, I turn the cube in a counterclockwise direction, and they awaken. So you don't have to depend upon verbal constructions because you want your patient to do a lot of things. You don't want to have to tell the patients everything they are to do.

R: Otherwise the therapist would have to do all the work rather than helping the patients utilize their own creativity.

E: Therefore you build up a situation so they are free to respond on their own initiative. [Erickson illustrates by making a fist over the cube and then turning it.]

R: You attract the patient's attention by putting one fist over the cube, and then you turn it to induce trance or awaken the patient from trance.

E: Use a 180-degree clockwise turn to enter trance and then a 180-degree counterclockwise turn to awaken.

R: Is that an easy thing to do? I'm worried it won't work.

E: You are worried about it working, and I assume it *will* work!

R: That assumption is a very potent thing.

E: It is a *very* potent thing!

R: They feel it and are caught in the strength of your assumption.

E: You've had the experience innumerable times of knowing that somebody was expecting something of you.

R: That's it! That's what you create—that *expectancy!*

E: But I don't define it verbally!

R: A person's life history of experience with expectation is a very powerful built-in mechanism that you utilize in your induction.

E: It is very powerful.

R: As children we have a lot of daily experience in struggling to live up to expectations, and it is this life long experience that you are utilizing.

E: That's right. It belongs to them, why not use it?

Serial Posthypnotic Suggestion: Utilizing a Negative Mood

R: Another approach you describe in the same paper (Erickson & Erickson, 1941) and our previous work (Erickson & Rossi, 1979) is sequential phenomenon leading to trance induction. Can you elaborate on the value and purpose of serial posthypnotic suggestions? You mention the example of a five-year-old girl who was induced to enter trance by suggestions for sleep. You then proceed as follows (Erickson & Erickson, 1941):

> Then she was told, as a posthypnotic suggestion, that some other day the hypnotist would ask her about her doll, whereupon she was to (a) place it in a chair, (b) sit down near it, and (c) wait for it to go to sleep. . . . This three-fold form (sequential) of a posthypnotic suggestion was employed since obedience to it would lead progressively to an essentially static situation for the subject, (p. 118)

E: [Erickson now gives another illustration of this use of sequential structuring of behavior. In order to conduct an oral examination on one of his daughters at the age of three—while she was in a recalcitrant mood— he proceeded as follows, while she was sitting on the bed holding her favorite toy rabbit.]

E: Rabbit *can't* lie down with its head on the pillow!

Daughter: Tan too! [She lays the rabbit down to prove it.]

E: Rabbit can't lay down with its eyes shut *the way you can.*

D: Tan too! [She now lays down with the rabbit.]

E: Can't go to sleep like you can.

D: Tan too!

> E: And then they both went to sleep!
>
> R: A series of suggestions phrased in a negative way neatly utilizes her recalcitrant mood. You progressively channel her behavior until it became trance behavior.

E: Can't lay still when touched.

D: Tan too [said noticeably softer].

E: Can't have mouth open and throat looked at [spoken very softly].

D: Tan too [whispered].

> E: At this point she opened her mouth and I looked. After the examination a physician who was in attendance said, "Now that didn't hurt, did it little girl?"

D: You're poopid [stupid]! It did too hurt, but I didn't mind it.

R: So the importance of sequential or serial behavior is to gradually built up a momentum, shaping behavior in the desired direction.

An Indirect Approach to Automatic Writing: Utilization Rather than Programming

E: [Erickson illustrates further with an example of shaping automatic writing through a series of verbal suggestions as follows.] Ordinarily, when there is paper and pencil available, something can be written. Often one doesn't know what is going to be written. Of course, the pencil that I've picked up before has written. Now, a left-handed person will pick it up with the left hand.

E: The patient is right-handed. I've made an observation, but I haven't said, "Pick it up in your right hand." The patient thinks, "I'm not left-handed, I'm right-handed. *I pick up the pencil with my right hand."* That's the patient's thinking.

R: This approach is the ingenious aspect of your approach: You get patients to think certain things in a very indirect way by *implication.* You don't make direct suggestions to put something in the patient's mind. You arrange circumstances so the patients make the suggestions to themselves.

E: Yes. If they hesitate to pick up the pencil, I say, "Now ..."

R: You say, "Now . . ." and pause as if reflecting in order to say something unrelated to the subject at hand. But the unconscious hears that "now," and that facilitates picking up of the pencil *now.* The conscious mind heard the "now" as belonging to another context, but their unconscious channeled it into the previous series of suggestions to facilitate the picking up of the pencil.

E: Yes! They've got that word *now* hanging there, to which they have to attach a meaning. I've done this with people awake as well as in trance. You don't have to know hypnosis. All you have to know is how people think this way and that way. You say this, and they are absolutely conditioned to think in a certain way.

R: You utilize those conditionings that are built in us as often as possible in waking as well as hypnotic work.

E: This is a *naturalistic* technique, a *utilization* technique.

R: This is your unique contribution, isn't it? Previous to your work, hypnotherapists thought they were programming their patients. You have shown that actually we are utilizing what is already there in the patient.

E: *Programming is a very confusing way to tell a patient to use his own abilities*.

SESSION 2: The Experiential Learning of Hypnotic Phenomena

Trance Induction via Body Immobility: Intercontextual Cues and Suggestions

[This session begins the next day with Dr. Q questioning Erickson about his selection of good hypnotic subjects from an audience. Erickson explains that he looks for "frozen people," who show little body mobility. He then tells Dr. Q he can experience it by remaining as immobile as *he can.]*

E: To remain frozen fixates attention. You can enter hypnosis through this door or that, whichever you wish. "As he can" covers all the possibilities: He can do it a little, he can do it 90 percent; I've covered all the possibilities from 0 to 100 percent.

R: The last two words, "he can," are also a strong indirect suggestion that he can remain immobile.

E: Yes, it is a strong suggestion.

R: The unconscious can pick up suggestions out of context and utilize them in ways unrecognized by consciousness.

E: In my paper, "The method employed to formulate a complex story for the induction of the experimental neurosis" (Erickson, 1944), I emphasize and contrast the meaning of this word with the following word. For example, the phrase "Now as you continue": *Now* is the present: *as you continue* brings in the future; *continue* is a command.

R: The same word can have many meanings: only some of them are evident from the total context perceived by consciousness; most of them are buried within the context. We could call the buried ones *Intercontextual Cues and Suggestions.*

"Try" for Fail-Safe Suggestions

E: *Try to remain frozen.* [Long pause as Dr. Q fixates his eyes and remains immobile. He soon closes his eyes, and a quieting of his respiration is noted after he takes a deeper breath or two. After about 10 minutes of silence, wherein Dr. Q makes only minor facial movements and an occasional finger movement, Erickson continues.]

E: All suggestions are used to reinforce, substantiate, and validate others. Right there, for example: *"Try* to remain frozen." If he has any doubt, all he has to do is make a good *try.*

R: So even if he fails, it is okay, since he tried.

E: Yes, he made a try.

Implication to Ratify Trance

E: And you can begin counting backward from 20 to one, now!

E: For what reason do you count backward from one to 20? From a trance!

R: Dr. Q thought he was just demonstrating his ability to remain frozen, but because counting from one to 20 was used to induce trance in the previous session, counting backward now turns his current experience into a ratified trance as you awaken him.

E: Yes, I say it is a trance without making my statement disputable. It is an implication, and you can't test implications.

R: How about if someone says, "Gee, I don't like the implications of your remarks."

E: Then I would say, "I don't know what they are for you."

R: Whatever implications they get are their associations and not necessarily yours. You may have an idea of what you are implying, but the implication is actually a construction that they build within themselves.

Ratifying Trance by Implication and Reorienting to Normal Body Tonus

[After a one-minute pause Dr. Q reorients to his body by stretching, opening his eyes,

clenching and unclenching his hands, adjusting his feet and seat posture, etc.]

