The Neuroscience Edition

The Complete Works of Milton H. Erickson, M.D.
On Therapeutic Hypnosis
Psychotherapy and Rehabilitation

Volume 4: Advanced Approaches to Therapeutic Hypnosis

Edited by:
Ernest Lawrence Rossi, Ph.D.
Roxanna Erickson-Klein, Ph.D.
Kathryn Lane Rossi, Ph.D.
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This New Neuroscience Edition of Milton H. Erickson's Complete Works has been updated with current concepts of neuroscience for students, clinicians, and researchers who wish to explore in depth the work of one of the most seminal minds in the history of hypnosis and psychotherapy. When Erickson began publishing his studies in the early 1930s, hypnosis was in a curious position: most investigators agreed that hypnosis had played a central role in the early studies of psychopathology and our first efforts at psychotherapy, but the authoritative approaches associated with its use were supplanted on the one hand by the seemingly more sophisticated approaches of the psychoanalytic schools, and on the other hand by experimental psychology.

The situation might have continued in just this manner, with hypnosis regarded as nothing more significant than a colorful curiosity in our therapeutic history. Into this situation, however, came the accident that was Milton H. Erickson. He was an accident of nature born with a number of congenital sensory-perceptual problems that led him to experience the world in ways so different that his acute mind could survive only by realizing at a very early age the relativity of our human frames of reference. To these early problems was added the rare medical tragedy of being stricken by two different strains of polio at the ages of 17 and 51. His efforts to rehabilitate himself led to a personal rediscovery of many classical hypnotic phenomena and how they could be utilized therapeutically.

Erickson's experimental and therapeutic explorations with the hypnotic modality span more than 50 years. His successful rejuvenation of the entire field may be attributed to his development of the non-authoritarian approaches to suggestion wherein subjects learn how to experience hypnotic phenomena and how to utilize their own potentials to solve problems in their own way. The contents of these volumes can be best understood as working papers on a journey of discovery. There is little that is fixed, final, or permanently validated about them. Most of these papers are heuristics that can stimulate the mind to evoke the awe of discovery, which is unlimited in the realm of human consciousness.

The problem of how to present Erickson’s papers could have been solved in many ways. A simple chronological order seemed unsatisfactory because the record of much of Erickson's earliest work was published only at a later date. Many papers dealing with the same theme, which should obviously be grouped together, were published in different phases of his career. The editor decided to make a balanced presentation wherein each volume identifies a major area of exploration with appropriate sections wherein the papers are presented in an approximation of chronological order. Each section has a brief introduction to the concepts of current neuroscience that are of relevance for updating our understanding of Erickson’s approaches to therapeutic hypnosis and suggestion.

A summary of the 12 key concepts of current neuroscience and a mini-concordance of important terms of shared by neuroscience and therapeutic hypnosis that were presented in detail in volume one are appended here for easy reference by the readers who wish to apply them to the papers of this volume as an exercise in active learning by doing. News, research, continuing education, and consultation on the new neuroscience of Erickson’s approaches to therapeutic hypnosis, psychotherapy, and rehabilitation are available on www.ErnestRossi.com.

**KEY CONCEPTS OF THE NEUROSCIENCE OF THERAPEUTIC HYMNOSIS, PSYCHOTHERAPY AND REHABILITATION**

1. **Special states:** A new science of the states of consciousness and creativity is emerging from current research on the functional concordance of co-expressed genes assessed with DNA microarrays and brain imaging. The emerging discipline of info-kinetics relates information to the kinetics (activity, motion, dynamics, energy) of molecular-genomic transformations.

2. **Elevated gene expression levels generate elevated levels of neuronal activity and brain plasticity that distinguish human from non-human primate brains. This elevated genotype is an adaptive selection mechanism for the evolution of the cognitive-behavioral phenotype commonly called “curiosity and the search for the hidden meaning of things” so characteristic of human consciousness.**

3. **Clock genes and their associated profiles of co-expressed genes interact with psychological and behavioral states to co-create the circadian and ultradian rhythms of consciousness, creativity, emotions, moods, and performance.**
4. The positive and negative psychological experiences of arousal and behavioral activity evoke immediate-early genes, activity-dependent gene expression, and brain plasticity in a wide range of psychosocial processes that modulate mind-body communication and healing.

5. The novelty-numinosum-neurogenesis effect. Novelty, enriching life experiences, and exercise associated with a positive sense of curiosity and wonder can turn on activity-dependent gene expression to construct and reconstruct the neural networks of the physical brain throughout our entire lifetime. Consciousness is a novelty responsive modality.

6. Sleep, dreaming and offline neural replay in Ericksonian approaches to posthypnotic suggestion and the reconstruction of negative fear, stress, and traumatic memories.

7. The memory trace reactivation and reconstruction theory of therapeutic hypnosis, psychotherapy, and rehabilitation, shock, surprise, and the unexpected in Erickson’s neuro-psycho-physicsology of therapeutic hypnosis, psychotherapy, and rehabilitation.

8. Creative replay, resynthesis, and reconstruction at the molecular-genomic level of the 4-stage creative process, which engages Darwinian natural variation and selection on all levels from mind to gene, is the essence of therapeutic hypnosis, psychotherapy, and rehabilitation as well as the creative arts and humanities.

9. Implicit processing heuristics (indirect suggestions) facilitate the 4-stage creative process on all levels from gene expression to brain plasticity and mind-body healing in the recreation of mind, memory, learning, behavior, and self-identity.

10. Mirror neurons and empathy: rapport, response attentiveness, and responsive behavior in Erickson’s therapeutic hypnosis, psychotherapy, and rehabilitation.

11. A future orientation to the creation and reconstruction of memory via implicit processing heuristics facilitates mind-body healing via therapeutic hypnosis, psychotherapy, and rehabilitation.

12. The self-facilitation of each person’s unique psychosocial genomic resources of consciousness, creativity, and happiness is the essential drama and dynamic of human destiny as portrayed in the arts, hero myths, and humanities of all cultures.

A Concordance of Therapeutic Hypnosis and Neuroscience

This is a concordance of the concepts and processes of therapeutic hypnosis and neuroscience that intuitively cluster together at the levels of molecular-genomics, brain plasticity, and psychological experience. There are general and suggestive links but few exact one-to-one correspondences between the Therapeutic Hypnosis and the Neuroscience columns. Many of the most significant phenomena of therapeutic hypnosis are associated with Gene Expression (GE) and Brain Plasticity (BP).

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Ernest Lawrence. Rossi  
Los Osos, California 2006
1. Advanced Approaches to Therapeutic Hypnosis

The advanced demonstrations of therapeutic hypnosis and suggestion presented by Erickson in this section are not always easy to understand. Yet, his genius is most evident in these demonstrations where hypnotic phenomena somehow becomes evident without Erickson making any direct or indirect suggestions for them. Erickson commented in informal discussions that confusion was the basis of most of his approaches to trance induction and suggestion. In one way or another, Erickson believed, momentary periods of confusion were useful to help so-called "resistant" patients bypass their apparently rigid conscious mental sets so that they could more readily get into contact with the creative edge their own inner experiencing on an implicit level. All of Erickson’s advanced approaches to trance induction share this common feature of momentary confusion.

After 40 years of experience, however, I find that I do not use many of these advanced approaches to confusion and resistance. I am not entirely sure why. Perhaps it’s because of my own lack of perception and interpersonal skills that Erickson seemed to have in superabundance. Or it may be because I now interpret confusion and so-called “resistance” as a natural part of stage 2 of the creative process in all areas of life. I do not need to induce confusion; rather, I usually need to help people work their way through confusion as the unpleasant but unavoidable second stage of their therapeutic encounters with themselves and the world.

My alternative to the complexities of Erickson’s advanced approaches to therapeutic hypnosis and suggestion demonstrated in this section has been to develop the carefully structured “activity-dependent approaches” and “implicit processing heuristics” that enable people to monitor and guide their own experiences during the 4 stage creative process of therapeutic hypnosis (Rossi, 2002, 2004). These carefully structured activity-dependent approaches are consistent with the methods of historical hypnosis as well as current research in neuroscience and functional genomics as outlined in the Editor’s neuroscience preference to this volume. They are relatively easy to learn and apply to wide variety clinical problems during training workshops in therapeutic hypnosis (Rossi, 2002, chapters nine and ten).

It is an essential part of clinical training in the use of therapeutic hypnosis for each student to learn what talents and creative skills they have in relating to themselves and others that can be most reliably applied in professional practice. My own experience as a young professional learning about therapeutic hypnosis may serve as an interesting and instructive example. I still wonder whether I had an experience of Stendhal’s Syndrome when I first attempted to read all the advance papers of this section in one intense weekend. Let me explain with the true story about how I became acquainted with Milton H. Erickson and began studying with him, in the first place.

Stendhal’s syndrome, which we touched upon in the introduction to volume one of this Neuroscience Series, has been described on the Internet as follows (http://en.wikipedia.org/wiki/Stendhal_syndrome).

“Stendhal's syndrome is a psychosomatic illness that causes rapid heartbeat, dizziness, confusion and even hallucinations when the individual is exposed to an overdose of beautiful art, paintings and artistic masterpieces. It is named after the famous 19th century French Author, Stendhal (pseudonym of Marie-Henri Beyle), who gave an early detailed description of experiencing the phenomenon his 1817 visit to Florence, Italy, which he published in his book Naples and Florence: A Journey from Milan to Reggio.

Although there are many descriptions of people becoming dizzy and fainting while taking in the art in Florence, especially at the Uffizi, from the early 19th century on, this was not described as a specific syndrome until 1979, when it was written up by Italian psychiatrist Graziella Magherini, who observed and described more than 100 similar cases among tourists and visitors in Florence, the cradle of the Renaissance.”

Another internet site provides this detail on Stendhal’s own description of his experience (http://www.wordspy.com/words/Stendhalssynrome.asp).

"I was in a sort of ecstasy, from the idea of being in Florence, close to the great men whose tombs I had seen. Absorbed in the contemplation of sublime beauty ... I reached the point where one encounters celestial sensations ...
Everything spoke so vividly to my soul. Ah, if I could only forget. I had palpitations of the heart, what in Berlin they call 'nerves.' Life was drained from me. I walked with the fear of falling."

160 years later, in the late 1970s, Dr. Grazziella Magherini, at the time the chief of psychiatry at Florence's Santa Maria Nuova Hospital, noticed that many of the tourists who visited Florence were overcome with anything from temporary panic attacks to bouts of outright madness that lasted several days. She remembered that Stendhal had had similar symptoms, so she named the condition Stendhal's syndrome.

Note, too, that a similar affliction is the Jerusalem syndrome, which hits tourists who visit the holy city of Jerusalem and are overcome by the mental weight of its history and significance."

I believe my personal experience of Stendhal’s syndrome occurred in the first year of my private practice 40 years ago—not upon visiting Florence or Jerusalem—but upon my first reading of the paper’s of this section by Erickson in Jay Haley’s (1967) early collection. Haley’s book was loaned to me by an elderly client who was convinced that I secretly had been using Erickson’s indirect hypnotic techniques on him while pretending to be analyzing his dreams (Rossi, 1972/2000). This was impossible, however, because at that time I had never even heard of Erickson. My client’s belief that I used Erickson’s indirect hypnotic techniques apparently worked, none-the-less, because his symptoms were quickly resolved after a few sessions. He wanted to know why I did not admit that I was using hypnosis. Shocked, I protested that I had never heard of Milton H. Erickson before—hence my client loaned me Haley’s book.

My young family lost me completely on that fateful weekend when I carried the book home. Once I began to read it on Friday night I could not stop. I read through the entire night; I continued without pause all Saturday and Sunday completely aloeof and even a bit brusque when my wife and children tried to approach me. I was at first delighted and amazed with Erickson’s papers but I became more and more perilously preoccupied with them as the weekend progressed. I became alternately excited, exhausted, and finally impatient, withdrawn, and finally sullen. Late Sunday night I was still intensely reading in bed. I was still desperately trying to comprehend Erickson’s paper on confusion techniques even while slowly attempting to put the book down by the side of the bed to go to sleep. The book slipped out of my hands when I felt an unfamiliar and intense burning in the pit of my stomach and finally fell into a fitful and restless sleep.

The next morning the pain in my stomach was worse. I walked across the street from my office for an emergency visit with a physician I knew. He was aghast at my disheveled and morose condition. He asked me what in heavens name I was I trying to do to myself! Whatever I was doing, I was to stop it immediately! I had a case of acute gastritis and if I did not cease I would soon have a full-blown ulcer. An Ulcer! How could that be? I was a rock, a stone whose only understanding of psychosomatics came from textbooks.

So now I had a psychosomatic illness, so naturally now I had to telephone Erickson for an appointment to get some therapy. He gave me an appointment for the next week. I mailed him a copy of my first book on dreams that had just been published. The first hypnotherapeutic session went well and I experienced immediate relief from my symptoms. After I had about half a dozen sessions at weekly intervals I told Erickson that on the long eight hour car drive from my home in Los Angeles to his home office in Phoenix I frequently found myself writing papers in my mind integrating his work with my own developing theories about dreams and psychotherapy. He wanted to hear more about what was going on in my mind about these possible papers. After a cursory description he said I should not pay Betty (his wife) anymore for my sessions. I asked why, feeling crestfallen because I thought he was dismissing me and ending my therapy.

Erickson fixed me with that laser like eye contact for which he was famous and very evenly and slowly said with a deep growl, “Just as I thought, you’re not a real patient, are you? Your really here to learn hypnosis, aren’t you!” I immediately acknowledged that at the end of our sessions I always went quickly to my car and secretly wrote down every word he said during our sessions so I could never forget. Erickson seemed mollified and continued in a more affable manner saying, “Now you write those papers but just remember one thing when you do: I will always be the senior author and you will be the junior author—because I am you senior, you know!”

Throughout our sessions Erickson always had my first book on dreams prominently displayed on the corner his desk where I could not help but stare at it since it was directly in the line of sight between us. In spite of its obvious prominence in that spot we had never even spoke about my book. As I got up to leave I asked with elaborate casualness whether he ever had a chance to take a look at it. He looked at the book absentlymindedly for a moment as if seeing it for the first time and quietly murmured, “Yes, well—it is a bit elementary, don’t you think?” Without a word I stumbled dizzy in a daze to the door and accidentally banged it real loud on my way out. My therapy had ended and my mentorship by Erickson had begun.
The Confusion Technique in Hypnosis

Milton H. Erickson


**GENERAL CONSIDERATIONS AND RATIONALE OF DEVELOPMENT**

The request has been made many times that I record in the literature an account of the Confusion Technique that I have developed and used over the years, including a description, definition, illustrative examples, and various observations, uses, and findings from it.

It is primarily a verbal technique, although pantomime can be used for confusional purposes as well as for communication, as I shall describe in another article. As a verbal technique, the Confusion Technique is based upon plays on words, an involved example of which can be readily understood by the reader but not by the listener, such as “Write right right, not wright or write.” Spoken to attentive listeners with complete earnestness, a burden of constructing a meaning is placed upon them, and before they can reject it, another statement can be made to hold their attention. This play on words can be illustrated in another fashion by the statement that a man lost his left hand in an accident and thus his right (hand) is his left. Thus two words with opposite meanings are used correctly to describe a single object, in this instance the remaining hand. Then, too, use is made of tenses to keep the subject in a state of constant endeavor to sort out the intended meaning. For example one may declare so easily that the present and the past can be so readily summarized by the simple statement, “That which now is will soon be was yesterday’s future even as it will be tomorrow’s was.” Thus are the past, the present, and the future all used in reference to the reality of “today.”

The next item in the Confusion Technique is the employment of irrelevancies and non sequiturs, *each of which taken out of context* appears to be a sound and sensible communication. Taken in context they are confusing, distracting, and inhibiting and lead progressively to the subjects’ earnest desire for and an actual need to receive some communication which, in their increasing state of frustration, they can readily comprehend and to which they can easily make a response. It is in many ways an adaptation of common everyday behavior, particularly seen in the field of humor, a form of humor this author has enjoyed since childhood.