E: *What happened to you?*

Dr. Q: Well, I enjoyed the first trance so much I *thought I'd do another one.*

E: You thought you'd do another. Why?

Dr. Q: I watched you and I got the signal from you that it was okay.

E: The signal?

Dr. Q: *You told me not to move.*

E: [To Dr. R] Seems the unconscious really understood. But his conscious mind didn't—it found that out afterward.

E: How often do you go around clenching and unclenching your hands? It is his behavior, and it is ratifying the trance.

The implication of my question, "What happened to you?" is that something did happen! In his answer he is validating verbally that his first experience was a trance.

R: So he is now putting all his previous doubts to rest.

E: "I thought I'd do another one." He now taking all the credit. That is what we want him to do.

Anything he wants to consider a signal to achieve his wishes is okay, especially if it is going in my direction. "You told me not to move"—that is his interpretation. I only told him to try and you can. He is the one who carried it out.

Experiential Learning of Hypnotic Phenomena

Dr. Q: I think it was the second time you told me to try again. I'm thinking backward. That gave me the idea of—letting it go.

E: Here he is defining the times at which he learned. He is validating the previous trances and trying to determine at which point he learned this and that hypnotic phenomenon. I'm not telling him to learn this at this moment and that at that moment.

R: This is characteristic of your approach to the *experiential learning of hypnotic phenomena.* You do not attempt to directly program hypnotic phenomena; you simply arrange circumstances so the patients will learn through their own experiences.

Ratifying Trance with Questions

E: How long do you think you would have remained in the trance? Dr. Q: Fifteen or 20 minutes.

E: I ask him this question to give him another opportunity to validate his trance, and he does so when he answers, "fifteen or 20 minutes."

Truisms and Distraction to Discharge Resistance

E: *You could have remained in it for hours, so long as you didn't hear me leave*.

E: I'm telling him it can be hours long and then make the unnecessary stipulation, ". . . so long as you didn't hear me leave."

R: Why that unnecessary stipulation? E: That takes up his attention!

R: You've made a daring direct suggestion that he could remain in trance for hours.

Then to obviate resistance, you immediately distract his attention with the unnecessary stipulation. You have simultaneously displaced his attention and discharged his resistance.

E: Yes, in a very safe way. I don't know how much resistance anybody has, but I can talk as if he had a great deal of resistance. It does not alter the meaning of what I say to mention a few unnecessary words. They are too few to bother about.

R: Is this another technique of displacing and discharging resistance: simply adding on unnecessary words? You tack an unnecessary truism onto a strong direct suggestion, and that distracts attention and tends to discharge resistance.

E: Yes, and it makes the subject agree with you. You ought to have your techniques so worded that there are escape routes for all resistances—intellectual, emotional, situational.

A Surprise: Unconscious Communication not Understood Consciously

Dr. Q: I agree with that. *I don't know why.*

E: There is nothing mystical or magical about that.

Dr. Q: It is *surprising.*

E: Surprising to you, yes, because you didn't realize the whole series of indirect suggestions leading up to it.

Dr. Q: *I didn't realize?*

E: An emphatic agreement here, but "I don't know why." That is a beautiful communication at the unconscious level that is consciously heard but not understood.

R: He agrees but does not know why. He is not aware of your approach of using a truism to gain acceptance of an associated suggestion. It is the conscious mind that finds the situation "surprising."

E: When he questions, "I didn't realize?" it implies that he didn't recognize all my indirect suggestions. That is beautifully said.

Posthypnotic Suggestions: Conscious and Unconscious Communication

E: *That would send you in a trance.* But I knew it would, and I let Dr. Rossi watch it. *What is the meaning of posthypnotic suggestion?!* Posthypnotic suggestion isn't, "Now you must at such and such a time, under such and such circumstances, do such and such."

R: It is not that direct.

Dr. Q. *It's not?!*

E: "That would send you in a trance," seems ungrammatical, but I'm actually speaking of the series of indirect suggestions.

"What's the meaning of posthypnotic suggestions?!" has both a question mark and an exclamation point because it is communication on the conscious (requiring a question mark) and unconscious (requiring an exclamation point) levels.

R: It's interesting that he responds with the same mixture of question and exclamation when he says, "It's not?!" That suggests he did receive your communication on both

levels.

"Now": Conditioned Trance Induction and Arousal Through Voice Dynamics

E: It isn't. You know that *now!* You say something that seemingly has some simple meaning, and then you find out what it means after you start doing it.

E: I have been conditioning Dr. Q to this word *now.*

R: When you say the word *now* very softly and a bit drawn out, it has acquired conditioning properties for entering trance because you always say it that way when giving people instructions to enter trance. I had to close my eyes for a moment just then as you said it, so strong was the hypnotic conditioning I have acquired simply by being an observer. When you say "now!" sharply and abruptly, as in "You can awaken from trance by counting backwards from 20 to one, *now!"* it becomes a conditioned cue for awakening. When you use emphasis and particular intonation with certain words, you are actually conditioning patients through voice dynamics.

E: That isn't verbal communication, even though it is verbal. How can you really describe that to our readers?

The Illusion of Free Choice: A Lacuna of Consciousness

Dr. Q: *I have a feeling of choice in that.* That I realized what was happening and I chose to have it happen.

E: That makes you feel very comfortable, doesn't it? Kubie speaks about "illusory choice."

Dr. Q: Illusory choice?

E: *The Godfather choice:* your signature or your brains on this contract. Which is no choice at all.

Dr. Q: It is not a choice if you want to do something?

E: But I set it up that way. Only you didn't hear or see or know that I set it up that way.

Dr. Q: *I had a need to cooperate.* So I can't say how much I was setting up with you and how much you were setting up. I had the feeling of choice.

E: Now he is stepping over to my side.

R: He believes he had free choice in what he did, but actually you were conditioning him.

E: I gave him no choice. While he is puzzling about the "Godfather choice," his unconscious is understanding that I did tell him to do certain things. I merely reinforced previous suggestions.

He then makes an effort to defend his conscious mind with, "It is not a choice if you want to do something?" And again with "I had a need to cooperate." His consciousness is defending its rights.

R: That is a significant lacuna of consciousness: He has a conscious feeling of choice even though his behavior is determined by your relation to his unconscious processes.

E: I give him a feeling of choice even though I'm determining it.

The Fundamental Problem of Modern Consciousness: The

Experiential Release of Involuntary Behavior

E: [Erickson reaches over and with very light touches indicates direction, so that Dr. Q moves his arm to a position about a foot above his thigh. The arm remains cataleptic, and he gradually closes his eyes and remains quiet and immobile for about five minutes. He then wiggles his fingers, very slightly at first, then more so. His hand moves about in space and finally touches his knee, seemingly by accident. He makes an almost imperceptible startle, probably nothing more than a tensing about the eyelids, and then opens his eyes and reorients to his body with the typical movements of awakening.]

Dr. Q: *I wanted to test it. I wanted to test the suggestion. I wanted to see how much choice I had. I was afraid to test it too much.* Then at a point I just decided, well, let it go. At one point I wanted it [his arm] to go this way, but it wanted to go that way, and I could feel that.

> R: He now illustrates and describes his own efforts to test his free choice in trance by altering his arm position. He makes the fascinating phenomenological discovery that although he did have voluntary control ("I was afraid to test it too much"), there was also an involuntary component that wanted the arm to go another way. He is thus involved in the experiential learning of the involuntary or autonomous processes that are released during trance. He is learning that he can "let it go"—he can give up conscious control and let other response systems take over within him. This is the most basic and fundamental experience, that the modern, rationalistic mind needs to break out of the illusion that consciousness creates and controls everything. It's an experiential prolegomenon to deeper trance.

Fascination with Autonomous Behavior: A Numinous State of Being

R: Your free choice was to extend it, and yet—

Dr. Q: *I felt it resting. It wasn't like it took over, it's like I felt it was there. I kind of felt like I still had the feeling of choice. But it seemed to have its—it's a hand*!

E: And you know what it is. It's an undefinable thing. It's neither father nor mother nor child nor parent. *It is it: a state of being.*

Dr. Q: One that is very hard to accept as existing even in spite of seeing it. E: You had it.

> R: Referring to his own hand as "it" suggests he is dissociating it. Does that mean his hand is outside the usual range of ego control?
>
> E: It is completely out of it.
>
> R: From a Freudian framework one would say that some of the usual ego cathexis has been withdrawn so the hand is closer to autonomous unconscious functioning?
>
> E: Yes.
>
> R: You actually use more of an existential framework when you say, "It is it: a state of being." But Dr. Q is so fascinated with it that I'm more reminded of Jung's conception of the numinous as an experience of "the other" or otherness within ourselves. This experience of the autonomous quality of his hand is necessary to help him break out of the limiting conceptions of his rational mind. As is characteristic of so many professionals, it is obvious that he very much wants this experience. It is very clear that we are here touching upon the fundamental problem of modern consciousness: How can consciousness observe and maintain some control while yet giving more room for autonomous processes of creativity—the unconscious—to take over when consciousness recognizes that it has reached its limitations? How can consciousness

participate in and to some degree direct those creative processes that are usually autonomous and unconscious? After centuries of struggle to develop the rational functions of the left hemisphere and rejecting the nonrational processes of the right hemisphere, man finds himself impoverished. In our current quest for release from the rational (via psychedelic drugs, Eastern religions, yoga, the mystical, etc.), we are desperately searching for means of reaching the inner potentials that are sometimes released through ritual, cult, and the practices of faith and miracle healing. The holographic approach of Pribram (1971, 1978) and Bohm (1977, in Weber, 1978) is a currently interesting effort to understand and integrate the rational and nonrational functions. (See also Jung, *Collected Works,* Vols. 6 and 8 [especially "The Transcendent Function"].) From this new point of view modern hypnosis can provide an experiential access to the unconscious and the nonrational, and the possibility of integrating it with consciousness.

Faking It? Resistance to Dissociating Conscious and Unconscious

Dr. Q: *I feel resistance to that being legitimate and having—I can't tell how much I'm faking it and how much it is happening*.

E: AH right, what was the deciding factor in your awakening? Dr. Q: In my awakening? I don't know, I just felt like I wanted to.

R: This statement about not knowing how much is fake and how much is happening by itself is highly characteristic of most people when they first learn to experience involuntary movements.

E: Yes, and he is trying to convince himself there isn't that dissociation by asking if he is faking it.

R: The modern scientific mind really does not believe in the unconscious and the possibility of dissociation, because it is so caught up in its belief in its own unity and the dominance of its ego and consciousness. The modern mind has a dangerous hubris; it does not believe it can be split, dissociated. Yet that is what happens in modern consciousness when individuals are caught up in mass movements and belief systems that alienate them from their own basic nature and personal background. Jung *(Collected Works,* Vols. 8, 9,18) felt this was the basis of psychopathology in the individual as well as in mass movements and in all the *isms* that eventually lead to conflict and war.

Awakening with the Alien Intrusions Ending Dissociation: Time Distortion: Different Names in Trance

E: I know what the deciding factor was. When you touched your hand to your knee, that was the crucial moment, that tipped the balance in favor of awakening. *Something alien was introduced. The alienness was a realization that belonged to your conscious mind.*

Dr. Q: Yeah.

E: Tell me, what time do you think it is?

Dr. Q: It is about—12:20.

E: Want to look? How long were you struggling with your hand?

Dr. Q: Three or four minutes.

R: I did not time it, but my impression is that it was a little bit longer.

E: Over 10 minutes.

Dr. Q: That amazes me. I did not think I did that many things that took 10 minutes to do.

R: Can you say more about how the alien realization from the conscious mind intruding on the unconscious led to awakening?

E: His hand is dissociated from his body, and therefore his body is dissociated from his hand. When his hand touches his knee, they are brought together again.

R: Contact of the dissociated parts naturally unites them and ends their dissociation. That is probably why you don't like people to have their hands in contact when you induce a trance in a formal way; it facilitates dissociation to keep hands apart. That is why in inducing trance you often try to separate things: You want to separate me from Dr. Q; the conscious from the unconscious; the person from his surroundings, his time sense, his memories (as in amnesia), his sensations, anesthesia, etc. You use division to divide consciousness; it breaks up the unity of consciousness.

E: Yes, it breaks up the unity.

R: That is why you will sometimes give the person in trance a different name, a different personality. So division is very important; divide and conquer. [See Chapter 10 on creating identity in Erickson & Rossi, 1979.]

E: Note his complete readiness to accept my statement about 10 minutes here.

Prestige and Magic: Their Function and Basis

E: That is why I keep that clock there [on a bookcase in back of the patient], nobody knows when I look at it. Is there anything prestigious about what I'm doing? You mentioned that yesterday.

Dr. Q: Well, I don't know of anything. *I just have a feeling of magic about someone who understands how a mind works.*

E: Do you think it is magic to be able to speak Chinese?

Dr. Q: I think it is magical to be able to understand, let's say, how atoms combine to form water and oxygen.

E: Do you really understand that? Does anybody? Dr. Q: I don't know.

E: Any Chinese baby knows how to speak Chinese. It would be magic if you started talking Chinese, even baby Chinese.

Dr. Q: Yes, that would be magic.

R: Do you really believe therapist prestige is not important in doing hypnotherapy?

E: Prestige is important, but you don't brag about it. A patient comes to you because he can't do the things he thinks he should be able to do. Therefore he comes giving you the prestige.

R: The patient gives the therapist prestige, a form of potency, to do the things the patient cannot do for himself. The giving of prestige is a desperate hope that something can be done.

E: Yes. You accept that prestige and enhance it indirectly because he needs it. You keep it by being very modest about it.

R: That's an interesting idea: It is the patient who needs to give the therapist prestige. The therapist accepts the prestige because the patient needs it. It is not the therapist who needs prestige. The phenomenology of prestige, from this point of view, becomes very interesting. We naturally confer prestige on those who help us transcend our own limitations. Hopefully, the hypnotherapist is helping the patients transcend their learned

limitations in order to realize their own potentials. That is the only legitimate basis of prestige. Something similar can be said for the sense of the magical: Magic is essentially understanding how the mind works, and facilitating its potentials is "white magic"; using that understanding for harmful intent, of course, is "black magic."

Appropriate Moment for Induction: indirect Suggestion for a Kiss and the Basic Paradigm of Hypnosis

E: I did not do anything you [R] could not do. Only difference was I knew when to reach my hand out.

R: And how did you [E] know when to reach your hand out?

E: When I thought Dr. Q could do it, I knew if I reached my hand out, what he would do. And I let him find out and I let you [R] find out. And you found out how Dr. Q struggles.

Dr. Q: How I could struggle against control?

E: When you tried to extend your arm, it pulled back.

R: There is an appropriate moment to initiate ah induction or hypnotic phenomenon?

E: Yes.

R: How do you know when? Do you notice spontaneous shifts toward a trance condition that you then merely facilitate? Do you see the eyes glazing, the face freezing, body motion being retarded? Do you notice partial aspects of trance and then realize that is the appropriate moment for induction?

E: Take an example from ordinary life. When do you kiss a pretty girl?

R: When she seems to be ready for it.

E: That's it! When she is ready, not when you are ready. You wait for that undefinable behavior that she manifests. You don't ask a girl for a kiss, but in her presence you just gaze thoughtfully at the mistletoe. You are just being thoughtful. She gets the idea, and she starts thinking about the kiss.

R: You've indirectly planted an idea in her head. E: Yes, she doesn't know you did.

R: Therefore it is all the more potent because she is going to soon wonder, "Gee, I want a kiss," not, "He wants a kiss."