A primary consideration in the use of a Confusion Technique is the consistent maintenance of a general casual but definitely interested attitude and speaking in a gravely earnest, intent manner expressive of a certain, utterly complete expectation of their understanding of what is being said or done together with an extremely careful
shifting of the tenses employed. Also of great importance is a ready flow of language, rapid for the fast thinker, slower for the slowerminded, but always being careful to give a little time for a response but never quite sufficient. Thus the subjects are led almost to begin a response, are frustrated in this by then being presented with the next idea, and the whole process is repeated with a continued development of a state of inhibition, leading to confusion and a growing need to receive a clear-cut, comprehensible communication to which they can make a ready and full response.

The incident, one of spontaneous humor on my part, that led to its adaptation as a possible hypnotic technique was as follows. One windy day as I was on my way to attend that first formal seminar on hypnosis conducted in the United States by Clark L. Hull at the University of Wisconsin in 1923, where I reported on my experimental work and graduate psychology students discussed my findings, a man came rushing around the corner of a building and bumped hard against me as I stood bracing myself against the wind. Before he could recover his poise to speak to me, I glanced elaborately at my watch and courteously, as if he had inquired the time of day, I stated “It’s exactly 10 minutes of two,” although it was actually closer to 4:00 p.m., and I walked on. About a half a block away I turned and saw him still looking at me, undoubtedly still puzzled and bewildered by my remark.

I continued on my way to the laboratory and began to puzzle over the total situation and to recall various other times I had made similar remarks to my classmates, laboratory mates, friends, and acquaintances and the resulting confusion, bewilderment, and feeling of mental eagerness on their part for some comprehensible understanding. Particularly did I recall the occasion on which my physics laboratory mate had told his friends that he intended to do the second (and interesting) part of a coming experiment and that he was going to make me do the first (and onerous) part of that experiment. I learned of this, and when we collected our experimental material and apparatus and were dividing it up into two separate piles, I told him at the crucial moment quietly but with great intensity, “That sparrow really flew to the right, then suddenly flew left, and then up, and I just don’t know what happened after that.” While he stared blankly at me, I took the equipment for the second part of the experiment and set busily to work, and he, still bewildered, merely followed my example by setting to work with the equipment for the first part of the experiment. Not until the experiment was nearly completed did he break the customary silence that characterized our working together. He asked, “How come I’m doing this part? I wanted to do that part.” To this I replied simply, “It just seemed to work out naturally this way.”

As I reviewed and studied these occurrences and numerous others of a comparable character, they all appeared to have in common a certain number of psychological elements.

1. There was an interpersonal relationship of a sort that required some kind of joint participation and experience.
2. There was the sudden and inexplicable introduction of an irrelevant idea, comprehensible in its own context, but which was completely unrelated and irrelevant to the immediate situation.

3. Thus the person was confronted by (1) a comprehensible situation for which a pattern of response would be easily forthcoming, and (2) an utterly irrelevant, but comprehensible in its own context, non sequitur, thereby leaving the person without any means of response until sufficient time had passed to permit adequate mental reorganization to dismiss the non sequitur from the pertinent situation. Thus in the first instance the inadvertent collision called for conventionalized social responses between two people, but instead a non sequitur, uncalled for and presented as an earnest factual communication despite the contradiction of it by reality, left the man inhibited in making any expectable conventional response, and the non sequitur, in itself comprehensible, called for no response since it had not been asked for, thereby leaving the man in a state of bewilderment until he could reorganize his mental activity to exclude the non sequitur and go about his business.

In the second example George and I completed the task of dividing the material and apparatus, and at the moment when he knew what he was going to do but did not know what I was really going to do, I impressively presented him with an irrelevant communication comprehensible in itself but offering no opportunity for a response on his part. Then as a mere matter of course I took that part of the material and apparatus chosen by me and he, inhibited by the unanswerable irrelevancy, automatically and passively followed my example by taking the remaining material, and we simply set to work in our customary silent manner. By the time he had dismissed the irrelevancy from his mind, it was much too late for him to say, “You do that and I will do this.”

4. Thus there is a structuring of a situation so that definite and appropriate responses are called for but, before they can be made, an irrelevancy or non sequitur, which in itself alone is a meaningful communication, is introduced into the situation, thereby inhibiting the other person from making his natural response to the original situation. This results in a state of bewilderment and confusion and progressively leads to a profound need to do something, just anything, uncritically and indiscriminatingly. In the first instance the man merely stared helplessly after me; in the second instance George passively followed my example, and automatically and indiscriminatingly did the task he did not want to do, but a task which was proper and fitting in the total laboratory setting, although previously rejected by him apparently without my knowledge.

In actuality, there was no essential difference in the psychology of the performance of the two men. Both had been profoundly inhibited in making their natural responses. Both were bewildered and confused and had a profound need to do something, anything, but, in a non-critical, indiscriminating way. The first man stood passively, helplessly, in the strong wind, looking after me until time itself or some other stimulus “shook” him out of his state of confusion. On the other hand George, inhibited in his natural responses, merely passively, automatically, and uncritically followed the example I carefully set for him.
5. In summary, if into any simple little situation evocative of simple natural responses there is introduced just previous to the moment of response a casual simple irrelevancy or non sequitur, confusion results, and there is an inhibition of natural responses. The non sequitur is completely meaningful in itself but has no bearing except as an interruption upon the original situation calling for a response. The need experienced to respond to the original situation and the immediate inhibition of that response by a seemingly meaningful communication results in an increased need to do something. Quite possibly this increased need is a summation of the need to respond to the original stimulus and the need to understand the inexplicable, seemingly meaningful addition. As this procedure is continued for hypnotic purposes, there often arises an intolerable state of bewilderment and confusion and a compelling, growing need for the subject of this procedure to make some kind of a response to relieve his increasing tension, and he readily seizes upon the first clear-cut, easily comprehended communication offered to him. In the meantime he has been presented with a wealth of seemingly related ideas, all of which have an underlying implication of primary but unrecognized significance leading to the development of hypnosis or of hypnotic phenomena.

This thinking led to extensive experimentation by deliberately making out-of-character, irrelevant, non sequitur remarks in groups and to single persons. The latter proved to be the better procedure, since the variations in individual behavior in group situations tended seriously to interfere but did not render the task impossible.

As originally worked out, the Confusion Technique was based upon the following items of procedure and employed primarily for the purposes of age regression before it was recognized as readily applicable to other hypnotic phenomena.

The original procedure consisted of the following items:

1. Mention of some commonplace item of everyday living such as eating.

2. Relating that item as an actual fact or possibility for the subject for the current day or present.

3. Mention its absolute probability in the future, specifying some one particular day of the week, preferably the current day.

4. Comment on its probable occurrence (the eating) on that same day in the past week.

5. Comment on the identity of the day preceding the named day of the past week, emphasizing that such a day is a part of the present week even as it will occur in the future week.
6. Add that today’s day had occurred last week, even last month, and that learning the names of the days of the week had constituted a childhood problem. (Thus the period of regression desired is subtly introduced.)

7. Mention that just as in the past a certain month would follow the present month even as the present month had been preceded by the previous month during which a meal had been eaten on some named weekday. And that weekday had been preceded by another weekday, just as the previous week had a day of an earlier ordinal position. (For sake of clarity to the reader, let us assume that the current day is the second Friday of June, 1963, that next Friday eating will occur even as it did this Friday, and as it undoubtedly did last Friday which was preceded by a Thursday, just as it was earlier in the present month and would be in the future weeks. Days, weeks, months, past, present, and future are all intermingled.)

Then one proceeds with mention that last month (May) had a Thursday—in fact, several Thursday—each preceded by a Wednesday while the month of April preceded May, another childhood task of learning the months of the year. (Thus from Friday June 14, 1963, by a simple valid statement, an underlying implication of time is employed to arouse thoughts of childhood, or any chosen past time, without seemingly direct suggestion to that effect.)

8. This intermittent and varied reference to the present, future, and past is continued with increasing emphasis upon the past with an implication of the actual past as belonging to the present and then to the future. Again to clarify for the reader one might say;

“Not only did you (Reader, please bear in mind that it is the second Friday of June 1963) eat breakfast on Wednesday of last week, but before that you ate dinner on Tuesday in May, and June was then in the future, but before May was April and before that was March and in February you probably had the same thing for lunch, and you didn’t even think of having it next April, but of course on January 1st, New Years Day, you never even thought of the 14th of June 1963 (an implication of possible amnesia developing), it was so far in the future, but you certainly could think of Christmas, December 1962, and wasn’t that a nice present you got—one that you didn’t even dream of on Thanksgiving Day in November and what a Thanksgiving dinner, so good (a present tense description of a series of ideas with an emotionally charged validation of the actual past as the present and then the future), but Labor Day came in September of ’62, but before that was July 4, but on January 1st of 1962 you really couldn’t think of July 4th because it was (this use of “was” implies a present tense) just the beginning of 1962. And then of course there was your birthday in 1961, and maybe on that birthday you looked forward to your birthday in 1962, but that was in the future, and who could even guess a year ahead about the future? But the really wonderful birthday was your
graduation year birthday. Twenty-one and a graduate at last!” (An item of fact you have carefully learned and to which you lead and finally state in terms of present reality with utter and pleasing emphasis. Or one could continue as above to the 17th birthday or the 10th or whatever year might be desired.)

9. Thus there has been a rapid and easy mention of realities of today gradually slipping into the future with the past becoming the present and thereby placing the mentioned realities, actually of the past, increasingly from the implied present into the more and more seemingly remote future.

10. Significant dates which are in themselves indisputable are selected, and as the backward progress in time orientation continues to the selected time, some actual positive strongly tinged emotional event is mentioned.

11. Throughout, tenses are watched carefully and one speaks freely, as in the illustration given of the 21st birthday. It is the year of 1956, hence one speaks joyously of the instructorship that will being in September, which is yet to come. (Reorientation in time by implication and emotionally validated by vivifying the emotions of the past.)

12. Throughout the entire time each statement is made impressively, with adequate and appropriate inflections, but before the subjects in their attentiveness have any opportunity to take issue with or to dispute mentally what has just been said, a new utterance compelling their attention has been offered to claim their thought and which arouses more effort toward further new understandings, with only a frustration of effort to respond resulting.

13. Finally a clear-cut, definitive, easily grasped and understood statement is uttered, and the striving subject seizes upon it as a Rock of Gibraltar in the running flow of suggestions that has kept him helplessly following along (graduation day and birthday—emotionally potent and coincidental and a valid fact).

14. Reinforcement of the patient’s reorientation in the past by a “specific orientation” to a “general” orientation such as a vague general reference to his “father’s job,” and by wondering, “Let’s see, did it rain the last week?” and followed by mention of the instructorship. (Two general, vague, possible ideas, followed by the validity of the instructorship, all to fixate the regression to the past as the present.)

15. Follow up with the specific statement, “Now that it is all over [the graduation], what shall we do now?” and let the subject lead the way, but carefully interposing objections to some impossible remark such as, “Let’s go down to Lake Mendota and have a swim.” (This is “impossible” since a
bathing suit becomes an immediate reality). Instead one agrees that it would be nice to go to Lake Mendota, there to watch the waves, the birds, and the canoes, thereby leading to hallucinatory activity, and as this develops, hallucinatory swimming may then follow.

At what point does the subject develop the trance and begin to regress? You have mentioned eating, days of the week, months of the year, a backward succession of years, each in itself and by itself a valid utterance but in the total context requiring a constant shifting in the temporal orientation of the subject’s thoughts and marked by the changing of tenses, and along with all this there is aroused an increasing vividness of emotions related to the past. (A personal example may be cited here: While relating to a friend in great detail the events of a trip made 10 years previously in the Rocky Mountains with a car having a floor shift, the author, who was driving in a steering-wheel-shift car which he had driven for more than five years, suddenly saw a red light and sought frantically with his right hand to find the floor shift to put the engine into neutral while his friend watched in amazement. The car was stopped only by the expedient of jamming the brake and turning off the ignition before the author realized that the vividness and extensiveness of his memories about the past trip had extended over into the field of unrecognized associated motor memories.)

To answer the question of when hypnosis develops is difficult. If one wishes to induce hypnosis with age regression as the goal, one continues until the subject’s overt behavior (more easily recognized by long experience) discloses evidence of the desired trance state. However, the process can be interrupted at any point, depending upon the purposes to be served. This will be illustrated later.

To summarize the main points of the above Confusion Technique the following outline may serve. It is a general form that I have used many times, always with different wordings as partly illustrated in the outline to be given. The outline is put into brief form and then remodeled to insure proper inclusions at the right places of general items of actual personal significance, but so that they cannot be recognized for their eventual significance, yet can progressively serve to validate the subject’s progress.

Thus the following might be used as one of the outline forms for the above illustration; to which, when put into use, are added many details with ready spontaneous modifications as determined by the subjects reactions.

<table>
<thead>
<tr>
<th>I am so very glad you volunteered to be a subject</th>
<th>Joint participation in a joint task</th>
</tr>
</thead>
<tbody>
<tr>
<td>You probably enjoyed eating today</td>
<td>Irrelevant—most likely factual</td>
</tr>
<tr>
<td>Most people do, though sometimes they skip a meal</td>
<td>A valid, commonplace utterance</td>
</tr>
<tr>
<td>You probably ate breakfast this morning</td>
<td>The temporal present</td>
</tr>
<tr>
<td>Maybe you will want tomorrow something you had today</td>
<td>The future (an indirect implication of a certain identity of the past and of today with the future)</td>
</tr>
<tr>
<td>You have eaten it before, perhaps on Friday like today</td>
<td>The past and the present and a common identity</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Maybe you will next week</td>
<td>The present and the future</td>
</tr>
<tr>
<td>Whether last week, this week, or next week makes no difference</td>
<td>The present, future, and past all equated</td>
</tr>
<tr>
<td>Thursday always comes before Friday</td>
<td>Irrelevant non sequitur, and valid</td>
</tr>
<tr>
<td>This was true last week, will be true next week, and is so this week</td>
<td>Irrelevant, meaningful, and true, but what does it mean? (Subject struggles mentally to put a connected meaning on all this future, present, and past, all included in a meaningful statement which lacks pertinence.)</td>
</tr>
<tr>
<td>Before Friday is Thursday and before June is May</td>
<td>How true: But note use of present tense in relation to today’s yesterday and to May.</td>
</tr>
<tr>
<td>But first there is “whan that Aprille with its shoures soote”</td>
<td>Here comes April of the past (remote past), and it also pinpoints a particular area in the subject’s life—his college days. (An item of fact predetermined—it might have been in high school—to introduce Chaucer creates a problem of relating it meaningfully to what has been said but this is a confusing task.)</td>
</tr>
<tr>
<td>And March followed the snows of February but who really remembers the 6th of February</td>
<td>Back now to March, then to February, and one does (present tense) remember February 12th, 14th, and 22nd. February 6th only offers confusion (It has been predetermined that February 6th is not a birthday or some such event but if it is meaningful, this serves only to impel the subject to validate that day also).</td>
</tr>
<tr>
<td>And January 1st is the beginning of the New Year of 1963 and all that it will bring</td>
<td>Thus is given a memory task. It will bring June (already here) but slipping unaccountably into the remote future because January is given a present tense.</td>
</tr>
<tr>
<td>But December brought Christmas</td>
<td>True, valid, vivid memories of the past December and the implied coming of the year of 1963</td>
</tr>
<tr>
<td>But Thanksgiving preceded Christmas, and all that shopping to get done and what a good dinner.</td>
<td>November 1962 with an impending urgency to do something in the coming December, an emotionally valid dinner memory, all of 1962. (And there have been many New Years, Christmases, and Thanksgiving Days, all strongly emotionally tinged)</td>
</tr>
</tbody>
</table>
From then on progressively larger steps based upon factual and valid events, Labor Day, Fourth of July, New Year’s Day, remembrance that a December of 1961 wish came true, and then finally the 21st birthday and college graduation all set up as a final culmination by the quotation from college Chaucer setting a goal for a specific regression in time and so early in the outline and so unrecognizably. But one is careful to use such a reference as Chaucer only after making sure when there was a reading of Chaucer. Similarly one might make reference to a song of a certain vintage. A few well-placed questions, even with total strangers, obscurely put, will yield much information around which the immediate details of the technique can be built. But bear in mind that while June is the present, it belongs also to all the past as well as to all of past birthdays for this subject, and also to all past graduations. In regression in time any small series of stated personally meaningful events can be used and subtly mentioned early in the procedure in some unrecognized form.