E: That's right, and there is the excuse, mistletoe. R: That is a paradigm of all hypnotic work, isn't it?

E: Yes, you know what the frames of reference can be and you utilize them.

R: That is the basic knowledge of the hypnotherapist: knowing what the frames of reference can be and how to facilitate them.

The Experiential Learning of Trance: Ratifying the Phenomenology of Dissociation

Dr. Q: I had the feeling, though, of initiating the struggle. I feel that is part of my curiosity. I was able to question it and felt a need to test it. I needed not to be completely passive in the situation. *I needed to make the situation valid by testing it. Not understanding, not believing what was happening until it did. Up until that time I could not be sure whether I was faking it or what was happening.*

E: How did you know what to fake?

Dr. Q: You told me to reach my arm out. You were saying by that, "You're supposed to

now act hypnotized."

E: What was your arm supposed to do after I touched it?

Dr. Q: *It wasn't supposed to stay there.*

E: He really verbalizes beautifully, doesn't he?

R: Yes. What is the struggle he is engaged in here?

E: He knows what his usual behavior is, but what is this behavior? Now he begins conceptualizing two separate types of behavior.

R: Normal ego control versus dissociated behavior. Here is a modern rationalistic mind learning that its own conscious ego does not always control everything. That is the basic experience for the modern mind to have if it is going to learn trance. His experiential learning takes place through the typical processes of hypothesis testing: Can I initiate control over my own hand movements in trance? He does not believe in the situation until he can make it valid by testing it.

E: Yes, this is also indicated when he says, "It wasn't supposed to stay there," yet it did! So it wasn't faking! It wasn't supposed to stay there!

The Typical Process of Testing the Reality of Trance and Dissociation

E: Now, I wanted Dr. Rossi to see how your eyes didn't close completely and how you struggled with your arm.

Dr. Q: I can't imagine how you wanted me to struggle with my arm.

E: I knew that you would because everybody else does it!

Dr. Q: I thought I was being a bad kid!

E: So does everybody else!

R: [To Dr. Q] You thought you were being a properly skeptical psychiatrist—scientific.

Dr. Q: I didn't want to accept something when you were suggesting.

E: But I had to offer some suggestion, so I just touched your hand.

Dr. Q: I know what that meant.

E: What did it mean?

Dr. Q: It meant I had to hold my arm out.

E: Did it?

R: Dr. Q believed he was unique in his scientific doubts about the reality of his trance experience. Yet his experience is so typical that it makes an excellent case for illustrating your approach to coping with this critical and debunking attitude of the current climate of scientific opinion. His need to reality test the inner phenomenology of his experience is entirely appropriate because there is in fact so much bunk that goes on about psychology and especially hypnosis these days. That's why the older authoritarian approaches are no longer appropriate today. In an open and democratic society a high value is placed on everyone being free to question and test the reality of their life experience. Because of this, your Experiential Approach to learning trance is most appropriate.

Delicate Tactile Guidance for Dissociation and Catalepsy:

Bypassing Habitual Frameworks; Initiating Unconscious Responses

Dr. Q: You grabbed it and you held it.

E: Did I?

Dr. Q: It seemed that way.

E: I didn't grab it and I didn't hold it. You had your hand up in the air, and I touched it. [Erickson again reaches out and touches Dr. Q's right hand, which was poised in a natural gesture about halfway between his lap and chest as he spoke. His eyes close after a few minutes of carefully watching his hand remain fixed in one position. His breathing changes, and he is obviously going into trance. His right arm remains cataleptic in the position it was in when Erickson touched it. After a while Dr. Q begins to make small, tentative movements of his hand, obviously testing it. He moves a finger or two slightly, and then his elbow. The fingers and arm always return to the cataleptic position. He then tries to push his right arm with his left and obviously encounters resistance.]

R: [Erickson now demonstrates on R's arm.] You didn't grab it. Your hand is so soft in touching my arm, but it does indicate direction, and I actually move it without seeming to.

E: You are moving it! You maintain the same contact with my hand. I'm moving my hand, but you're keeping that contact.

R: My hand is following yours, but you are not pulling my hand. There is a subtle difference. With the slightest of pressures you are indicating where my hand should go.

E: Yes.

R: This is training the patient to follow you and be very sensitive to you. The patient has to reach out and ask: What is he doing? What does he want? Where does he want it to go? Where? Where? Where? His whole consciousness is directed to following you.

E: And I haven't grabbed a thing!

R: I'd resent it if you grabbed my hand or pulled it. But since your touch is so light, I have to cooperate with you and follow you.

E: The patient doesn't know what he did.

R: He doesn't know the degree to which he cooperated.

E: That's it! The delicacy of your touch is important.

R: That is a tactile way of doing what you always do verbally: You guide the subject, but so lightly he has to listen very carefully and then naturally seems to do something in the range of possibilities you have initiated. But he can't resent it because he is supplying so much of the momentum and choice himself. That is a fundamental aspect of your work in whatever modality of communication you use: You provide only the lightest and most indirect suggestion to initiate a process, so the patient has the experience of behavior taking place autonomously.

[Erickson demonstrates again on R's arm.] You're touching my hand so lightly with cues for downward movement that I have to sense very carefully and then let it go. And as I follow your touch, I start to get a strange dissociated feeling.

E: Yes.

R: It is dissociated because I'm not used to sensing another's touch so carefully. I'm thrown out of my usual frames of reference.

E: The slight touch, the silence, and the look of expectancy.

R: That is your form of mumbo-jumbo that bypasses the habitual frames of reference.

E: Um-hum.

R: It bypasses the usual frames of reference, and the subject is thrown back on the questions: What is expected of me? What am I to do? He is desperately trying to do something.

E: And he has to follow his own patterns of behavior!

R: Now that is it! The subject has to follow his own patterns of behavior. He is really not following you except for the most general context. You are initiating something, but you do it so delicately that his own patterns of behavior come forth from his unconscious, his behavioral matrix, to fill the gap.

E: That's right. Then I can select any one of those patterns— R: —for a therapeutic goal.

E: Um-hum.

R: And it is not the subject's conscious mind that is directing, because his conscious mind does not know what to do in this unusual frame of reference, so he is thrown back on habitual patterns from the unconscious.

E: It is all his own exploration. R: You've initiated this in him.

E: I've set up a situation in which his patterns can come forth. He doesn't know they were called forth, but there they are, so he starts examining them. We all can dissociate naturally.

R: Dissociation is a natural ability we all have. Every time we daydream, we are dissociating.

E: But we don't know how well we can do it.

R: The modern mind has forgotten all about dissociation and no longer believes it can do it. The modern mind likes to believe in its fundamental oneness, its fundamental unity.

A Self-Induced Analgesia

[Dr. Q then pinches his right hand, evidently testing it for analgesia.]

Dr. Q: It lost a lot of its sensitivity.

E: Why?

Dr. Q: I don't know.

E: I didn't suggest, did I?

Dr. Q: No. I just thought of testing if it was analgesic.

R: You never did anything to initiate an analgesia—not even directly, except insofar as analgesia and many other sensory-perceptual distortions take place spontaneously during catalepsy. The analgesia Dr. Q is experiencing could be either the spontaneous sort or the result of an inner suggestion he is giving himself without realizing it under the guise of reality-testing his dissociation. His own unconscious expectations and processes are becoming activated in ways he does not himself understand.

Indirect Reinforcement of Hypnotic Learning

E: *Yesterday* I tried to impress upon you how ignorant you were. I knew you'd be a

good subject.

Dr. Q: How did you know?

[We all nod in acknowledgment that such recognition of good subjects has become rather automatic to Erickson.]

E: I can make this attack on him here because I say, "yesterday."

R: You are implying he was ignorant yesterday but smart today. That indirectly reinforces all the new learning he is going through today and bypasses his skepticism of yesterday even more.

E: That's right. A very careful use of "yesterday." Then his questioning about how I knew he'd be a good subject implies a complete acceptance!

Trance as a State of Inner Exploration

Dr. Q: That time I was much more interested in pushing the limits of the test a lot further than before.

E: I'll tell you something you didn't know, though. You also developed some analgesia in your left arm and hand.

Dr. Q: ***In my arm, too?***

E: In your hand, I'm certain.

Dr. Q: ***How?***

E: You didn't know it?

Dr. Q: ***No.***

E: Dr. Rossi could see there was something wrong with your hand movements.

Dr. Q: ***Of my left hand?***

E: Yes, through analgesia you lost the proper mobility.

R: This testing is the essence of the modern experiential approach to trance experience. The testing is actually a form of internal self-exploration. It fixates and focuses attention inward, and this, of course, is a basic aspect of trance. It has that peculiarly detached, impersonal, and objective quality of ego observation in trance.

E: Notice the ease with which he now accepts my observations about his left arm and hand anesthesia. His questions all imply an acceptance.

Dissociation as a Creative Act: New States of Awareness in Modern Hypnosis

Dr. Q: Of my left hand? I noticed something else when I was pushing my arm. ***When I let it go, I seemed to be losing, I seem to be threatening this state by letting go rapidly.*** **Now, I didn't want to threaten this state, so I started letting go gently.** ***Another threat to this state when I felt my muscles tensing.***

E: Let's go back to that word ***threat.*** **What was the threat?**

R: What does he mean by "threatening this state"?

E: Any break is a threat. You break a state of awareness; the break carries with it a destructive significance. I can break a pencil, I can break a state of dissociation.

R: Breaking a state of dissociation brings you back to ordinary consciousness. It is like

when people say, "I was flying high, and then they brought me down." They mean their inflated mood was broken. So to maintain the dissociated state is a creative act.

E: That's right.

R: It's not just a passive splitting of consciousness.

E: You call it "creative," I call it "discovering." He doesn't want to do anything that will threaten that discovery.

Normalizing Forces Interfering with Creative Dissociation: Self-Discovery as the Appropriate Frame of Reference for the Experiential Approach to Trance

Dr. Q: I was aware that there were forces at work that would wake me up, that would cause me to be what I'm used to being,

E: But why is that a threat?

Dr. Q: Well, it was against what I wanted. It was a threat, too.

E: That's the word you are using. Why do you say threat? There was an awareness.

Dr. Q: I see.

E: But the word you used was threat. It's just an awareness, not a threat.

E: He is verbalizing the forces that interfere with his discovering more about trance.

R: He knows he is outside his usual frame of reference (". . . what I'm used to being"). Now, what were those "forces at work that would make me wake up?"

E: There are so many forces: foci of attention.

R: The tendency to go into the multiplicity of foci of attention characteristic of normal consciousness is always tending to intrude on the creative dissociation where there are relatively fewer foci. Then, with the distinction you make between *threat* and *awareness,* you are just trying to educate him about that awareness?

E: Yes.

R: Would you say that modern hypnosis is the discovery of other states of awareness that are there but not always explained in a conscious way? The old-time hypnotherapy was a process of being directly programmed by someone who did mumbo-jumbo on the patient, shook up his frames of reference, and then tried to stick in new stuff. But in modern work we don't dare use mumbu-jumbo because that is against the modern scientific world view. But discovery and self-discovery are acceptable with Dr. Q's frames of reference; therefore, we can use them to give him new states of awareness.

E: I agree.

Recognizing the Developing Presence of the Unconscious and Trance

Dr. Q: There was one other piece of information you gave me that was very helpful when I recall it. When you said that "your conscious mind was an intrusion" that changed the state, *I could see my unconscious mind intruding again.*

E: Did I say a single word to you the second time?

Dr. Q: No, it was a way of thinking about the situation which I was able to use.

E: I didn't ask you to change your way of thinking, did I? Dr. Q: No.

E: He could see his unconscious mind intruding on his conscious mind—taking over, in other words.

R: He is developing a sensitivity to that. A similar sensation develops in me while lying in my hammock on a Sunday afternoon—getting drowsy and sensing the unconscious come in as daydreamy thoughts, images, and that comfortable, easy feeling of deepening relaxation. You realize you must be going to sleep since your body feels so light.

E: Yes. [Erickson now gives an example from his youth of lying in the hay on a sunny day and thinking how nice it would be to go to sleep. He heard a chicken cackling and wondered how soon the cackling would fade away, indicating that he was asleep. The cackling seemed to get further and further away as he went into sleep.]

The Subjective Exploration of Catalepsy: Distortions of Suggestions as Indicators of Trance

E: I suppose you [Dr. R] ought to dictate into the record what you have observed. Go ahead.

R: [Dictating a summary of observations] The procedure was initiated when Dr. Erickson touched Dr. Q's hand. Dr. Q watched his hand while Dr. Erickson carefully watched Dr. Q's eyes and face. Dr. Q seemed to become really involved in watching his hand. Dr. Erickson sat back, relaxed, and after a moment or two Dr. Q closed his eyes. Then there was a five-minute period where Dr. Q seemed to be just simply drifting into trance, letting his right hand hover in a cataleptic manner. One would assume by Dr. Q's bobbing head movements and altered breathing that he was apparently dozing.

E: Head movements, but he wanted to move his hand. He had the concept of lifting and lowering. But he lifted his head and lowered his head because he couldn't get the concept of lifting from his head to his hand. He was trying to move his hand! It is like a child learning to write. He tries to move his hand with his head. Here is Dr. Q, an adult, trying to move his hand with his head!

E: He had the concept of lowering his hand, but moved his head instead.

R: Recently I had a patient whose hand did not lift very much with suggestions for hand levitation, but her whole body began to tilt toward the hand. I then utilized that body-tilting to continue the induction. It's in just such distortions of your suggestions that the patient's altered state become more obviously manifest. That peculiarly lethargic and seemingly obstinate contrariness of some people in the early stages of learning to experience trance is, in fact, a marvelous indicator of autonomous processes beginning to take over.

Idiosyncratic Ideomotor Signaling

Dr. Q: I had the pendulum going with a friend of mine, and I wanted it to answer Yes or No, but I found myself moving my head. I was aware that I was moving my head [in today's trance], but I did not know why.

E: He is discovering why he did not move his head.

R: It's fascinating to note how a modern scientific consciousness discovers the idiosyncratic and autonomous within itself. We simply do not know at this point why his psychological system is more prone to expressing itself in ideomotor signals with his head than his fingers with the chevreul pendulum.

Catalepsy as an Early Level of Psychomotor Functioning: Unfamiliar Frames of Reference as Altered States of Consciousness

R: [Continuing the dictation] After about five minutes Dr. Q's left hand reached over toward his cataleptic right hand, and I wondered if he was coming out of trance. But all he did was to touch the lower edge of his right hand, as if to gingerly test it. As he proceeded in testing, his touches got firmer and firmer, as if he was trying to knock his right hand out of its poised alignment. I was really amazed, because I now realized his cataleptic right arm was really fixed.

E: He discovered he could not move his right hand. To move his right cataleptic hand, he had to use his left hand. He found out he had to use his left hand to lift that right arm at the elbow. He tried to bend it and move it up and down. He moved his right fingers back and forth with his left hand. But he could not move them with his right.

E: Ordinarily when you want to move your right hand, you use your right hand to do it, but here he was using his left hand to move his right.

R: Was he thereby protecting the dissociation in his right hand?

E: He did not know how to move his right hand. His right hand was an object he had to move with his left. Just as you can see a baby reach for its right hand (seen as an object) with its left hand. It takes quite some time for the baby to see the hand as part of itself.

R: So dissociation is a return to those early levels of functioning? E: That's right.

R: Does the dissociation phenomenon support the atavistic theory of hypnosis?

E: Would you call a baby's cooing atavistic?

R: No. It is a matter of terms. You don't like the term *atavistic* even though we are going back to modes of functioning that were more prominent earlier in our lives?