Originally, in the 1920’s, the Confusion Technique was used to induce hypnotic age regression. Numerous manifestations noted, at first by chance and then later by watchful observation, led to the realization that the technique could be variously employed to induce hypnosis itself or to elicit specific or isolated phenomena for either experimental or clinical purposes, and much experimentation was done.

**ILLUSTRATIVE EXPERIMENTAL PROCEDURES**

These studies led to a special experimentation when I attempted in 1932 and 1933 to expound the concept of a certain type of spatial orientation found in schizophrenia, which had interested me since 1929. I had much discussion of this topic with Dr. Govindaswamy, now deceased, a diplomate in psychological medicine and later superintendent at the mental hospital in Mysore, India, who was spending 15 months in the United States to study American psychiatry. In attempting to outline to him my understanding of how schizophrenic patients could conceive of themselves as simultaneously sitting in a chair looking out a window and at the same time lying on a bed with eyes closed, I realized painfully the inadequacy of my verbal explanation. He could not follow my explanation of the equality and coexistence of two separate spatial concepts of the self without an accompanying spontaneous comparison or contrast and a consequent evaluative judgment. Accordingly I volunteered to let him witness and participate in such an experience through the utilization of hypnosis, which was also a modality in which he was intensely interested. This particular instance is cited because it was so well recorded at the time and illustrates so clearly the building up of a Confusion Technique.

To accomplish this purpose, in a large vacant room I stationed two chairs and then Dr. Govindaswamy and myself in a 12-foot square arrangement, the chairs on one side, we two on the other. The respective positions for the chairs were A and B, those for us, C and D. Miss K, an excellent somnambulistic subject who had been used extensively in experimental work, was then summoned. (Miss K had been deliberately selected for the experiment because of her high intelligence, her quick-wittedness, her fluency of speech, and her remarkably acute ear for changes in voice inflection and voice direction.) All of
us are responsive, often unwittingly so, to a minimal change in the spoken voice when the head is changed to a different position and the voice thereby is given a new direction, and Miss K was unusually keen in this respect. One might recall to mind the common experience of the uninteresting lecturer who speaks to a spot on the back wall, contrasted to the interesting lecturer whose eyes roam constantly over the audience, thereby commanding their attention and giving each member of the audience the feeling that each and all of them are being addressed.

In Dr. G’s presence it was explained to her that she was to develop a profound somnambulistic trance in which she would be in full rapport with Dr. G as well as with me. Shortly Miss K opened her eyes and looked at me, passively awaiting further instructions.

While Dr. G listened and watched, the author pasted paper labels bearing in small characters the letters A and B on the respective chair seats, and Dr. G was asked to note, for himself that the east chair was labeled A and the west chair was labeled B. He was asked to take up his position north of chair B and to draw a small circle around his feet with chalk. The author stood 12 feet north of chair A and drew with chalk a small square about his feet.

During this procedure Miss K stood quietly, staring unblinkingly into space. She was then asked to sit down in chair A, which was nearest the author, facing the chair B, the one nearest to Dr. G. Miss K took her seat and again passively awaited further instructions.

Since this entire procedure was a specific experimental effort, full notes were to be made by both Dr. G and the author. (Also, without disclosing his intentions, the author excused himself to correct an oversight, left the room briefly, and secretly summoned Miss F, an assistant, who had worked previously with the author and was well trained in how to record in full his experimental procedures including both words and action. She was asked to remain out of sight behind a certain curtain but where she would have a good view and to make a full shorthand record of all events).

Slowly, distinctly, Miss K was told:

I wish to teach Dr. G something about geography [“spatial orientation,” as a term was purposively avoided] and I need your help. You are to do exactly as I say and nothing more, with one exception. [Italics here indicate a special inflection of slow, intense emphasis with a slight deepening of the voice.] That exception [no special inflection on this use of the word “exception” had been given] is this. You will note mentally and remember whenever I do something that Dr. G does not do and vice versa. This you will do separately and apart from all the rest you are to do, and tomorrow, when you do some typing for Dr. G and for me, these separate memories will come to your mind, and you will fit them into the typing you are doing without saying a word about it to either of us.
Now for today’s work. The special task I have for you to do is this: You are to sit right where you are continuously, continuously, continuously [the same special inflection used in the preceding paragraph with one exception was again used with the word “continuously”] without ever moving. Dr. G will watch you and so will I. Yet, I want you to know that that chair [pointing at A] you are in is here to you [pointing at B] is there, but to Dr. G this chair [A] is here and that chair [B] is there, but as we go around [the same special inflection mentioned above again being used for go around] the square, I am here and you are there, but you know you are here and you know I am there, and we know that chair [B] and Dr. G are there, but he knows he is here and you are there and that chair [B] is there and I am there and he and I know that you and that chair [B] are there, while you know I am here and Dr. G and that chair [B] are there, but you know that Dr. G knows that he is here and you are there and that chair [A] is there and that I am really there, and if that chair [B] could think, it would know that you are there and that Dr. G and I both think we are here and that we know that you are there even though you think you are here, and so the three of us know that you are there while you think you are here, but I am here and you are there and Dr. G knows that he is here, but we know he is there, but then he knows you are there while he is here.

All this was said slowly, carefully, impressively, while Miss K listened intently, and the author strove to record his statements and tried to give Dr. G an opportunity to record them. (His record was later found to be most confused and incomplete as was the author’s record, but fortunately Miss F obtained a full and accurate record because of her previous training in recording the author’s Confusion Techniques).

Shortly Dr. G appeared to be unable to record any of the author’s impressively uttered statements, glanced at and traced with his finger the chalk mark about the author’s feet. The instructions were continued:

And now Miss K, slowly at first and then more and more rapidly until you are talking at a good speed, explain to Dr. G that while he thinks he is here and you are there, that you are here and that he is there even as I think that chair is there and I am here and you are there, and just as soon as you are saying it rapidly and Dr. G is beginning to understand that he is here and you are there, still talking rapidly, you slowly change from this [pointing at A] chair to that [pointing at B] chair, but keep his attention on your explanation of how each of us can think be here and be there or be there and think be here and then when he sees you sitting there, and thinks you are here, gently return, still explaining and even laughing at him for thinking you are there when you are here, and then not recognizing that you are there while he is still thinking you are here.

Miss K then took over, first speaking slowly, then with increasing rapidity. At first Dr. G ceased to try to record, and it soon became impossible for the author to record Miss K’s rapid utterances identifying here and there variously employed.
At about this time the author noted horizontal nystagmus in Dr. G’s eyes, and Miss K, still talking rapidly, reiterating variously the author’s explanations of here and there, glided gently from chair A to chair B. Dr. G checked visually his chalk circle, the author’s chalk square, and suddenly shouted, “You are sitting here in this chair,” to which Miss K replied simply, “Yes, I am sitting here [changing places] in that chair there [changing places again].”

The horizontal nystagmus in Dr. G’s eyes became worse, and he seized a piece of chalk and walked hastily over and marked a small x in front of one chair and a small o in front of the other chair. The author promptly signaled Miss K with his right hand, pointed at the chalked x and o with his left hand, and made a covering movement with his foot. Miss K kept on talking here and there, gliding back and forth between the two chairs, sitting first in one and then the other, each time covering the x or the o with her foot while Dr. G said “You are sitting in the x chair—no, the x is gone but the o is there, so you are sitting in the o chair, but the o is gone (Miss K had quickly moved over) and the x is there, but the x is gone and the o is here and so you are there.”

His eye nystagmus increased greatly, he complained of severe vertigo, nausea and a painful headache. The experiment was discontinued, Miss K was aroused and dismissed, and the author deliberately began a continuation of the original question of dual spatial orientation in schizophrenia. Gradually Dr. G’s headache, nausea, and vertigo disappeared; he picked up his notebook, began to read, and seemed suddenly to have a partial sudden recollection of some of the experimental procedure.

He explained that as the author had given his original instructions about here and there he had experienced much confusion, but that when Miss K had taken over and increased the rate of her speech, he had felt himself becoming dizzy and that suddenly the room began turning around and around. This he had attempted to stop by making x and o marks, but those seemed to shift back and forth and to disappear unaccountably even though the chalk circle and square remained constantly present. He appeared to have no realization that Miss K had actually changed back and forth from one chair to another, only that the room kept whirling around with increasing subjective distress and confusion on his part.

The next day Miss K was asked to type her recollections of yesterday’s experimental procedure. She promptly developed a spontaneous trance and remained inactive. She was given instruction to recall and given a posthypnotic suggestion that she then type her recollections. She explained in the trance state, “I was so busy watching Dr. G and you and remembering here and there that I can’t remember. I was just concentrating on saying here and there in different ways and being sure of what was being said just to me and what was being said to both Dr. G and me by the inflections of your voice. When you first said “one exception” and then said I was to sit `continuously, continuously, continuously’ with that same inflection three times, I knew you were saying one thing to Dr. G but something different to me, and I had to watch for it (the inflection) again because I knew you meant something special.”
Nevertheless in the waking state Miss K readily typed my notes and Dr. G’s, but it was noted that she apparently developed brief spontaneous trances whenever she inserted parenthetically various items in both Dr. G’s record and mine, arousing spontaneously and continuing her typing without apparently noticing the insertions. (Much later I thought of time distortion and its possible bearing on Miss K’s spontaneous trances and parenthetical insertions in her typing without there being any interruption of her typing. Perhaps, even quite possibly, she relived in distorted time the events of the previous day despite her trance assertion of inability to remember. These parenthetical insertions were less complete, but in good accord with Miss F’s full record).

In Dr. G’s effort to record Miss K particularly noted his failure of recording certain notes, his marking of the x and the o, his glancing at and fingering the chalk circle about his feet and glancing at the square about mine, and his apparent confusion when he emphatically announced that she was sitting in chair A and then noting that she was actually in chair B without having noticed her shifting of her position. She also noted his confusion about the appearance and disappearance of his marks of x and o, and she had observed the nystagmus. (This latter Miss F did not note—she could not see it—but she did note unsteadiness and arm waving as if to keep his balance. This latter Miss K also noted). She also noted many gaps in the author’s record because of his intense concentration on the task and correctly interpreted the author’s notations of x and o and his writing of them crossed out or not crossed out as meaning “covered up” and “in view.”

Miss F’s account was fully comprehensive but could not be read by Dr. G, despite repeated attempts, without developing vertigo, nausea and a headache. (This recurrent reaction is a most suggestive experimental induction of profound psychological and physiological responses.) Reading by Dr. G of his record with Miss K’s parenthetical insertions elicited sudden but not complete recollections, such as, “That’s right, she did change chairs, only I didn’t see her do it,” and “She put her foot on the x, that’s why it disappeared.” However he could not fully recall the entire experience. After this experiment Dr. G sought out schizophrenic patients who showed altered spatial orientation for special interviews and explained that their assertions had become much more meaningful to him. He also expressed much sympathy for certain patients who complained of distress from altered spatial orientation. It may be added that he was unwilling to be a hypnotic subject, but he did inquire several times if he had been hypnotized on that occasion. An evasive answer each time seemed appropriate to the author and was each time readily accepted by Dr. G. That he did not want to know with certainty is a reasonable interpretation.

As a further test of this procedure with Dr. G it was employed separately on three other subjects, all having doctoral degrees in clinical psychology. The first such subject, Mr. P from Princeton University, personally disliked the author but was an ardent experimentalist who did not let his emotions interfere with his work. In fact he tended to dislike far too many people, but would collaborate wholeheartedly with them in experimental work.
The second subject, Miss S of Smith College, was interested in hypnosis but opposed for no reason that she knew to being a subject. She had observed others going into a trance unexpectedly without having been asked to do so or without volunteering while observing the induction of a trance in volunteer subjects. She had remarked to the author that she was too wary to allow this ever to happen to her, and when asked what she would do if it were to happen, she replied, “Once would be enough. Then I’d see to it that never did again.”

Mr. Y of Yale University had done some work with Hull, had tried many times to go into a trance as an experimental subject, and had never succeeded. Hull termed him an “impossible subject.” While he was highly intelligent and extremely capable of working out an adequate protocol for controls, subjects, and procedures, he always insisted on a few rehearsals of his experiments with nonsubjects, even in simple nonsense-syllable learning experiments.

All of the subjects, including Dr. G, were in the age range of 27 to 31. Exactly the same procedure was employed with them as had been followed with Dr. G. Separately with each of them the author had discussed the problem of spatial orientation as observed in some schizophrenic patients and then proposed the possibility of doing a hypnotic experiment on the matter by using one of his subjects. Each was interested and expressed interest in being an observer.

Exactly the same procedure as had been employed with Dr. G was followed, with the exception that the term “spatial orientation” was used instead of “geography” as had been done with Dr. G. The reason for this was that in Dr. G’s case the author did not know just what Miss K would understand by “spatial orientation,” but he did know that she understood the game of “I am here and you are there and New York is there,” etc.

Another difference was that Miss F had read all the reports on Dr. G and was placed so that she could observe the subjects’ eyes and still be out of their sight. Secretly Miss K had been given hypnotic instructions to have an amnesia for Miss F’s presence. Much rereading of the Dr. G record enabled the author to proceed with greater ease and comfort, and both Miss K and Miss F were better qualified for their tasks, having done it once.

The results obtained with all three subjects were comparable to those secured from Dr. G with minor individual differences. None used the chalk, as available to them as it had been to Dr. G, to mark an x or an o to identify the chairs A and B. Each personally inspected the seat of the chair on which the author pasted the letters A and B. Mr. Y made this inspection three times for each chair, while Dr. G merely accepted the author’s statement. Miss S and Mr. P merely watched the author draw the chalk circle and square about their feet and his, but Mr. Y glanced back and forth at the circle and square.

With Dr. G a little over an hour elapsed before the experiment was concluded. With Mr. P, who was the first of the three to be used, 35 minutes were sufficient. Miss S was the second, and 45 minutes were needed. Mr. Y needed only 25 minutes.
All three developed nystagmus, Mr. P and Mr. Y by their movements manifested vertigo, Miss S complained verbally of feeling dizzy.

None noticed Miss K slipping back and forth from one chair to the other.

Mr. P was noted to become angry first at Miss K and then at the author in addition. Miss K’s record and that of Miss F typed the next day showed respectively (getting angry me), (more angry) (still angrier me and Dr. E) (yelling at us) (furious) and (getting mad at K) (madder), (really mad both), (yelling and then screaming at both Miss K and Dr. E).

Miss S was noted by both suddenly to glance about the room in a bewildered way and to complain of a severe headache and general physical distress.

Mr. Y was noted to keep moving his arms about as if to balance himself as his nystagmus grew worse. Then suddenly he closed his eyes and stood passively, presenting the appearance of a deep hypnotic trance.

The experiment for Mr. P was concluded by signaling silence to Miss K and stepping over to Mr. P and gently leading him outside the experimental room, closing the door behind us, the author resuming the conversation of spatial orientation at the point that it had just reached at the moment of beginning to open the door of the experimental room to perform the experiment. This had the effect of reorienting him in time to the moment at which we were about to enter the experimental room and had the effect of arousing him from an obvious hypnotic trance and with an amnesia for that trance state. Glancing at my watch I remarked that we had spent so much time in discussion that the experiment would have to be postponed, and the suggestion was offered that arrangements would be made at a later date. He was dismissed in an ordinary waking state.

The same procedure was employed with Miss S and Mr. Y with similar results.

These experiments were all done in one day, and assignments were so arranged that there was no opportunity for the three to meet that day.

The next day Miss K and Miss F typed up their respective reports on each subject. After reading them through and comparing them with each other and with the author’s own memories, they were set aside for several days.