E: Yes, we are going back to an early learning period, but not atavistic. When your hand becomes an object, how are you going to handle an object? You use the natural way you use as an adult to handle an alien thing. The dissociation of your right hand makes it alien, and you naturally pick up that alien thing with your other hand, which is not alien. That isn't really primitive because that is what you do all the time. You pick up a pencil because it is alien to you.

This is the Experiential Mode of Hypnotic Induction. You let the subject experience his own behavior and toy with it. It is an experiential phenomenon by which the self teaches the self by studying dissociated frames of reference, frames of reference that are unfamiliar.

R: These unfamiliar frames of reference are what many people now call altered states of consciousness.

Analgesia: Testing Sensations and Movements as an Experiential Ratification of Trance

Dr. Q: *I* used about 25 pounds of force to move my right arm.

R: After about seven or eight minutes of that you began pinching your right hand, testing for analgesia.

Dr. Q: I felt what it was doing, but it was not painful. It was a diminished sensitivity.

R: You were aware of touch but not pain.

Dr. Q: I still have a little of it [analgesia] left.

R: I was very interested in your question about free choice. You felt you had free choice in the trance.

E: He was disputing with me about that.

R: Yes, you feel it is an illusory free choice.

Dr. Q: I feel I haven't tested definitely. It was a test within certain limits.

E: All right, now, how many times did I have to test to see if my glasses are there?

Dr. Q: Well, you have had a lifetime of leaving an object there and knowing it will stay there.

E: And you have had a lifetime of feeling at one touch. But you kept on repeating your test.

> E: It is ridiculous when he talks of using 25 pounds of force because you don't bend one arm with the other. He didn't realize the absurdity of it. And you don't have to "test" your sensations in the normal state of consciousness.
>
> R: If you have to test your sensations, you are already in an altered state.
>
> E: Yes.
>
> R: So all these tests and explorations are actually experiential ratifications of trance.
>
> E: He likes this altered state, he doesn't want to do anything to destroy it. Therefore he is going to put limits on his tests. You see a beautiful, fragile thing, and you want to feel it, you lift it, you touch it, you want to be very careful because you don't want to break it.
>
> R: This is the experience of someone who is beginning to learn how to experience trance. It is a fragile state initially, and he is going to be very careful he doesn't break it. Other well-experienced subjects don't have this concern.
>
> E: Dr. Q has his need to support his skepticism.
>
> R: He is still supporting his skepticism with all this testing even though it is also a way of very gingerly learning how to experience trance in a safe way. But why does the hand tend to become analgesic when dissociated?
>
> E: When the hand becomes alien—
>
> R: —All the sensations of the hand become alien because they are in a new frame of reference, and we don't know how to experience that frame of reference yet. Is that right?
>
> E: That's right. With a good subject any frame of reference is okay because he or she trusts us.
>
> R: So when we bypass our shift frames of reference, we must support the patient in a safe way, and that is usually the transference.
>
> E: Or trust.

Shift in Frame of Reference for the Experiential Induction of Trance

Dr. Q: *It is a new situation to me. I did not quite have the same awareness*.

E: OK, let's take up the next thing. Have you ever heard someone say, "I'm just frozen here. I was so astonished I didn't know what to say and I couldn't speak"?

Dr. Q: Yeah, I haven't experienced that myself a lot. I can't think of any. E: But that is a learning you've had since childhood. Dr. Q: Yeah.

E: That's what you're inquiring into right now: past moods, past learnings.

R: His initial statement about not having quite the same awareness in a new situation implies that a *shift in frame of reference is part of hypnotic induction,* doesn't it? A new situation, a new frame of reference, results in an altered state of awareness.

E: Yes.

R: Theoretically you could induce a trance simply by asking a patient to sensitively explore one hand with the other. That would introduce a fairly unusual frame of reference; it would focus and fixate attention, and then you are on your way.

E: I have induced trance in that way. It works. It is slow, but it is

very impressive later to the subject.

Resistance to Accepting the Altered State of Trance

Dr. Q: *Still I feel a foreignness about the whole thing. It still has an unnaturalness. I kind of feel a part of me is unwilling to accept what I've experienced, somehow*.

E: Those are your words. The correct statement is, "Part of you does not know how to accept the other part." The new learning doesn't fit with your previous learnings. How do you accept it?

Dr. Q: I'm willing to accept that experience as a valid one that does not— so unfamiliar.

E: It has to be valid because you are having trouble with it. You wouldn't be having trouble with it if it wasn't valid. [Erickson elaborates several personal experiences of being dumfounded.]

R: So it is misunderstandings that give rise to the experience of being dumbfounded.

E: An inability to understand.

R: Why are you emphasizing this inability to understand now?

E: He [Dr. Q] cannot understand how analgesia develops out of catalepsy. He couldn't understand the passage of time. And he kept on testing and testing. He always found the same response. All the results were contradictory to past experiences and learnings.

E: He's still feeling "unnaturalness."

R: That means he is still experiencing an altered state.

E: Yes.

R: I used the word "misunderstanding," while you spoke of "an inability to understand." Is there any substantial difference in meaning here?

E: Yes. It is not a "misunderstanding" but an *absence of understanding* that leaves you dumbfounded and open.

R: Your usual frames of reference are bypassed, leaving you open and ready for structuring suggestions.

E: Yes.

R: It is very important for the hypnotherapist to tune into the hypnotic process along a dimension of structure or lack of structure in a patient's comprehension. Dr. Q's very *absence of understanding* indicates that his usual conscious sets and habitual frames of reference have been bypassed to the point where he experiences himself in an alien territory of consciousness; he senses a "foreignness about the whole thing." This foreignness is in fact the altered state of trance that his usual everyday states of

consciousness find so difficult to accept.

"Fake" and the Skeptical View of Hypnosis as a Rationalization: Creative Moments in Everyday Life as an Altered State

Dr. Q: *Yes, and a part of me wanted to make the conclusion that it was a fake, because that would explain it. I was faking it*.

E: But how could you fake it when you did not know what was going to happen?

Dr. Q: *I had to have a way of understanding it*.

E: The easiest way is to *not* understand and call it a fake. That's an avoidance of understanding.

Dr. Q: Yeah, but it satisfies my need for the meantime. If I understand it as a fake, I can drop it.

E: You can drop it and then not have to learn. Just as Dr. Harvey was called a faker when he said the blood circulated. No doctors wanted to understand. It was so much more comfortable thinking the blood did not circulate.

Dr. Q: Yes, there is an unwillingness to change a system of knowledge.

E: And a willingness to accept magic if you don't have to think about it. Hypnosis was a forbidden subject because it required understanding.

E: "Part of me wanted to make the conclusion that it was fake."

R: Yes, that is his old skeptical frame of reference. Labeling the experience as "fake" would be a safe way of rationalizing it back into his old familiar skeptical point of view.

E: But he couldn't, and he kept testing and testing.

R: So this is the problem of those who have the skeptical view about hypnotic phenomenon. They are trying to fit their new hypnotic experience into their old rationalistic frame of reference. They are denying the reality of their living experience in order to support their old views.

E: "I had to have a way of understanding it." The only view that was open to him was "fake," and so he had to test it until the fake explanation didn't fit.

R: Would you say this was the problem of many researchers of the past generation in hypnosis who were on the skeptical end of the continuum? They were trying to fit phenomena they did not understand into the typical rationalistic frames of reference of the 19th century that in essence believed hypnotic phenomena were fake: Nothing but "motivated instruction," role-playing, or what not.

They failed to understand the very real struggle we are all constantly engaged in to stabilize our world view with the familiar, which in turn must give way to the new that is constantly created within us. When the new comes forth into our consciousness (Rossi, 1972), it is frequently experienced as a threat. It is in fact a threat to our older frames of reference, which must now give way to the new. This is the essence of the constant struggle of consciousness to renew itself. The actual transformation between the old and the new usually takes in an altered state: a dream, a trance, a meditative reverie, a moment of inspiration, the creative moment in everyday life when our usual point of view is momentarily suspended so that the new can become manifest within our consciousness.