However, the next day Miss S came to the author with a peculiar complaint to the effect that she had to get some material out of the “Observation Room” but that she had developed “a peculiar phobia all of a sudden.” This was a fear of entering that room (it had been the experimental room), and when she had forced herself to open the door, she had developed an excruciating headache. She wanted to know what was wrong. The answer was given that she was a clinical psychologist and had just described a phenomenon that she might like to explore on her own for a day or so, especially since she had said the headache had disappeared immediately upon closing the door.
Care was taken to have adequate contact with Mr. P and Mr. Y. Nothing new or unusual was noted. Nor was anything of note observed by Miss F or Miss K.

That weekend each was called separately into the office and each was given the accounts of the other two subjects to read. Each read those accounts with interest but with no seeming recollection of their own experience. They all thought the whole procedure was a most interesting, complicated hypnotic experiment and asked if they might be present to observe, should the author ever repeat the experiment. Each was then handed the record on Dr. G. Before each had finished reading the account, they realized that Dr. G referred to Dr. Govindaswamy. They then took the other records and studied them, speculating upon the possible identities of the other subjects without any success (each had been given the initial of the institution from where they came). Only Miss S ventured the speculation that Mr. P’s record sounded like something Dr. M (Mr. P’s actual initial) would do, but she went no further than that in her speculation.

Each was given his own record to read. Mr. P read his and commented that he would probably feel the same way if that sort of thing were done to him.

Mr. Y’s only comment was, “Well, that chap figured out a good escape for himself.” Miss S read and reread the record on her with utter intentness and with an expression of growing understanding on her face.

Finally she looked up at the author and said, “So that’s it. No wonder I had that phobic feeling and developed a headache. This is a record on me—”. With this she jumped up from her chair, rushed down the corridor, and returned in a few minutes to report, “It’s me, all right, I’m dead sure. I have a total amnesia, but I’m afraid of that room. I got a headache the moment I started to open the door. It vanished when I yanked the door shut. But I still don’t remember a thing about it, but I am completely convinced that this is a record on me.” Then she demanded, “What are you going to do about my phobia and headache?”

Reply was made, “That will be very simple. I can deal with it effectively, but I would like to do it in a way most instructive to you.” Very warily she said, “And what is that?” My reply was to pick up the telephone and ask Dr. T (Mr. Y) to come to my office. Upon his arrival I asked him, “Do you mind showing Dr. W (Miss S) something?” He agreed readily, and the three of us walked down the corridor to the “Observation Room.” There I suggested that we all enter it, and would Dr. T go first? He did so readily, but immediately developed a deep trance state as he entered the room. Motioning to Dr. W to step back out of sight, I stepped inside, took Dr. T by the arm, gently led him outside, and resumed my original discussion of spatial orientation, again reorienting him to the time of the original approach to that room. He wakened with a total amnesia, and I commented that it was really too late to attempt an experiment that day. We returned to my office with Dr. W following discreetly behind me. I signaled her to enter the office, and as we all took seats I handed him the report on himself. He glanced at me quizzically, at the record casually, and then with a look of bewildered amazement practically shouted,
“That’s me, that’s me.” He added, “That happened last Monday, and when we came into the office, I was still thinking it was Monday.”

Dr. W remarked, “And this record on Miss S is mine. When I saw that massive recollection by Dr. T, I experienced the same phenomenon.” She paused thoughtfully, darted out of the office, and shortly returned to ask, “Why don’t I have the phobia and headache now?”

Reply was made that much earlier she had commented that she was “too wary” to allow an unexpected trance induction in her, but that if it ever happened, she would see to it that it never happened again. Hence her own unconscious mind had prevented her from entering the room where she had unwittingly gone into a trance lest a spontaneous trance such as Dr. T had just demonstrated might occur. This possibility her unconscious mind appreciated, hence her “protective phobia.” This had led her immediately to seek out the author when she could have gone to a number of other physicians. Thus her unconscious had recognized that he was responsible and that the reply he had made carried an implication that there was no danger but an opportunity to learn. Hence she had readily accepted the statement that since she was a clinical psychologist, she could spend a few days thinking about it. By implication this signified that her phobia and headache could and would be corrected.

Then when she witnessed Dr. T’s massive recollection, she was unconsciously impelled by her own spontaneous massive recollection to put it to test by dashing to the Observation Room and entering it with no fear of unwittingly developing a spontaneous trance.

The question then arose about Mr. P, about whom Dr. W immediately declared, “When Dr. M read that account of Mr. P, he said that was just the sort of a response he would make in such a situation. Let’s call him in, and how shall we handle it?”

The author suggested that when Dr. M arrived, he would hand each of them their own records, asking them to reread them and that the author would sit so that he could see the page numbers on Dr. M’s record. They were told that all three of them would be instructed to reread the records previously read by them, but that they (Dr. W and Dr. T) were to turn pages as if they were being read, but that they should primarily watch Dr. M’s face. Then when the author cleared his throat, Dr. W was to say quietly, “I am Miss S,” whereupon Dr. T would follow suit by saying, “I am Mr. Y.” Dr. M read the record of Mr. P assiduously, and when he reached the place at which Miss F described Mr. P as “yelling and screaming at Miss K and Dr. E,” the author cleared his throat and Drs. W and T made their remarks. Dr. M started violently, flushed deeply, and in a tone of utter amazement, he declared, “Wow! I certainly was raging mad right then”.

He went on, “The whole thing is completely clear now in my memory. All week I’ve been haunted with a feeling that I knew something that I didn’t know. No wonder I said that I would act like that fellow if that sort of thing were done to me.”
Immediately Dr. W took Dr. M’s hand and led him down the corridor to the Observation Room. She opened the door and asked him to step inside. Dr. M unhesitatingly walked in, looked around, and remarked, “That’s right. This is where it happened.” Thereupon he began to reconstruct verbally from memory the original experimental management of the room.

Thus did Dr. W demonstrate to her satisfaction that unconscious knowledge shared with the conscious mind would preclude a spontaneous trance such as Dr. T had developed. She asked what would have happened had she gone into the Observation Room before recollection had been made possible for her. She was told, “You would have developed a spontaneous trance, recognized that face unconsciously, and then you would have aroused immediately with most unkind thoughts and attitudes toward me, and it would have taken a long time to get back into your good graces.”

Later Dr. W sought hypnotherapy for chronic dysmenorrhea accompanied by a severe headache; Dr. T acted as a subject in various experiments, and the attitude of Dr. M became much more friendly toward the author.

**ILLUSTRATIVE CLINICAL PROCEDURES**

Almost exactly the same technique of here, there, this, and that has been used repeatedly by the author for clinical purposes. Patients who enter the office and state frankly that they are resistant or who merely manifest an overt resistance to therapy and yet are obviously seeking it are offered the casual comment that as they sit in that chair they are resistant, but would they be resistant were they sitting in this other chair, or would they be nonresistant in this chair and thus leave their resistances in that chair they now occupy; that they can mentally consider changing chairs and sitting here in this one and leaving resistance in that chair there or sitting in that chair there while their resistance remains here in this chair here; that they might try sitting in that other chair there without resistance and then coming back here to this chair here and taking up their resistances either to keep or to leave them there in this or that chair or here or there with as much and as varied repetition as is needed.

Thus they are given a confusion in relation to their resistances and in a manner inexplicable to them. There results an unwillingness to keep the confusion, and hence they tend to relinquish their resistances and to cooperate with the therapy they are seeking. Sometimes a trance ensues, sometimes not, depending upon the intensity of their needs.

Clinically the Confusion Technique has been used in various other instances. Two such cases will be cited, similar in character, both seeming to be suitable patients for a Confusion Technique and each having a similar complaint. One was a 28-year-old woman, the other a 45-year-old man. Both complained bitterly of a complete hysterical paralysis of their right hand whenever an attempt was made to use it in writing. Both had positions requiring writing, and both were right-handed. In all other relationships and activities there were no right-handed difficulties, not even in typing. But a pen, a pencil, a
stylus, or even a large stick with which to outline on the floor their names, a letter, or even a line, straight or crooked, resulted in a completely rigid paralysis of the right hand. Like all such patients this author has seen and has had reported to him by colleagues, both patients were adamant in their refusal to learn to write left-handedly, even to sign their names. Experience has also taught the author that any insistence upon learning to write left-handedly is likely to cause the loss of the patient, an experience also reported by colleagues.

Remembering the old childish game, “Put your right hand in front of you over your heart; now really pretend to throw away your left hand by putting it behind you. Now, which hand is left?” Inexplicably to the child, he finds himself in the difficult position of describing his right hand as his left hand. Furthermore, one can only write right from left to right, one cannot write right from right to left and write is not right nor is right write while left, though left, can write though not be right, yet left and write right from right to left if not from left to right.

With this sort of thinking in mind an extensive history was taken (actually not really extensive, since such patients in the author’s experience are definitely restricted in the personal information they can offer) to obtain items of personal significances.

Another appointment to give the author adequate opportunity to work out a technique was given each patient.

In this preliminary preparation careful outlines were made in which to include meaningful personal items as irrelevances in a Confusion Technique centering around the words right, left, and write, intermingled with minor personal details to make them applicable respectively to each patient.

The woman was the first patient, and as the Confusion Technique was gradually intruded into the initial casual conversation, she became increasingly confused and uncertain, and finally developed a good trance state when told in prolonged detail that “it is right and good that your left hand is now on the right (it had elaborately and quite forcibly been placed by the author on her right shoulder) and that your right hand which cannot write is on the left (thigh, thus to establish a specious anatomical relationship). And now your right hand that cannot write is on the left, you have the hand on the right (shoulder) to write.”

With further elaboration and repetition, and several further trances with carefully worded posthypnotic suggestions, the patient made a permanent transfer of her right-handed writing disability to her left hand, to which was added by posthypnotic suggestion “a peculiar, not unpleasant, but interesting dollar-size spot of coolness on the back of your left hand.” Three years later she was still working steadily, still had her left-handed paralysis whenever she attempted so much as to pick up a pencil with it, and the “cool spot” was still present and a source of childishly intense pride. Clinically she was regarded as a therapeutic success, although there was much about her that warranted change but with which she was entirely satisfied—for example, her extreme untidiness in
her housekeeping and her extreme tardiness in her many social activities such as arriving two hours late for a birthday dinner prepared for her by a friend who had made repeated telephone calls to speed her arrival and to avoid keeping the other guests waiting. Nevertheless she was well-liked or at least extremely well tolerated, and she continued to be adequate with respect to right-hand functioning.

An even more carefully devised Confusion Technique was worked out for the man, who was of decidedly superior intelligence, a more difficult problem, and much quicker-witted. Since his work involved insurance, the words “insurance, assurance” insure, assure, reinsure, and reassure were intermingled with write, right, left, and fortuitously a relative of his was “named Wright but was not a wheelwright, though he could wheel right around right and thus go left which would be right.” In other words the more difficult technique simply involved a more elaborate play on words and more utilization of various items taken from the patient’s history together with quicker and more confusing changes of tense. In no way could there be secured a shift of his disability from right hand to the left. However, it was possible in the trance state to get him, perhaps as a measure of escaping his confusion, to accept his disability resignedly, to give up struggling to overcome it, and to accept a promotion previously offered him many times which did not require writing, and which he had consistently refused on the grounds that “I’m going to lick this thing [the writing disability] even if I never do anything else.” He was also rated as a therapeutic success even though several years later he again sought out the author for another attempt at therapy for his writing disability, but he was easily put off with a promise to try again when it was most convenient for him. To date he has found no convenient time.

VARIOUS REACTIONS TO CONFUSION TECHNIQUES

The first Confusion Technique discussed in this article, which was also first worked out by the author to involve a time disorientation, offered a relatively easy means for the development of confusion and to use the confusion to elicit age regression. However, careful observation of such use soon disclosed other possible variations and applications. Accordingly a whole series of procedures was worked out, first in outline form and then by filling in details permitting the evocation of a state of hypnosis of specific phenomena and of isolated phenomena.

Another item of particular interest in regard to the Confusion Technique is the reaction of both experimental and clinical subjects. The latter, because of their therapeutic ‘motivation, often lose their resistances and simpler techniques can then be employed. Occasionally, while resistances persist, they do not seem to mind repetitions of the same or varied forms of the Confusion Technique.

With experimental subjects the reactions vary greatly and sometimes in an intriguing way. For example, Miss K had had many variations of the Confusion Technique employed on her, and she always responded readily to the same or to variations of it. Additionally in the trance state she was much more adept than the author in using a
Confusion Technique on other subjects, and it mattered not whether it had been used on her or merely, as above, described for the first time to her in the trance state.

In Miss F’s case she too responded repeatedly to the same or other Confusion Techniques. However, she could not use a Confusion Trance when she was either in or out of hypnosis. In fact most subjects while in a trance and who have been hypnotized by a Confusion Technique seem unable to use it, although in the trance state they will use successfully the ordinary traditional techniques even when they fail to be able to induce a trance in the waking state. Indeed long experience has disclosed that the easiest and quickest way to learn to induce a trance is to be hypnotized first, thus to learn the “feel” of it.

It is also of interest that subjects who respond readily and repeatedly to Confusion Techniques are likely to develop a trance while listening to a Confusion Technique being used on someone else. Miss K and Miss F, however, were remarkably competent secretaries and could listen to the Confusion Technique previously used on them and later record that same technique being used word for word upon someone else, making a complete record with no hypnotic response on their part. Apparently the presence of their sharpened pencils and the task constituted an adequate counterset against any hypnotic response. Also, upon request, both could record in shorthand in the trance state the Confusion Technique used on someone else. It is of interest to note that the measure of using a Confusion Technique to induce a trance in them, and then having them in the trance state record the use of the same technique on others with slight subtle alterations pertaining to them as persons did not affect their trance state or ability to record.

Miss H and Mr. T were excellent subjects for either traditional or the Confusion Techniques. However, after a few experiences with the Confusion Technique they reacted by bypassing it and developing a trance at once, no matter how subtly the author made his approach. As they would explain in the trance state, “As soon as I experienced the slightest feeling of confusion, I just dropped into a deep trance.” They simply did not like to be confused. Neither of these subjects, fully capable with more common techniques, could seem to learn to use a Confusion Technique or even to outline a possible form. There were others who responded similarly.

Mr. H (no relative of Miss H) responded readily to various Confusion Techniques, spontaneously discovered that he could use them in the trance state and that he could conduct experiments on other subjects while he was still in the original trance I had induced in him by a Confusion Technique, and later investigate his waking capacity to devise and use effectually Confusion Techniques. In this connection his first spontaneous discovery of his capacity to use a Confusion Technique will be related here as an interesting and informative example.

Professor M at Yale University was highly critical of Clark L. Hull’s work there and most disbelieving of hypnosis as an actual phenomenon. He sought out the author for further enlightenment about hypnosis and to see if the author could duplicate some of the hypnotic studies being made at Yale University. He was a psychologist himself, had
never done any hypnotic work, and was not yet convinced of the validity of hypnosis by the studies to date at Yale. He was frank and free in his statements of his understandings and asked if the author would demonstrate hypnosis to him and perhaps duplicate some of the things, that had been done by Hull and his students.

After some thought the author agreed and summoned by telephone two excellent somnambulistic subjects. Upon their arrival they were introduced to Professor M, who explained simply and fully his attitudes and wishes. Both subjects expressed a willingness to do anything he wished if the author approved.

This approval was given by suggesting to Miss R, who had a Ph.D. in psychology, that she hypnotize Mr. H and demonstrate hypnotic phenomena fully, in accordance with Professor M’s request. The author then excused himself, after explaining to both Miss R and Mr. H that they would remain in rapport with the author despite his enforced absence at that time to work on an ergographic study of fatigue abolishment by hypnosis which was under way with another colleague. It was also added that the author would be absent for about an hour, possibly more, hence Miss R could take her time in whatever Professor M wished.

When the author returned about an hour later, he was confronted by a bewildering sight. Professor M was sitting at the desk ineffectually trying to make notes with a bemused and puzzled expression on his face. Miss R, who had been told to hypnotize Mr. H, was most obviously in a deep somnambulistic trance. Mr. H was also in a deep somnambulistic trance. Only Mr. H retained rapport with the author, manifesting it by looking up at the author as the author entered the room. Miss R apparently was unaware of the author, despite the fact that her eyes were wide open, and the author had immediately asked, “What has been taking place, Miss R?”

Her failure apparently to hear the author and the total situation itself suggested that a record be made of the situation. Miss K was immediately summoned, and upon her arrival with notebook and pencils the author stated, “Maintain the status quo. Now Mr. H, are you in a trance? And is Miss R in a trance?” To both questions H answered “Yes.” “Are you both in rapport with me?” “No.” “Who is, and why?” “Just me. I told Miss R to be in rapport only with me.”

The author immediately said, “Stay as you are, maintain the status quo, do nothing more. I am taking Professor M out of the room for a while, and the two of you remain as you are, inactive. Is there any comment you wish to make about Professor M?”

Mr. H said simply, “He recognizes hypnosis as a genuine thing now,” but made no response to the presence of Miss K or the professor.

Professor M, Miss K, and the author went into the next room. Systematically Professor M was asked what had happened.
In summary he explained that Miss R had induced a “deep trance” in Mr. H by hand levitation and had then used him to demonstrate anaesthesia, catalepsy, amnesia, positive and negative ideomotor and ideosensory phenomena, hypermnesia, posthypnotic suggestions, trance awakening, and reinduction.

In relation to each of these demonstrations she had asked Professor M to make his own tests of each phenomenon. This had convinced him that he was observing a most interesting and valid phenomenon.

When Miss R reinduced hypnosis in Mr. H, Professor M stated that Miss R had asked Mr. H if there were anything else that might be done to instruct Professor M. Mr. H had answered with a simple “Yes.” She then asked if he would do it. Again he replied with a simple “Yes,” but made no move of any sort. She had then asked, “Well, what is it?” To this he replied, “Can’t tell, just do!”

The professor then said;

“That was when I really got my eyes opened. Mr. H slowly got up out of the chair where he was sitting, his eyes open and unblinking, pupils dilated and apparently lacking in peripheral vision. He walked over to Miss R, took her hand very gently, lifted it up slowly, and softly told her to go deeply asleep in a deep trance. Then, when she started to say something, he began to talk in a very confusing way about you and me and Miss R and him and hypnosis and demonstration and ergographs and phenomena, and I got so confused that I didn’t know what was happening until I suddenly realized that Miss R was in a trance and that he was too. Neither one took any notice of me, and he asked Miss R to do a lot of things comparable to what she had him do, but he added some. For example he told her to awaken with an amnesia for her name and whereabouts. At first I thought she was awake and I asked her her name, but she didn’t seem to hear me, and Mr. H didn’t seem to hear me either. I shook them both by the shoulders, but they made no response. Then she seemed to be frightened, so he told her to sleep deeply and feel comfortable and at ease. I was trying to think this through when you came in. I guess from the questions you asked, you grasped the situation.”

We returned to the room where Miss R and Mr. H were waiting passively.

Mr. H was told to awaken. He did so at once, and a few simple questions disclosed the fact that he was reoriented in time to the author’s announcement of his impending departure for the ergograph experiment.

The author then spoke to Miss R, but she failed to make any response. Mr. H looked astonished and bewildered, but before he could say anything, the author quickly intervened and asked Mr. H to tell Miss R to listen to the author. This he did, and the author said, “Is there anything you would like to say to me now that I have come back?” (This was a disguised instruction for her to arouse from the trance state.)
Her reply was one of instant arousal with a temporal orientation to the time at which she had reinduced the trance state in Mr. H. She replied simply that she had demonstrated all the usual phenomena to Professor M but that the author might wish to take over, explaining that Mr. H was still in a trance. Immediately Mr. H declared, “No, you are the one in a trance. I just had to transfer rapport to Dr. Erickson so he could talk to you, and he hasn’t yet told you to rouse up from the trance.”

In bewilderment she answered, “No, you are in a trance, but I don’t understand your behavior.”

For another hour we let the two of them try to solve the situation while Miss K took notes.

Both had amnesia for their own trances, both believed the other to be in a trance, both could recognize that the other was behaving as in a waking state, and neither could elicit trance behavior from the other, nor could they even agree on the time. (I had confiscated Miss K’s and Professor M’s watch and removed mine, an neither of them had a watch.)

Miss R was certain that I had just returned after an hour’s absence, and Mr. H was equally certain that the author was about to depart and Miss R about to begin her task. Both could not understand Miss K’s presence and her note taking, nor could they understand the refusal of Professor M and the author to clarify matters.

Finally they were dismissed, still arguing, and Miss K typed up her complete records. Later Professor M made another visit, and they and Miss K were summoned. To Miss R and Mr. H the issue was still unsettled, and neither seemed able to follow with recognition their respective trance experiences when reading Miss K’s typewritten account.

However, interviewed separately in a deep trance state, both recalled all trance events, except that Mr. H had to ask Miss R to reestablish rapport with the author at the time he had withdrawn it before she could continue to relate her experiences at the author’s request.

Posthypnotic suggestion to them both that they recover full waking memories of their total experiences were successful, and this established a most extensive topic of discussion with them and between them and others.

As for Professor M, he later did extensive experimental work with both Dr. Hull and the author.

Several years after this incident with Miss R and Professor M, for no known reason, Mr. H lost completely for a number of years his interest in, but not his respect for, hypnosis.

Then one day he was confronted with the statement by the anaesthesiologist and the surgeons that an elderly friend of his, absolutely needing a serious operation, would not survive the combination of surgical shock and chemoanaesthesia. Since Mr. H then had
his medical license, he persuaded the reluctant surgeons to operate upon the patient while he used a Confusion Technique to induce a trance state and then a spatial and situational disorientation to effect a hypnoanaesthesia, and the patient underwent extensive abdominal surgery while hypnotically hallucinating a visit at home with Dr. H. His reason for using the Confusion Technique was that the patient and her relatives had been informed that surgery would result in nonsurvival. The patient actually made an excellent recovery, and Mr. H, or rather Dr. H, now uses hypnosis extensively. But he does not want to go into a trance nor can he give the author any explanation of why this is so, nor can he explain his long period of personal disinterest in it.

There is also another type of subject who first reacts well to the Confusion Technique and then turns violently against it. This can be best illustrated by the following eloquent statement:

I have always felt somewhat annoyed and distressed by the Confusion Technique, and I have resented its use, but initially I was willing to listen and cooperate as best I could. Part of my resentment was undoubtedly due to my own mental pattern of thought; I always like to grasp each idea and organize my thoughts before proceeding. However, I went along with the confusion suggestions and I know they worked on me, although not as well as other techniques did.

At the present time they will not work on me. No matter how deep a trance I am in and how cooperative I am, I simply stop listening if that type of suggestion is begun. Nor will I make any pretense of listening. If the operator insists on keeping on talking, I shut off my hearing (self-established hypnotic deafness) and I may wake up—feeling strongly annoyed.

I can pinpoint the changeover from unwilling and somewhat resentful compliance to flat refusal to listen to any confusion suggestions. One day I was trying to decide whether or not I ought to disclose to the operator some information—I am not certain what it was, but I believe it was some information about the work at hand concerning which I was not sure whether or not I ought to disclose it. The operator was seeking that information and suddenly tried a tactic to confuse my thinking—namely, a topic to distract me was mentioned as I was preoccupied with something else, and the operator felt that the information was urgently needed. I cannot remember the confusing way in which the operator urgently demanded the information and attempted to distract me. I felt a surge of anger—I did not reply. Upon thinking it over now, I realize that I thought the tactic was unfair—trying to rush and confuse me into replying instead of allowing me to make a decision based on my considered judgment. I realized, too, either right then or possibly the next time the Confusion Technique was attempted on me, that it was basically the same thing, and it made me angry, too. I’m all through with it. It won’t work again.

Such indeed is the case. Yet for other techniques this subject is remarkably responsive. And as the careful observer will note, both experimental and clinical subjects often have
definite preferences which should be respected. Thus one subject may object strenuously to a relaxation technique but like the hand-levitation technique and at another time be responsive only to yet another technique.

**VALUES OF CONFUSION TECHNIQUES**

The values of the Confusion Technique are twofold. In experimental work it serves excellently to teach experimenters a facility in the use of words, a mental agility in shifting their habitual patterns of thought, and allows them to make adequate allowances for the problems involved in keeping the subjects attentive and responsive. Also it allows experimenters to learn to recognize and to understand the minimal cues of behavioral changes within the subject.

Clinically it is of much value with patients desperately seeking therapy but restricted and dominated by their clinical problem and uncontrollable resistances which prevent the initiation of therapy. Once these resistances are circumvented, there is then the possibility of securing the patients’ cooperation in correcting both their clinical problems and dissipating the resistances. A final value is that long and frequent use of the Confusion Technique has many times effected exceedingly rapid hypnotic inductions under unfavorable conditions such as acute pain of terminal malignant disease and in persons interested but hostile, aggressive, and resistant.

Perhaps it would be well to give an example of a Confusion Technique used in handling resistant, disbelieving cancer patients, one suffering continuous pain and one suffering from irregularly periodic bouts of excruciating pain lasting from 10 to 30 minutes and often longer. In this author’s experience the only real difference lies in the patients themselves, since essentially the same technique can be used on either type of patient with slight modifications to make it more personally applicable.

One patient suffering continuous pain with numerous metastases throughout her body was highly resentful over her impending death, unwilling to accept narcotics because she received no relief unless made stuporous, and she was most eager to spend all the time possible with her family. Her entire family had adverse religious ideas about hypnosis, even though it had been recommended by her family physician, a member of her faith. Fortunately the family was convinced by the printed words in a medical book, an article in an encyclopedia, and a personal letter to the author from a missionary of her faith telling of the successful use of hypnosis on her converts in treating them medically.

The other patient was a man in his 50’s, who suffered at irregular but frequent and unexpected intervals from bouts of excruciating pain that were becoming progressively longer, ranging from 10 minutes to one hour, but with short bouts becoming fewer and the long bouts becoming increasingly more frequent.

His attitude was one of scornful disbelief and mockery as well as bitter resentment at his fate and a hostile attitude toward everyone, especially the medical profession for being so “stupid about cancer.”
At all events the same general Confusion Technique was used, except for the special references of personal implications.

The approach was;

You know and I know and the doctors you know know that there is one answer that you know that you don’t want to know and that I know but don’t want to know, that your family knows but doesn’t want to know, no matter how much you want to say no, you know that the no is really a yes, and you wish it could be a good yes and so do you know that what you and your family know is yes, yet you wish that yes could be no and you know that all the doctors know that what they know is yes, yet they still wish it were no. And just as you wish there were no pain, you know that there is but what you don’t know is no pain is something you can know. And no matter what you knew no pain would be better than what you know and of course what you want to know is no pain and that is what you are going to know; no pain. [All of this is said slowly but with utter intensity and with seemingly total disregard of any interruption of cries of pain or admonitions of “Shut up”.] Esther [John, Dick, Harry, or Evangeline, some family member or friend] knows pain and knows no pain and so do you wish to know no pain but comfort and you do know comfort and no pain and as comfort increases you know that you cannot say no to ease and comfort but you can say no pain and know no pain but you can say no pain and know no pain but know comfort and ease and it is so good to know comfort and ease and relaxation and to know it now and later and still longer and longer as more and more relaxation occurs and to know it now and later and still longer and longer as more and more relaxation and wonderment and surprise come to your mind as you begin to know a freedom and a comfort you have so greatly desired and as you feel it grow and grow you know, really know, that today, to-night, tomorrow, all next week and next month, and at Esther’s [John’s] 16th birthday, and what a time that was, and those wonderful feelings that you had then seem almost as clear as if they were today and the memory of every good thing is a glorious thing ....

One can improvise indefinitely, but the slow, impressive, utterly intense, and quietly, softly emphatic way in which these plays on words and the unobtrusive introduction of new ideas, old happy memories, feelings of comfort, ease, and relaxation are presented usually results in an arrest of the patients’ attention, rigid fixation of the eyes, the development of physical immobility, even catalepsy and of an intense desire to understand what the author so gravely and so earnestly is saying to them that their attention is sooner or later captured completely. Then with equal care the operator demonstrates a complete loss of fear, concern, or worry about negative words by introducing them as if to explain but actually to make further helpful suggestions.

And now you have forgotten something, just as we all forget many things, good and bad, especially the bad because the good are good to remember and you can remember comfort and ease and relaxation and restful sleep and now you know
that you need no pain and it is good to know no pain and good to remember, always to remember, that in many places, here, there, everywhere you have been at ease and comfortable and now that you know this, you know that no pain is needed but that you do need to know all there is to know about ease and comfort and relaxation and numbness and dissociation and the redirection of thought and mental energies and to know and know fully all that will give you freedom to know your family and all that they are doing and to enjoy unimpeded the pleasures of being with them with all the comfort and pleasure that is possible for as long as possible and this is what you are going to do.

Usually the patients’ attention can be captured in about five minutes, but one may have to continue for an hour or even longer. Also, and very important, one uses words that the patients understand. Both of the above patients were college graduates.

When such cases are referred to me, I make a practice of getting preliminary information of personality type, history, interests, education, and attitudes, and then in longhand I write out a general outline of the order and frequency with which these special items of fact are worked into the endless flow of words delivered with such earnestness of manner.

Once the patients begin to develop a light trance, I speed the process more rapidly by jumping steps, yet retaining my right to mention pain so that patients know that I do not fear to name it and that I am utterly confident that they will lose it because of my ease and freedom in naming it, usually in a context negating pain in favor of absence or diminution or transformation of pain.

Then one should bear in mind that these patients are highly motivated, that their disinterest, antagonism, belligerence, and disbelief are actually allies in bringing about the eventual results, nor does this author ever hesitate to utilize what is offered. The angry, belligerent man can strike a blow that hurts his head and not notice it, the disbeliever closes his mind to exclude a boring dissertation, but that excludes the pain too, and from this there develops unwittingly in the patients a different state of inner orientation, highly conducive to hypnosis and receptive to any suggestion that meets their needs; sensibly one always inserts the suggestion that if ever the pain should come back enough to need medication, the relief from one or two tablets of aspirin will be sufficient. “And if any real emergency ever develops, a hypo will work far greater success than ever.” Sometimes sterile water will suffice.

**BRIEF CONFUSION TECHNIQUES**

All of the foregoing indicates that the Confusion Technique is a prolonged, highly complicated and complex procedure. Working one out and explaining the rationale of the procedure is indeed a long hard task, but once one has done that more than once, and has learned to recognize the fundamental processes involved, there can then be a very easy, comfortable; and rapid trance induction under some most unfavorable conditions. To illustrate this, both a spontaneous experimental instance and a clinical case will be
reported. The first of these occurred at a lecture before a medical society. One of the physicians present was most interested in learning hypnosis, listened attentively during the lecture, but in the social hour preceding the lecture he had repeatedly manifested hostile, aggressive behavior toward most of his colleagues. When introduced to the author, he shook hands with a bone-crushing grip, almost jerked the author off his balance (the man was at least six inches taller than the author and about 65 pounds heavier) and aggressively declared without any preamble that he would like to “see any damn fool try to hypnotize me.”

When volunteers for a demonstration were requested, he came striding up and in a booming voice announced, “Well, I’m going to show everybody that you can’t hypnotize me. “ As the man stepped up on the platform, the author slowly arose from his chair as if to greet him with a handshake. As the volunteer stretched forth his hand prepared to give the author another bone-crushing handshake, the author bent over and tied his own shoestrings slowly, elaborately, and left the man standing helplessly with his arm outstretched. Bewildered, confused, completely taken aback at the author’s nonpertinent behavior, at a total loss for something to do, the man was completely vulnerable to the first comprehensible communication fitting to the situation that was offered to him. As the second shoestring was being tied, the author said, “Just take a deep breath, sit down in that chair, close your eyes, and go deeply into a trance.”