E: It ruins a magician's act if he explains to you how he did it. You've taken it out of the alien frame of reference and put it into the ordinary frame of reference.

R: It is the very fact that hypnotic phenomena are in an alien frame of reference that

allows us to bypass the limitations of our ordinary frames of reference during trance so that we can do things we could not ordinarily do with our everyday ego consciousness. If you rationalize away the "alien" quality, you lose the potency of the altered state of trance. Is that right?

E: Yes. The best way to "not understand" is to call it a "fake." It is an easy way out and an avoidance of understanding.

R: So you'd say a lot of research purporting to support the skeptical view of hypnosis as an altered state is an avoidance of understanding.

E: Um-hum. It is a "fake," so I can drop it. I won't have to exercise any more intelligence.

R: This reminds me of that difficult situation in science, particularly psychology, where a fundamentally new insight can crystallize only when we are able to redefine or expand our view of what something is. Freud gave us profound insights into the dynamics of sexuality, but he could only do it by changing, broadening, our definition of what was sexual. In a similar way you can maintain the view of trance as an altered state only by expanding our definition of an altered state to include those familiar acts of daydreaming, reverie, meditation, moments of inspiration, etc., as being varieties of altered states. Even the moment of radically shifting one's point of view or frames of reference is now defined as an altered state. There is actually much justification for this, since people are momentarily frozen in cataleptic poses during such creative moments, just as they are immobilized while dreaming and hallucinating. There seems to be an inverse relationship between body activity and moments of intense inner work. That's why people are typically quiet and immobile during the deeper states of trance.

Difficulties in Learning Hypnosis

E: You know what human behavior is. The unfamiliar is unacceptable unless you can make it very mystical.

Dr. Q: That explains a lot of things.

E: I knew you could do analgesia from past experience. I don't think Dr. Rossi knew it, but he could see you doing it.

Dr. Q: I don't know what made me test for analgesia, maybe things I read. E: Because you had lost sensation and you had to find out something.

R: You were not consciously aware that you lost sensation, but something in you knew and prompted you to test.

E: Acupuncture was so easily accepted in this country because it is so easy to do. Anybody can put a needle in a certain spot.

R: But that is not the case with hypnosis. It is difficult to do.

E: Yes, it is difficult. You have to learn to recognize different frames of reference.

R: In the workshops of the American Society of Clinical Hypnosis they are always telling the beginning students that hypnosis is very easy. It is very simple to learn by rote some mechanical approaches to hypnotic inductions, but to learn to recognize and understand the unique manifestations of trance in each individual requires much patience and effort.

E: That's right.

R: There is a lot of subtle thinking about frames of reference that is required.

E: I say you have to understand this, and every time I demonstrate something before a

professional audience, I tell them, "Now you didn't see, you didn't hear, you didn't think. These are the steps." It is so much easier to think there is something special about me then learn to really observe and think. "Erickson is mystical," they say.

R: Rather than really trying to understand what Erickson is doing.

The Experiential Ratification of Trance: Assessing Sensory-Perceptual Differences

Dr. Q: *There were a lot of differences*.

E: And if you wanted to identify some of those differences, you weren't faking. I did not suggest catalepsy, I just touched your hand in midair.

E: If he wanted to identify some of those differences, he wasn't faking.

R: The very fact that he is trying to identify them means there is something there.

E: And it was his endeavor, not my instructions.

Conscious Conviction and the Ratification with Altered Sensations and Movement

Dr. Q: It's much easier for me to accept the analgesia. Having tested it that way seems very satisfying. I believe only 20 percent in the catalepsy and 95 percent on the analgesia.

E: You don't dispute with patients when you see them responding.

R: You don't argue with the skepticism of their conscious mind regarding the genuineness of the hypnotic phenomenon they have just experienced.

E: Too many people who use hypnosis try to argue with that skepticism. I don't bother. That is part of my prestige—I just don't argue.

R: Conscious conviction is something that is going to have to come out of their own experience gradually.

E: That's right. I can't put it there.

Dr. Q: I'm much more convinced this second time. The first time I was only 35 percent sure.

R: I noticed that you experienced three catalepsies in all, and the third was the most striking to see. The first required some support, with your hand touching your leg; the second was not as solid as the third, when your arm remained rigid in midair even when you tried to move it with your other hand.

E: You build your confidence.

R: [To E] The catalepsy seemed to become more genuine as he began to test it. It became more solidly established as catalepsy as he tried to move that right hand with his left. Is that true of others?

E: That was his experience. Others simply accept it with no question.

R: Their conscious minds have a good receptivity to their inner experiences.

E: Only 20 percent belief in catalepsy, yet he has muscles. He has had long experience in growing and using his muscles, but how much fuss do we make about developing our ability to test sensations? We accept sensations, but we learn to develop our control over our muscles.

R: That accounts for the 20-95 percent discrepancy. Sensation seems to come by itself, and when it disappears, it is more startling to us; therefore he has 95 percent belief in hypnosis with analgesia. But muscle control is voluntary, and thus he has only 20 percent belief in catalepsy. Sensations are closer to autonomous levels of functioning, so when we see a change there, it is more convincing.

E: That's right. I don't argue, I take their frame of reference—in the direction I want it to go. You let your subjects see everything.

R: And the more they see, the more they can become convinced.

1. Dissociation and the Modern Experiential Approach to Altered States

R: Can you say anything about the how or why of dissociation and how it works in your experiential approach to altered states?

E: The unconscious has many foci of attention, and when you withdraw that from any part of your body, you don't destroy your intellectual, conscious comprehension of that part, but it becomes an object because the unconscious foci of attention are withdrawn.

R: The psychoanalyst would say that **the usual unconscious** body **cathexis** is withdrawn (Federn, 1952).

Observing your work, I've been struck by the extremely attentive and expectant attitude you shower on patients. Some of them have later commented to me about how moved they felt with your deeply searching eyes and manner. I wonder if this expectant attitude contributes to the ease with which you elicit dissociation in your hypnotic work. Your expectant attitude immediately changes the atmosphere so that it is strikingly different from ordinary everyday life experience; it places the patient in a new frame of reference charged with an expectancy that he is familiar with.

His ego becomes uncertain and now has to reexamine even the most familiar acts from this new point of view. This new point of view is, of course, strange and alien at first, and it is precisely this strange and alien feeling combined with his uncertainty and the apparent autonomy of his ordinary acts that makes them seem different or "hypnotic." The ego loses its usual sense of control when placed in the unusual frame of reference of "hypnotherapy," and that permits the patient's unconscious or the therapist to fill in that gap.

This could also account for the potency of "strange" gestures and atmospheres in religious and magical ceremonies as well as the potency of any charlatan who succeeds in mystifying an audience with a bit of mumbo-jumbo. For example, I once watched a stage hypnotist who divided his act into two parts. During the first half he simply performed a number of magical tricks: He began with the rabbit-out-of-hat type trick, and then progressed to "amazing" feats of memory and mind reading. He was really good, and I'd be at a loss trying to figure out how he performed them. Then the orchestra played a few tunes while his assistant removed the magical props, and finally, with a crescendo of music and an atmosphere of high expectation, it was announced that now he would do the hypnosis. Of course the audience was by now ready to believe anything; all their usual frames of reference were temporarily suspended, and he was highly successful in eliciting many hypnotic phenomena from volunteers he first carefully selected from the audience with a few suggestibility tests like the hand-lock and involuntary hand movements.