Uncertainly, hesitantly, the man sat down, sighed deeply, closed his eyes, and within seconds he had developed a somnambulistic trance. Various phenomena were demonstrated, and he was then awakened after the posthypnotic suggestion that he would ask me courteously “Well, when do we begin the hypnosis?” and sometime later when I shifted my chair he would have a complete recollection of everything. He aroused and asked the question, to which I replied evasively. After a brief, casual conversation I reached for a glass of water but had to shift my chair. With a startled reaction my subject said, “Well I’ll be damned! But how? Now do it again so I can know how you are doing it.”

He was offered a choice of several traditional techniques. He chose the hand levitation method as seeming the more interesting, and this technique was employed slowly both for his benefit and that of the audience, with another somnambulistic trance resulting.

As an experimental subject in that situation he presented in an excellent manner the problem of adequately meeting his behavioral patterns and eliciting responsive behavior of interest primarily to the audience, although he too was interested secondarily, but his primary interest as a person was one diametrically opposed. He wished to elicit responses of futility from the author, but even this was a tacit acknowledgment of hypnosis as a valid phenomenon.

The explanation of what happened is rather simple. The man came up to the podium with an intense determination to do something. The author’s rising as if to greet him with a handshake and then bending over to tie his shoestrings left the man standing with an outstretched hand, unable to do anything, interrupted so suddenly in the initiation of what
he was going to do, too astonished by the author’s completely nonpertinent behavior, utterly at loss for something to do, and hence completely susceptible to any clearly comprehensible suggestion of what to do fitting to the total situation, that he responded relievedly to the simple, quiet instruction the author offered. And of course the man’s underlying attitude toward hypnosis became manifest in his prompt request made upon his discovery of what had happened.

Similarly many clinical patients show comparable behavior of hostility, aggression, and resistance, yet they are earnestly seeking therapy. The Confusion Technique alters the situation from a contest between two people and transforms it into a therapeutic situation in which there is joint cooperation and participation in the mutual task centering properly about the patient’s welfare and not about a contest between individuals, an item clinically to be avoided in favor of the therapeutic goal.

To illustrate with a similarly handled clinical instance, a patient entered the office for her first appointment with a hesitant, uncertain manner but with what seemed to be too forceful and too defiant a stride. She sat down in the chair in a stiff, upright fashion with her arms rigidly holding the palms of her hands braced against her knees, and in a weak voice hesitantly explained, “I was sent to you by Dr. X, who worked hours on me. Before him was Dr. Y, who also worked hours on me. And before him was Dr. Z, and he worked 30 hours on me. All of them told me that I was too resistant to be hypnotized, but they all said you could do it. But I went to the other two because they were near my home town. I didn’t want to come all the way to Phoenix to be hypnotized, but even my family doctor has told me it would help overcome my resistances to therapy.” Her diffident, uncertain, hesitant bearing and voice, her definite stride, her stiff upright position, her overemphasis upon the hours futilely spent already in trying to induce a trance, her regretful statement that she didn’t want to come to Phoenix to be hypnotized, and her insistence on going to two other men when the first as well as both the others had recommended the author suggested: (1) that she would resist hypnosis; (2) that she was bewildered by her ambivalences; (3) that she could not be approached by any ordinary expectable technique of induction; (4) that she definitely wanted therapy; and (5) that she would try to embroil the author in a contest instead of accepting therapy.

Accordingly she was told rather brusquely, “Well, let’s get this clear. Three doctors, all good men, just as good as I am, have worked hard and long on you. They found you to be too resistant, as I will too. So let’s have that understood at once.” With markedly differing inflections and tempo the following was said to her as a two part statement, “I CAN’T HYPNOTIZE YOU, justyourarm.”

In a bewildered fashion she said, “Can’t hypnotize me, just my arm—I don’t understand what you mean.”

Again she was told with heavy emphasis and with the words spoken slowly, “THAT’S EXACTLY WHAT I MEAN. I CAN’T HYPNOTIZE YOU,” then with a soft, gentle voice I added rapidly as if it were one word, “justyourarm,see.”
As I said the word “See,” I gently “lifted” her left arm upward, the touch of my fingers serving only to direct the upward movement, not actually to lift it. Gently I withdrew my fingers, leaving her hand cataleptically in midair. As she watched her arm in its upward course, I said softly and sighingly, “Just close your eyes, take a deep breath, so deeply asleep, and as you do so, your left hand will slowly come to rest on your thigh and remain there continuously as you sleep deeply and comfortably until I tell you to awaken.”

Within five minutes after her entrance into the office she was in a deep, and as it proved to be, somnambulistic trance. What happened? The woman was desperately seeking therapy, had come a long distance to seek it in response to repeated advice, she came with a rigid counterset for any conventional, traditional, ritualistic, or other techniques that she could watch, hear, and understand. Believingly, agreeingly, she heard me say clearly and understandably, “I can’t hypnotize you,” to which was appended softly, quickly and gently while she was still in a believing or accepting frame of mind, the inexplicable three words, “just your arm.”

Thus the very thing that she had come to prove was already affirmed; it was a closed issue. We were in total agreement, her purpose to prove that she could not be hypnotized was already accomplished, her counterset for hypnosis rendered unnecessary, useless. But those three peculiar words, “just your arm,” confronted her with a most bewildering question of what was meant. Thereby she was literally forced to ask for some explanation. The reaffirmation was given with deliberate emphasis, and while her mind was still receptive, four more words were quickly added, the fourth a command, “See!” From earliest childhood we learn to interpret certain tactile stimuli as meaning, “Move,” and she made an automatic response to such a tactile stimulation. This she could not understand, she had no counterset for it, and she could “see” her arm behaving in a way she could not understand. Nor was she given any opportunity. The elicitation of one hypnotic response leads so easily to another, catalepsy, pupillary dilation, and then an all-comprehensive set of suggestions was given to insure a deep trance and its maintenance.

Hypnotherapy and waking psychotherapy were used on this patient, and the progress was phenomenally rapid for the simple reason that she was not allowed to interpose her resistances between herself and therapy, but put into a situation of objectively examining them. This was begun almost immediately with the statement, “Well, now we can proceed with therapy rather than wasting time on a question for which neither you nor I really knew the answer, but to which you have so easily found the correct answer, namely that you can develop and keep a deep trance state and that you don’t need resistances.”

**SUMMARY**

With the foregoing discussion and examples in mind it might be well to summarize the Confusion Technique as a play on words or communications of some sort that introduces progressively an element of confusion into the question of what is meant, thereby leading to an inhibition of responses called for but not allowed to be manifested and hence to an accumulating need to respond. It is reminiscent of the childhood word games such as “If it isn’t not raining, then it is raining,” or “I am here and you are not here and New York
is not here, so you must be in New York because you are there, not here, and New York is there, not here.”

Starting with these elementary ideas, the author has added to the play on words the modification of seemingly contradictory, irrelevant, or unrelated concepts, non sequiturs, and ideas, variously communicated, and each of which out of context is a simple, reasonable assertion, meaningful and complete in itself. In context such communications are given in a meaningfully emphatic manner along with valid, meaningful ideas, and thus the whole becomes a medley of seemingly valid and somehow related ideas that leads the subjects to try to combine them into a single totality of significance conducive to a response—literally compelling a response. But the rapidity of the communications inhibits any true understanding, thereby precluding responses and resulting in a state of confusion and frustration. This compels a need for some clear and understandable idea. As this state develops, one offers a clearly definite, easily comprehensible idea which is seized upon immediately and serves to arouse certain associations in the subjects’ minds. The medley is then continued, and another comprehensible idea is offered, enhancing the associations of the previous clear understanding. And in the process one throws in irrelevancies and non sequiturs as if of pertinent value, thereby enhancing the confusion. This sort of thing constitutes in certain situations a form of humor such as in the case of the childish riddle of “Two ducks in front of a duck, two ducks behind a duck, and one duck in the middle. How many ducks are there?” Even those of my playmates on whom I tried this and who knew the answer to be three ducks would find themselves hopelessly bewildered when I would add with earnest helpfulness, “Of course you must remember they were beside the left-hand door.” And for those who did not know the answer and who were struggling with the two and two and one, the left-hand door often constituted an insuperable barrier to a responsive reply as a result of a natural tendency to fit that irrelevancy into the problem.

However, a Confusion Technique is sometimes most difficult for some users of hypnosis, and they find much difficulty in attempting it for either experimental or clinical work. Nevertheless it does have significant values for those who cannot use it in a hypnotic setting, since repeated efforts to devise and deliver a Confusion Technique for the sake of practice only will soon teach the user of more conventionalized, ritualistic, traditional, verbalized techniques a greater fluency in speech, a freedom from rote suggestions, a better understanding of the meaning of suggestions, and a greater ease in shifting one’s own patterns of behavior in response to observed changes in the patients, and in shifting from one set of ideas to another. In repeated experience teaching hypnosis to medical and psychological students and residents in psychiatry, the assignment of the task of devising and analyzing a Confusion Technique aided them greatly in learning traditional verbalization techniques, even those who never could seem to learn to use a Confusion Technique spontaneously or intentionally in a hypnotic situation.

Thus the Confusion Technique is a presentation of ideas and understandings conducive of mental activity and response but so intermingled with seemingly related, valid but actually nonpertinent communications that responses are inhibited, frustration and uncertainty of mind engendered. The culmination occurs in a final suggestion permitting
a ready and easy response satisfying to the subjects and validated by each subject’s own, though perhaps unrecognized, on a conscious level, experiential learnings.
The Dynamics of Visualization, Levitation and Confusion in Trance Induction

Milton H. Erickson

Unpublished fragment, circa 1940s.

Hypnotic techniques are no more than methods of communicating suggestions and ideas. In themselves they are of no particular significance. It is only the responses and the behavior that they stimulate the subject to make that have any value. Hence in describing a technique a primary consideration should not be a slavish presentation of verbalizations, but an effort to indicate the purposes to be served. Unfortunately the general tendency is to attach labels to a technique and then to use it in accord with the sometimes meaningless label.

**VISUALIZATION APPROACHES**

For example, an excellent visualization approach has been labeled The House-Tree-Man Technique. This designation much more properly should be An Example of Visual Imagery Technique, or A Technique Based upon Visual Imagery, or Visual Imagery as a Technique. As a technique The House-Tree-Man differs in no significant way from The Garden-Woman-Sundial or The Schoolhouse-Teacher-Pupil-Desk-Blackboard-Chalk Technique. The essential consideration is to evoke visual images related to experiential learnings and thus to initiate within the subjects, apart from externalities, a progressive series of responsive reactions that can develop into a trance. It is of utterly no importance that a house, a tree, or a man be mentioned to use the “House-Tree-Man” technique. The only important purpose in this technique is the initiation and utilization of the processes of visualization, and the objects to be employed as visual images should be selected in relationship to the subjects, not to some printed page. The basic approach is to orient all hypnotic techniques about the subjects, who are the responsive components of the situation.

**HAND LEVITATION APPROACHES**

To cite another example, in the development and the teaching of the “hand levitation technique” this writer has endeavored to make clear and to emphasize that the technique is one in which the subjects overtly participate at a motor level—that it is a participatory technique involving motor activity. The term “hand levitation” is employed for several reasons.

The hand is employed for the reason that in the passively expectant state of the subjects, the idea of motor activity is easily related to the subjects’ hand without disturbing their
general physical inactivity. The subjects have a lifetime of experience of hand movement while the body is at rest.

It matters not which hand is levitated, yet uncritical, overenthusiastic innovators have attempted to develop as refinements separate techniques for levitation of the right, the left, of both simultaneously and alternately, and of the right index finger, the left index finger, etc., overlooking entirely that it is the motor activity and not the body part that is important. The body part is important only when it serves some other and specific purpose directly related to its use, as in finger signaling, for example, or in answering by gesture.

The term “levitation” is employed to signify primarily the subjective character of the motor activity and not the direction of the movement. It is the subjective sensation of lightness, of free, involuntary, or consciously effortless motor activity that is the primary consideration, not the direction of the movement. Hence the “levitation” may be upward or downward, horizontal or rotary. It is not even essential that there be actual movement since it is the subjective sensation of involuntary or consciously effortless movement that is desired and not movement through linear space. Hence the term “hand levitation” is properly used to present in an easily comprehensible form the suggestion of movement of a body part, any body part, of a special subjective quality.

**CONFUSION APPROACHES**

In a somewhat similar fashion many other techniques need to be discussed for their essential significance. For example, the “confusion technique” much mentioned, never really described in the literature, actually used more frequently than it is recognized, and regarded as rather involved and bewildering, is actually a relatively simple procedure. It is usually a verbal technique, but nonverbal elements can easily be added to it and even made the major part of the technique.

Defined simply, a “confusion technique” is one based upon the presentation to the subjects of a series of seemingly only loosely related ideas actually based upon a significant thread of continuity not readily recognized, leading to an increasing divergence of associations, interspersed with an emphasis on the obvious, all of which preclude subjects from developing any one train of associations, yet stirs them increasingly to a need to do something until they are ready to accept the first clearcut definitive suggestion offered. As stated, the technique may be purely verbal or an admixture of verbal and nonverbal elements; both may be used as rapid or slow inductions, depending upon the situation and the purposes to be served. [Editor’s note: The editor’s reading of this complex sentence is as follows: (1) “a series of seemingly only loosely related ideas actually based upon a significant thread of continuity not readily recognized” is a series of indirect suggestions that has as its common denominator an important therapeutic response that is to be evoked hypnotically; (2) “leading to an increasing divergence of associations “is the unconscious search and processes evoked by the indirect suggestions as the subjects struggle to find their meaning, their common denominator; (3) “interspersed with an emphasis on the obvious”
is essentially a *yes set* evoked by a stream of obvious truths from the therapist that keeps the conscious minds of the subjects open in a simple acceptance set during trance; (4) “all of which precludes subjects from developing any one train of associations” means we don’t want subjects to develop a train of conscious associations with their usual, habitual frames of reference and biases because these contain learned limitations that have prevented them from solving their problem by utilizing their own unconscious potentials; (5) “yet stirs them increasingly to a need to do something” means that since the subjects’ habitual frames of reference cannot find closure, they experience a state of unstable equilibrium or *expectancy*; (6) “until they are ready to accept the first clearcut definitive suggestion offered,” which will resolve the expectancy and effect closure by carrying a *direct therapeutic suggestion*. We see in this process how Erickson first sets up and activates patients’ unconscious potentials with a series of indirect suggestions (steps 1 and 2) while keeping the patients’ conscious mind open and accepting (steps 3 and 4). At the same time a certain tension and need to make some response is evoked in step 5, which is resolved by a direct therapeutic suggestion in step 6. This marvelous integration of indirect (step 1) and direct (step 6) suggestions follows the five-stage paradigm of the microdynamics of trance and suggestion.

For example, in a lecture before the professional staff of a V.A. hospital, a student nurse was pressured by her superior to volunteer as a subject. Fortunately she was interested in being a subject, but she disliked being told to act as one. Advantage was taken of this emotional setting to use a confusion technique primarily nonverbal in character to secure in the subject, who had neither witnessed nor experienced hypnosis previously, a deep trance in a minimum of time.

As she approached the front of the lecture room from a side aisle, a chair was moved somewhat ostentatiously into place for her. When she was within six feet of the chair, she was asked, “Will you sit in *this* chair *here*?” As the word “this” was spoken, the writer’s left hand was carefully placed on the back of that chair, as if to point it out. As the word “here” was spoken, the writer gestured with his right hand, as if indicating a chair to the side of the actual chair. There was a momentary pause in her behavior, but as she continued her approach, the chair was pushed slightly toward her, causing a slight noise as it scraped on the floor. This was readily audible. As she came still closer to the chair, it was pulled slightly to one side away from her, and immediately as she seemed to note this, it was pushed back an inch or so, and then another inch or so forward and to the side toward her. All of this she noted because the writer’s left hand on the back of the chair constituted a focusing point.

By this time she had reached the chair, had turned slightly, and had begun to lower her body into it. As soon as her knees were bent, the chair was rotated about one inch, and as she paused again momentarily to look at the chair, the writer took hold of her right elbow and moved it away from her body slightly and then slightly forward. As she turned to look in response to this, her elbow was released and her right hand and wrist were gently taken and moved slightly upward and then downward. As she shifted her gaze from her elbow to her hand, she was told quietly, “Just sit all the way down in the chair, and as you
do so just close your eyes and go 'way deeply into the trance, and as you continue to sit there, sleep ever more deeply in a hypnotic trance.”

As she settled in the chair, the additional statement was made, “And now you can take a deep comfortable breath while I go on with my lecture.” Thereupon, without further delay or training she was immediately employed to demonstrate somnambulistic trance and all the other phenomena of the deep trance. She was awakened approximately one hour later, and demonstrated spontaneously a total amnesia by stating, “But you’ve got me so confused I don’t know what to do. Is it all right to sit this way, and what do you want me to do with my hand?”

Reply was made, “Would you like to go into a trance?”

She answered, “I don’t really know. I’m not sure. I don’t even know if I can be hypnotized. I suppose maybe I could. I’m willing to try if you want me to.” She was asked what she meant by saying that she was confused.

“Well, when I started to come up here, you asked me to sit in this chair, and then you started moving it first one way and then another, and then somehow you started to move my arm, and before I knew what you wanted, you started on my hand and I’m still confused. What do you want me to do?”

In this last question the subject defines adequately the goal of a confusion technique, the pressing need to have a definite, easily comprehended understanding of what is wanted. In the distressing state of confusion developed, whether by verbal or nonverbal or combined methods, the subject is more than ready to accept and react to the first simple idea suggested that will end the confusion. In this instance she accepted at once the suggestions, “Sit down all the way,” “close your eyes,” and “sleep deeply.” It was, indeed, a relief to do so. In rousing from the trance, she reverted to the state of conscious bewilderment that had been interrupted by a rapid development of the deep trance.

To summarize this example, a train of physical activity was initiated in this subject. As she followed along in its development, first one and then another nonverbal suggestion of a motor type was offered just long enough to permit her to become aware of it, but before she could respond another had taken its place. Each suggestion in itself was acceptable, but each time she was precluded from a response although a need to respond was being increasingly developed. Furthermore, each new suggestion was a compound of contradictory significances (that is forward and backward or left and right) which compelled a need to select from these multiple choices which were repeatedly varied. When it was felt clinically that the subject had reached a psychological point at which she was ready to put into action her rising need for a response, a direct, simple statement was given her.

In a single sentence, we may define a confusion technique as one in which a series of interrelated acceptable stimuli ordinarily leading to responsive action are given in such
fashion that response is inhibited until the subject, in cumulative fashion, makes a massive response to the first clearcut definitive idea presented.

In the example cited, had the subject not yet been ready to develop a trance state, the writer could easily have continued by shifting attention from the right hand to the left, thence to the right elbow and then the left knee, in preference to any manipulation of objects about her. The reason is that one would want to build up increasingly within the subject a need to respond within the self.
Another Example of Confusion in Trance Induction

Milton H. Erickson

As told to the Ernest L. Rossi in 1976.

On one occasion Erickson was lecturing to a group of doctors about hypnosis. He was interrupted when another doctor brought in two women volunteers who were interested in experiencing hypnosis and introduced them to Erickson. In the following he describes the situation as he understood it.

E: I began by telling them that they really didn’t know anything about me but I had at least an average education; I’d gone to grade school; I’d lectured to doctors; I had learned to count, I could count to twenty easily; I could count to twenty by one, by twos, fours, fives, or tens; I could write my name. I told them a sheer bunch of nonsense along with that important statement about counting to twenty in different ways. And then I said, “Now, of course, whenever I count to twenty, you can go into a hypnotic trance.” They just looked at me and I continued with my nonsensical discussion of irrelevant facts about myself. I liked corned beef, I liked golden-eyed trout, etc. Then I looked at them significantly and said, “I had four boys and four girls—that makes eight. They really come cheaper by the dozen, you know.” With that they both went into a trance. Eight and twelve is twenty. The women came in expecting to go into a trance. They just didn’t know what a trance induction was, so I started the nonsense discussion in which I talked about my education and counting to twenty; telling them that when I came to twenty they would go into a trance—then slipping in the statement, four boys, four girls—they come cheaper by the dozen; four plus four plus twelve equal twenty. I had earlier said that I could count to twenty in any fashion, and when I come to twenty you go into a trance. They went into a trance just that quickly. All that nonsense was not really nonsense; it was a confusion procedure. While they tried desperately to make sense out of all of that nonsense I was telling them (because it is nonsensical for somebody lecturing to a group of doctors to talk in that fashion), they probably asked themselves, “Why is he talking in that fashion? Why is he saying that? Why is he telling that to us?” They tried desperately to make some meaning out of it, and the first possible meaning to it was four plus four plus twelve, and as soon as they put that meaning on it, they went into a trance. Nice demonstration of confusion technique and of subjects struggling to put a meaning upon what you say and your awareness that the subjects are going to put a meaning upon what you say. Give them plenty and let them select.
An Hypnotic Technique for Resistant Patients: the Patient, the Technique, and its Rationale and Field Experiments

Milton H. Erickson


There are many types of difficult patients who seek psychotherapy and yet are openly hostile, antagonistic, resistant, defensive, and present every appearance of being unwilling to accept the therapy they have come to seek. This adverse attitude is part and parcel of their reason for seeking therapy; it is the manifestation of their neurotic attitude against the acceptance of therapy and their uncertainties about their loss of their defenses and hence it is a part of their symptomatology. Therefore this attitude should be respected rather than regarded as an active and deliberate or even unconscious intention to oppose the therapist. Such resistance should be openly accepted, in fact graciously accepted, since it is a vitally important communication of a part of their problems and often can be used as an opening into their defenses. This is something that the patients do not realize; rather, they may be distressed emotionally since they often interpret their behavior as uncontrollable, unpleasant, and uncooperative rather than as an informative exposition of certain of their important needs.

The therapist who is aware of this, particularly if well skilled in hypnotherapy, can easily and often quickly transform these overt, seemingly uncooperative forms of behavior into a good rapport, a feeling of being understood, and an attitude of hopeful expectancy of successfully achieving the goals being sought.

Usually these patients have consulted more than one therapist, have encountered failures of treatment, and their difficulties have grown worse. This fact alone warrants increased concern and care in meeting their needs, particularly if it is appreciated that such a seemingly unfriendly beginning of the therapeutic relationship often actually augurs well for a more speedy therapeutic course if met comfortably and easily as a symptom and not as a defense.

Hence the therapist aids the patients to express quickly and freely their unpleasant feelings and attitudes, encouraging the patients by open receptiveness and attentiveness, and by the therapist’s willingness to comment appropriately in a manner to elicit their feelings fully in the initial session.

Perhaps this can be illustrated by the somewhat extreme example of a new patient whose opening statement as he entered the office characterized all psychiatrists as being best described by a commonly used profane vulgarity. The immediate reply was made, “You
undoubtedly have a damn good reason for saying *that and even more.*” The italicized words were not recognized by the patient as a direct intentional suggestion to be more communicative, but they were most effective. With much profanity and obscenity, with bitterness and resentment, and with contempt and hostility he related his unfortunate, unsuccessful, repeated, and often prolonged futile efforts to secure psychotherapy. When he paused, the simple comment was made casually, “Well, you must have had a hell of a good reason to *seek therapy from me.*” (This was a definition of his visit unrecognized by him.)

Again the italicized words were no more than part of a seemingly wondering comment spoken in his own type of language. He did not recognize that a therapeutic situation was being defined to him, despite his response of, “Don’t worry, I’m not going to develop a positive transference or [unprintable words] on you. I’m going to pay you good money to do a job on me, get it? I don’t like you, I know a lot of people that don’t like you. The only reason I’m here is I’ve read a lot of your publications and I figure you can handle a disagreeable, fault-finding, uncooperative [unprintable words] who is going to resist every damn thing you try to do for me. That’s something I can’t help, so either tell me to get the hell out of here or to shut up, and you get down to business, but don’t try psychoanalysis. I’ve had all that baloney I can take. Hypnotize me, only I know you can’t in spite of your writings. So, get a move on!”

The reply was made in a casual tone of voice and with a smile, “O.K., shut up, sit down, keep your damn mouth shut and listen; and get it straight, I am going to *get a move on* [using the words of the patient’s own request], *but I move just as slow or as fast as I damn please.*” My terms for the acceptance of his request for therapy were phrased in his own language, though said casually and in a voice free from any unpleasant intonations and inflections. Thus the patient is told effectively vitally important matters in the italicized words without his conscious recognition of the fact.

The patient seated himself and glared silently and belligerently at the author. He did not realize that he was thereby committing himself to a therapeutic situation. Instead he misunderstood his behavior as uncooperative defiance. With his attention and understandings thus fixated and centered a hypnotic technique was used that has been worked out over the years with the unintentional aid of many difficult, resistive, uncooperative patients and by much speculation upon how to transform their own utterances into vitally important suggestions effectively guiding their behavior, although without such recognition by them at the time.

**THE TECHNIQUE AND ITS RATIONALE**

The technique, to be given in detail shortly, which is used sometimes almost verbatim, can be shortened or made longer by repetitions and elaborations all in accord with the patient’s capacities to understand and to respond. It is advantageous to modify it to include the patient’s own style of speech, whether abrupt, impolite, or even outrageously profane. However, the author, in his use of it, usually discontinues very rapidly the discourtesies of the patient’s own type of language, but he is likely to continue any
ungrammatical constructions that may be characteristic of the patient’s speech. Thus the patient’s violence (linguistically expressed) is unnoticeably discarded and the patient and the therapist arrive at a safe, pleasant linguistic level familiar in form to the patient. The patient does not know how this happened nor does he often sense that it is happening because of its indirectness; nor is there any reason for the patient to be led to understand the techniques and levels of communication, any more than does the surgical patient need to have a full comprehension of the surgical techniques to be employed.

When sufficient material has been obtained from the aggressive, hostile, antagonistic, defensive, uncooperative patients to appraise their unfortunate behavior and attitudes and to judge their type of personalities, they are interrupted by an introductory paragraph of mixed positive and negative, seemingly appropriate and relevant remarks addressed to them in that form of language they can best understand at that moment. However, concealed and disguised in these remarks are various direct, indirect, and permissive suggestions intended to channel their reactions into receptive and responsive behavior.

For the patient cited above as an example, he was told, “I do not know whether or not you are going into a trance as you have asked.” (One needs to scrutinize well this sentence to recognize all the positive and negatives, something not possible when listening to it.) With this introductory remark to this specific patient utilization was then made of the following technique, which is actually no more than a casual, not necessarily grammatical, explanation loaded with direct and indirect permissive suggestions and instructions but not easily recognizable as such. Hence these will, in large part, be italicized to enable more easy recognition. Parenthetical inserts or explanatory paragraphs are for clarification for the reader only, and were of course not part of the verbalized technique.

“You have come for therapy, you have requested hypnosis, and the history you have given of your problem leads me to believe strongly that hypnosis will help you. However, you state more convincingly that you are a resistant hypnotic subject, that others have failed despite prolonged efforts to induce a trance, that various techniques have been of no avail, and that reputable men have discredited hypnosis for you and as a therapeutic aid in itself. You have frankly expressed your conviction that I cannot induce a trance in you, and with equal frankness you have stated that you are convinced that you will resist all attempts at hypnosis and that this resistance will be despite your earnest desire and effort to cooperate.” [To resist hypnosis one recognizes its existence, since there can be no resistance to the nonexistent and its existence implies its possibility. Thus the question becomes not one of the reality or value of hypnosis, but simply a question of his resistance to it. Thereby the ground is laid for the use of hypnosis but with his attention directed to his understanding of resistance to it. Hence hypnotic induction is rendered a possibility by any induction technique not recognizable to him.]

“Since you have come for therapy and you state that you are a fault-finding, uncooperative patient, let me explain some things before we begin. So that I can have your attention, just sit with your feet flat on the floor with your hands on your thighs, just
don’t let your hands touch each other in any way.” [This is the first intimation that more is being communicated than the ear hears.]

“Now so that you will sit still while I talk, just look at that paperweight, just an ordinary handy thing. By looking at it you will hold your eyes still, and that will hold your head still and that will hold your ears still, and it’s your ears I’m talking to. [This is the first intimation of dissociation.] No, don’t look at me, just at the paperweight, because I want your ears still and you move them when you turn to look at me. [Most patients tend at first to shift their glance, so eye-fixation is effected by a request not to move the ears, and rarely does it become necessary to repeat this simple request more than three times.] Now when you came into this room, you brought into it both of your minds, that is, the front of your mind and the back of your mind. [“Conscious mind” and “unconscious mind” can be used, depending upon the educational level, and thus a second intimation is given of dissociation.] Now, I really don’t care if you listen to me with your conscious mind, because it doesn’t understand your problem anyway, or you wouldn’t be here, so I just want to talk to your unconscious mind because it’s here and close enough to hear me, so you can let your conscious mind listen to the street noises or the planes overhead or the typing in the next room. Or you can think about any thoughts that come into your conscious mind, systematic thoughts, random thoughts because all I want to do is to talk to your unconscious mind, and it will listen to me because it is within hearing distance even if your conscious mind does get bored [boredom leads to disinterest, distraction, even sleep]. If your eyes get tired, it will be all right to close them but be sure to keep a good alert [a disarming word so far as any assumed threat of hypnosis is concerned], a really good mental or visual image alertly in your mind [an unrecognizable instruction to develop possible ideosensory visual phenomena while the word “alertly” reassures against hypnosis]. Just be comfortable while I am talking to your unconscious mind, since I don’t care what your conscious mind does. [This is an unrecognizable dismissal of his conscious attention following immediately upon a suggestion of comfort and communication with only his unconscious mind.]

“Now before therapy can be done, I want to be sure that you realize that your problems just aren’t really understood by you but that you can learn to understand them with your unconscious mind. [This is an indirect assertion that therapy can be achieved and how it can be done with more emphasis upon dissociation.]

“Something everybody knows is that people can communicate verbally [“talk by words” if warranted by low educational or intelligence level] or by sign language. The commonest sign language, of course, is when you nod your head yes or no. Anybody can do that. One can signal ‘come’ with the forefinger, or wave ‘bye-bye’ with the hand. The finger signal in a way means ‘yes, come here,’ and waving the hands means really ‘no, don’t stay.’ In other words one can use the head, the finger, or the hand to mean either yes or no. We all do it. So can you. Sometimes when we listen to a person we may be nodding or shaking the head not knowing it in either agreement or disagreement. It would be just as easy to do it with the finger or the hand. Now I would like to ask your unconscious mind a question that can be answered with a simple yes or no. It’s a question that only your unconscious mind can answer. Neither your conscious mind nor my
conscious mind, nor, for that matter, even my unconscious mind knows the answers. Only your unconscious mind knows which answer can be communicated, and it will have to think either a yes or a no answer. It could be by a nod or a shake of the head, a lifting of the index finger—let us say the right index finger for the yes answer, the left index for a no since that is usually the case for the right-handed person and vice versa for the left-handed person. Or the right hand could lift or the left hand could lift. But only your unconscious mind knows what the answer will be when I ask for that yes or no answer. And not even your unconscious mind will know, when the question is asked, whether it will answer with a head movement, or a finger movement, and your unconscious mind will have to think through that question and to decide, after it has formulated its own answer, just how it will answer. [All of this explanation is essentially a series of suggestions so worded that responsive ideomotor behavior is made contingent upon an inevitable occurrence—namely, that the subject “will have to think” and “to decide” without there being an actual request for ideomotor responses. The implication only is there, and implications are difficult to resist.]