His mumbo-jumbo, his bag of magical stunts, actually fixated and in part suspended the usual conscious sets of the audience. The amazing and unusual suspends and bypasses the frame of reference which gives us our usual reality sense. When this generalized reality orientation goes, normal ego control goes. When normal ego control goes, the unconscious comes in autonomously to fill the gap. The therapist can also step in at this point and evoke processes that would not be possible for the patient in his usual frames of reference. A flow diagram adapted from our previous formulation (Erickson & Rossi, 1979) would go somewhat

as follows:

1.	Fixation of Attention ↓	via	Utilizing the patient's beliefs and behavior for focusing attention on inner realities. Presentation of the strange, unusual and "amazing."
2.	Depotentiating Habitual Frameworks and Belief Systems ↓	via	Distraction, shock, surprise, "magic," doubt, confusion, dissociation, or any other process that interrupts the patient's habitual frameworks. Ordinary "Normal" awareness is disrupted.
3.	Unconscious search ↓	via	Implications, questions, puns, and other indirect forms of hypnotic suggestion. Direct suggestions are more likely to be accepted because of the disruption and gap in ordinary awareness.
4.	Unconscious process ↓	via	
5.	Hypnotic Repsonse	via	An expression of behavioral potentials that are experienced as taking place autonomously.

Usually it is no longer appropriate for the modern hypnotherapist to use tricks or the various forms of mumbo-jumbo to fixate attention and suspend a patient's usual frames of reference. For a well-educated subject like Dr. Q, therefore, you use your attitude of intense interest and expectancy about his inner exploration to fixate his attention and suspend his usual frames of reference. From that point on the process is as diagrammed above. Exploring self-experience in a new way, in an unusual context, replaces the older forms of mumbo-jumbo to initiate hypnotic phenomenon. Does that make sense to you?

E: Yes. [Erickson demonstrates a sleight-of-hand trick where he apparently loses his thumb and then finds it in a drawer and attaches it again to his hand.] The child watches you do that, and then he tries to do it by pulling at his thumb. He has seen you do it. That is a world of magic for a child. When you have an intellectual subject, you stick to the intellectual. That is what he will understand and will accept. You have to fit your technique to the patient's frame of reference.

2. Learning Indirect Communication: Frames of Reference, Metalevels, and Psychotherapy

E: When I first began the study of hypnosis, I wondered greatly about verbal technique. You take a subject in the present time, and you're offering him ideas that are to affect his future. You're also to distract his mind from the present. And you're to take his mind away from surrounding reality and direct it to his inner world of experience.

One of my first questions was, How do you move the patient's attention away from the immediate present and the immediate reality to the future and to future activities not yet known or not yet even thought about? And so I began trying to write out a verbal technique in which I could mention the present and define very exactly what I mean by the immediate reality situation. Then I make a reference to the future as if the future were in the remote future. And then I worked out phrases by which that remote future became closer and closer and closer to the immediate moment. By doing that, the subject had no opportunity to resist the fact that there is a next week and next Friday, next Thursday, next Wednesday, next

Tuesday, next Monday, the next afternoon, the next forenoon. And I build up an acceptance of all those statements of the future because I deprive him of the privilege, of the right, of the possibility of disputing that future. I bring the remote future closer and closer to the present. (See "The Method Employed to Formulate a Complex Story for the Induction of an Experimental Neurosis in a Hypnotic Subject," Erickson, 1944.)

I worked out a total of 30 pages single-spaced, typewritten verbalization for the induction of hand levitation, or the induction of regression, or the induction of hallucinations. Then I began refining that 30 pages down to 25 pages, 20 pages, 15 pages, 10 pages, five pages, selecting the phrasing that seemed to be the actually effective phrasing that enabled me to build up an automatic response of patient behavior. I tried that on a lot of fellow students, all 30 pages, 25 pages, and so on. It is a marvelous experience.

Anybody who does that learns a great deal about the way they are thinking. As they understand the way they are thinking, they have to entertain the idea of how the other fellow thinks in relation to these words. In that way you learn to respect *the frame of reference* of the other person.

When you are doing psychotherapy, you listen to what the patients say, you use their words, and you can understand those words. You can place your own meaning on those words, but the real question is what is the meaning that a patient places on those words. You cannot know because you do not know the patient's frame of reference.

A young man says, "It's a nice day today." His frame of reference is a picnic with his sweetheart. A farmer says, "It is a nice day today." His frame of reference is that it is a good day to mow hay. The young man's frame of reference was his own subjective pleasure, the farmer's was the work he did in relation to hard reality.

R: They used identical words with entirely different meanings, entirely different frames of reference.

E: Totally different meanings, yet you could understand them when you knew their frame of reference.

R: So the therapist is always working with a frame of reference rather than the actual words. In hypnotherapy, when you are talking to a patient, you are actually addressing his frame of reference.

E: You are dealing with his frame of reference.

R: Your words are changing his frame of reference?

E: You are using his own words to alter the patient's access to his various frames of reference

R: That's the therapeutic response: gaining access to a new frame of reference.

E: Yes, getting a new frame of reference.

R: A patient is a patient because he does not know how to use his different frames of reference in a skillful manner; I believe these frames of reference are actually metalevals of communication. Bateson (1972) has described metacommunication as communication (on a higher or secondary level) about communication (on a lower or primary level). Similarly, we may view a frame of reference as a metastructure that gives meaning to words on the primary level. The metalevels are usually unconscious. You are always dealing with these unconscious metalevels of communication, since they are the determiners of meaning on the primary level in consciousness. These metalevels of communication were found necessary by Whitehead and Russell in their monumental work, *Mathematica Principea* (1910), to resolve many of the paradoxes that arose in the foundations of logic and mathematics when we were limited to only one primary level of discourse. Carnap developed a calculus of these multiple levels of communication within logic in his *Logical Syntax of Language* (1959). I have previously illustrated in some detail how dreams utilize multiple levels of communication to cope with psychological problems (Rossi, 1972, 1973c). Psychological problems have their genesis in the limitations of a consciousness that is restricted to one primary level of

functioning.

I now suspect that you are doing the same thing with hypnosis. Consciousness on a primary level is stuck within the limitations of whatever belief system (frame of reference, metalevel of communication) is giving meaning to its contents. Consciousness at any given moment is limited to whatever is within its focus of awareness, and it can manipulate only these contents within its focus on its own level. Consciousness cannot reach up and change the metastructures, giving meaning to its contents; contents on the primary level cannot alter contents on a secondary level above it; it is the secondary or metalevel that structures and gives meaning to the primary.

Thus we may say that a patient is one who experiences the locus of his problem on the conscious or primary level, since he cannot make the contents of his conscious everyday experience what he wants them to be. He comes to the therapist and is really saying, "Help, help me with my metalevels, my frames of reference, so that I will experience more comfort (adaptation, happiness, creativity, or whatever) on my primary level of conscious experience. I cannot change my own conscious experience because it is being determined by metastructures outside the range of my own conscious control. So, Doctor, will you please work with my metastructures up there so I can experience some relief down here?"

With your indirect approaches you are attempting to deal with structure on these metalevels rather than the primary level of conscious experience. The patients usually do not know what you are doing because they are limited by the focal nature of consciousness to the contents on their primary levels of awareness. At present you are doing this somewhat as an art form. To make left-hemispheric science of this in the future, I believe we would need psychologists trained in symbolic logic to analyze the paradigms whereby you deal directly with a patient's metastructures. Then we will be able to analyze and outline those syntactical, semantic, and pragmatic paradigms of semiotic that are fundamental in coping with metalevels. These paradigms could then be tested empirically in a cont rolled and systematic fashion. (See "The Indirect Forms of Suggestion" in Vol. I of *The Collected Papers of Milton H. Erickson on Hypnosis,* 1980, for our initial effort to utilize symbolic logic in the formulation of suggestions; see also White, 1979.)

Alternatively, we may find that these metalevels are actually right-hemispheric styles of coping that have a peculiar logic of their own in the form of symbols, imagery, and all the nonrational forms of life experience that have been intuitively recognized as healing. In this case we need to develop a right-hemispheric science of what in the past has been the domain of mysticism, art, and the spiritual modes of healing.

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