“Hence in this difficult situation in which we find ourselves [this establishes a “relatedness” to the patient] we will both have to sit back and wait and wait [participatory behavior] for your unconscious mind to think the question through, to formulate its answer, then to decide, whether by head, finger, or hand, to let the answer happen.” [This is a second statement of suggestions and instructions in the guise of an explanation. Seemingly the subject has been asked to do nothing, but actually he is directly told to be passive and to permit an ideomotor response to occur at an unconscious level of awareness signifying an answer that he has been told carefully to “let happen” as another and definitive contingent result of mental processes. In all of this procedure there have been implied or indirect suggestions given that the conscious mind will be unaware of unconscious mental activity, in essence that he will develop an anamnestic trance state.]

“In other words I will ask a question to which only your unconscious mind can give the answer, and concerning which your conscious mind can only guess if it does at all; maybe correctly, maybe wrongly, or maybe have only some kind of an opinion, but, if so, only an opinion, not an answer. [Thus a lessening of importance of his conscious thinking not recognizable to him, and a further implication of a trance state.]

“Before I ask that question, I would like to suggest two possibilities. (1) Your conscious mind might want to know the answer. (2) Your unconscious mind might not want you to know the answer. My feeling, and I think you will agree, is that you came here for therapy for reasons out of the reach of your conscious mind. Therefore I think that we should approach this matter of the question I am going to put to your unconscious mind for its own answer in such a way that your own deep unconscious wishes to withhold the answer or to share the answer with your conscious mind are adequately protected and respected. This, to me, is a fair and equitable way in dealing with one’s self and one’s problems. [This is what he knows he wants from others, but has not quite recognized that he wants fair and equitable treatment from himself.]
“Now, to meet your needs, I am going to ask that yes or no question, and be prepared to be pleased to let your unconscious mind answer [this is an unrecognized authoritative suggestion with a foregone conclusion permissively stated], and in doing so either to share the answer with your conscious mind or to withhold it, whatever your unconscious mind thinks to be the better course. The essential thing, of course, is the answer, not the sharing nor the withholding. This is because any withholding will actually be only for the immediate present, since the therapeutic gains you will make [also an unrecognized authoritative statement given in the guise of an explanation] will eventually disclose the answer to you at the time your unconscious mind regards as most suitable and helpful to you. Thus you can look forward to knowing the answer sooner or later, and your conscious desires, as well as your unconscious desires, are the seeking of therapy and the meeting of your needs in the right way at the right time. [This is a definitive suggestion given as an explanation and a most emphatic positive suggestion.]

“Now how shall this question be answered? By speech? Hardly! You would have to verbalize and also to hear. Thus there could then be no fair dealing [socially and personally potent demanding words] with your unconscious mind if it wished, for your welfare, to withhold the answer from your conscious mind. How then? Quite simply by a muscular movement which you may or may not notice, one that can be done at either a noticeable voluntary level or one that is done involuntarily and without being noticed, just as you can nod your head or shake it without noticing it when you agree or disagree with a speaker, or frown when you think you are just trying to call something to mind.

“What shall that muscle movement be? I think it would be better to mention several possibilities [simply “think” or “mention,” apparently not demanding, ordering, or suggesting], but before doing so let me describe the difference between a conscious mind muscle response and that of the unconscious mind. [Muscle response is mentioned while his attention is being fixated; a maneuver to maintain that attention for the future introduction of related but delaying material. The reader will note the previous use of this psychological gambit of mentioning a topic and then entering into a preliminary explanation.] The conscious mind response cannot be withheld from you. You know it at once. You accept it and you believe it, perhaps reluctantly. There is no delay to it. It springs to your mind at once, and you promptly make the response.

”An unconscious mind response is different, because you do not know what it is to be. You have to wait for it to happen, and consciously you cannot know whether it will be ‘yes’ or ‘no.’ [How can a muscle movement be a ‘yes’ or a ‘no’? The patient has to listen intently for some reasonable explanation.] It does not need to be in accord with the conscious answer that can be present simultaneously in accord with your conscious mind’s thinking. You will have to wait, and perhaps wait and wait, to let it happen. And it will happen in its own time and at its own speed. [This is an authoritative command but sounds like an explanation, and it provides time for behavior other than conscious, in itself a compelling force. Additionally one never tells the patient that an unconscious reply is almost always characterized by a strong element of perseveration. Apparently an altered time sense in hypnotic subjects, possibly deriving from their altered reality relationships, prevents even experienced subjects from appreciating this point, and it
constitutes an excellent criterion of the character of the response. This perseveration of ideomotor activity, however, is much briefer in duration if the unconscious mind wishes the conscious mind to know; the time lag and the dissociated character are greatly reduced, although the unconscious answer may be considerably delayed as the unconscious mind goes through the process of formulating its reply and the decision to share or not to share. If the patient closes his eyes spontaneously, one can be almost certain that the reply given will be spontaneously withheld from the patient’s conscious awareness. When the answer is “shared,” especially if the conscious opinion is opposite in character, the patient shows amazement and sometimes unwillingly admits to the self an awareness or strong feeling that the unconscious answer is unquestionably correct, thereby intensifying his hypnotic response. A repetition for comparison by asking another simple question can be elicited by the operator by careful wording of a question such as, “But you can withhold an answer, can you not?” doing this so casually that the patient does not realize that a second question has been asked. Thus there can be secured a second ideomotor response that is withheld from, or not noticed by, the conscious awareness. Insuring that the patient learns both to share unconscious activity and to withhold it from conscious awareness greatly speeds psychotherapy. Thus I have had a resistant patient, in reply to my question, consciously and promptly shake his head in the negative, briefly and emphatically, and then sit wonderingly at my apparent tardiness of response to his reply, not knowing that I was waiting silently to see if there would occur a slow head turning in a perseverative way from left to right, or an up and down nodding. Experimenting with such patients has disclosed such perseverative movements, particularly of the head, that may last as long as five minutes without the patient becoming aware of what was occurring. Once the patient is in a trance, the ideomotor response can then be as rapid as movement in the ordinary state of awareness, although in general there is a cataleptic character that is most informative of the patient’s hypnotic state. This is another criterion for the operator’s guidance, unrecognized by the subject.

“Now what shall the movement be?” Most people nod or shake their head for a ‘yes’ or a ‘no,’ and the question I am going to ask is that kind of a question, one requiring either a simple ‘yes’ or a simple ‘no.’ Other people like to signal by an upward movement of the index fingers, one meaning ‘yes,’ the other ‘no.’ I usually, as do most people [the phrases “I usually” and “most people” indicate that naturally it is to be expected of both of us that behavior common to most people will occur] like to use the right index finger for ‘yes’ and the left for ‘no,’ but it is often the other way around for left-handed people. [Let there be no hint of arbitrary demands, since the patient is resistant and this suggestion is one of freedom of response, even though an illusory freedom.] Then again some people have expressive hands and can easily, voluntarily or involuntarily, move their right hand up to signify ‘yes’ or the left to signify ‘no.’ [“Expressive hands” is only an implied compliment, but most appealing to any narcissism. Indeed it is not at all uncommon for a person to beckon with a finger or to admonish with a finger or a hand.]

“I do not know if your unconscious mind wants your conscious mind to look at some object or to pay attention to your head or fingers or hands. Perhaps you might like to watch your hands, and if your eyes blur as you watch them fixedly while you wait to see which one will move when I ask my simple question, such blurring is comprehensible. It
only means that your hands are close to you and that you are looking at them intently.”

[Even if the patient’s eyes are closed, this paragraph can be used unconcernedly. In its essence it is highly suggestive of a number of things, but unobtrusively so. Actually the sole purpose of these purported and repetitious explanations is merely to offer or to repeat various suggestions and instructions without seemingly doing so. Also a variety of possibilities is offered, essentially as an indirect double bind, which renders a refusal to make a response most difficult. All of the items of behavior are being suggested in such fashion that seemingly all the patient does is to manifest his choice, but he has actually not been asked to make a choice of the possibilities merely mentioned to him. He is not aware of what else is being said or implied. The author’s personal preference is an ideomotor head movement, which can easily be achieved without conscious awareness, but regardless of the type of movement employed by the patient, the author immediately shifts to a second type of ideomotor response and perhaps to a third to intensify the patient’s total responsiveness. The hand movement offers certain distinct advantages in that it lends itself readily to the elicitation of other phenomena, as will be described later.]

“Now [at long last, and the patient’s eagerness is at a high point] we come to the question! I do not need to know what is to be your choice of the movements to be made. You have your head on your neck and your fingers are on your hands and you can let your hands rest comfortably on your thighs or on the arms of the chair. The important thing is to be comfortable while awaiting your unconscious answer. [In some way comfort and the unconscious answer become unrecognizably contingent upon each other, and the patient naturally wants comfort. Equally naturally he has some degree of curiosity about his ‘unconscious answer.’ Also, another delaying preliminary explanation is being given.] Now you are in a position for any one or all of the possible movements [an unrecognized authoritative suggestion]. As for the question I am to ask, that, too, is not really important. What is important is what your unconscious mind thinks, and what it does think neither you nor I consciously know. But your unconscious does know since it does do its own thinking but not always in accord with your conscious thoughts.”

“Since you have asked me to induce a trance, I could ask a question related to your request, but I would rather ask a simpler one [a possible threat of hypnosis removed]. Hence let us [we are working together] ask a question so general that it can be answered by any one of the various muscle ways described. Now here is the question to which I want you to listen carefully, and then to wait patiently to see, or perhaps not to see, what your unconscious answer is. [After so much apparently plausible delay, the patient’s attention is now most fixed, he is, so to speak, “all ears” in his desire to know the question, and such desire has to have an unrecognized basis of acceptance of the idea that his unconscious mind will answer.] My question is [said slowly, intently, gravely], Does your unconscious mind think it will raise your hand or your finger or move your head?” [Three possibilities, hence the conscious mind cannot know.] “Just wait patiently, wonderingly, and let the answer happen.”

What the patient does not know and has no way of realizing is that he is being communicated with on two levels, that he is in a double or triple bind. He cannot deny that his unconscious mind can think. He is inescapably bound by that word “think. “Any
ideomotor or nonvolitional movement, whether positive or negative, is a direct communication from his unconscious mind (but his thinking does not extend to that realization). If slowly his head shakes “no,” my gentle lifting of either his “yes” or “no” hand will result in catalepsy. This cataleptic response is also hypnotic; it is one of the phenomena of hypnosis. I can then ask him to be more comfortable, and if his eyes are open, I add, “perhaps by closing your eyes, taking a deep breath, and feeling pleased that your unconscious mind is free to communicate to me as it wishes.”

Thus without his awareness and before he has time to analyze the fact, he is communicating at the level of the unconscious mind, thereby literally going into a trance despite his previous conscious conviction that he would inevitably defeat his own wishes to be hypnotized. In other words his resistances have been bypassed by making hypnotic responses contingent upon his thought processes in response to seemingly nonhypnotic discussion of various items, and his false belief that he cannot be hypnotized is nullified by a pleasing unconscious awareness that he can cooperate. If he becomes aware that he is responding with ideomotor activity, he is bound to recognize that his unconscious mind has charge of the situation. This places him in another double bind, that of being in the position of letting his unconscious mind “share” with his conscious mind whatever it wishes, which as a further double bind will commit him quite unwittingly also to let his unconscious mind withhold from his conscious mind, with a consequent hypnotic amnesia at the conscious level. Thus with no seeming effort at trance induction as the patient understands it, a trance state has been induced.

Fortunately for both the operator and the patient the elicitation of a single hypnotic phenomenon is often an excellent technique of trance induction, and should, for the patient’s benefit, be used more often. The realization of this was first reached in the summer of 1923 while attempting to experiment with automatic writing. To the author’s astonishment the subject, his sister Bertha, who had never before been hypnotized or seen hypnosis induced, developed a profound somnambulistic trance while suggestions were being made only to the effect that slowly, gradually, her right hand, holding a pencil on a pad of paper, would begin to quiver, to move, to make scrawling marks until her hand wrote letters, then words forming a sentence while she stared fixedly at the doorknob just to enable her body to sit still. The sentence, “Grandma’s dog likes eating those bones,” was written, and the author inquired what she meant and received the reply, while she pointed cataleptically toward the door, “See! He is eating that dishful of bones and he likes them.” Only then did the author realize that a trance had been unintentionally induced and that she was hallucinating visually what she had written, since Grandma’s dog was miles away. Many times thereafter automatic writing was used as an indirect technique of trance induction, but was discarded because writing is a systematic ordering of a special skill and hence is too time-consuming. A ouija board was next utilized, but this, while somewhat effective in inducing a trance indirectly, was discarded because of its connotations of the supernatural. Resort was then more reasonably made to the simple movements of the type made automatically, promptly, requiring no particular skill. At first a modification of automatic writing was employed, a modification spontaneously and independently developed by a number of different subjects—namely, the use of a vertical line to signify “yes,” a horizontal line to signify “no,” and an oblique line to
signify “I don’t know.” This has been described elsewhere by Erickson and Kubie (Psychoanalytic Quarterly, Oct. 1939, 8, 471-509). It has often proved a rapid indirect technique of trance induction.

Once an ideomotor response is made, without further delay it can be utilized immediately. For example, should the patient shake his head “no,” his “yes” hand is gently lifted, and spontaneous catalepsy becomes manifest. Or if the “yes” finger makes an ideomotor response, the hand opposite is lifted to effect catalepsy; or the patient may be told that his head can agree with his finger. If his eyes are open (they often close spontaneously as the ideomotor activity begins), the simple suggestion can then be made that he can increase his physical comfort by relaxing comfortably, closing his eyes, resting pleasurably, taking a deep breath, and realizing with much satisfaction that his unconscious mind can communicate directly and adequately and is free to make whatever communication it wishes, whether by sign language, verbally, or in both manners. He is urged to realize that there is no rush or hurry, that his goals are to be accomplished satisfactorily rather than hurriedly, and that he can continue the unconscious mind communication indefinitely. Thus the words “trance” or “hypnosis” are avoided, and yet a multitude of hypnotic and posthypnotic suggestions can be given in the form of a manifestation of interest in the patient’s comfort, in explanations and in reassurances, all of which are worded to extend indefinitely into the future with the implied time limit of goals satisfactorily reached. (These italicized words are, in the situation, an actual double bind.) In this way a most extensive foundation is laid easily for good rapport, further trances, and rapid therapeutic progress, and usually this can be done within the first hour. In extraordinary cases the author has been forced by the patient to take as much as 15 hours, all spent by the patient in denouncing the author and the expected failure to result from the effort at treatment, with a good trance and therapeutic progress rapidly ensuing thereafter.

The use of this technique on the patient cited as an example above, whose intense, unhappy belligerency suggested its suitability, resulted in the development of a deep anamnestic trance employed to give posthypnotic suggestions governing future therapeutic hypnoanalytic sessions.

He was aroused from the trance by the simple expedient of remarking casually, as if there had been no intervening period of time, “Well, that is [note the present tense of the italicized word] some cussing that you have just been giving me.” Thus the patient was subtly reoriented to the time at which he had been verbally assaulting me and accordingly he arousal “spontaneously” from his trance state, appearing much bewildered, checked the clock against his watch and the author’s and then remarked in astonishment “I’ve been cussing you out for over 15 minutes, but a lot more than an hour has gone by! What happened to the rest of the time?” He was given the answer, “So you cussed me out about 15-20 minutes [a deliberate though minor expansion of his time statement], and then you lost the rest of the time! [Thus the patient is indirectly told he can lose.] Well, that is my cotton-picking business, and now that you know you can lose time, you ought to know you can lose some things you don’t want to keep just as easily and unexpectedly. So, get going, come back the same time next Friday, and pay the girl in the next room. The
patient’s own words were used but turned back upon him. Although these words were used originally in terms of starting therapy, they were now in relationship to the therapist instructing the patient about his part in the therapy. Also, since he had said that he was paying “good money” for therapy, by requesting immediate payment, he was unwittingly being committed to the idea that he was receiving that which he had so emphatically and impolitely demanded.

Upon his return on Friday he took his seat and asked in a puzzled but unduly tense voice, “Do I have to like you?” The implications of the question are obvious, the tension in his voice betokened alarm, and hence he had to be reassured with no possibility of his detecting any effort to reassure him. Accordingly the tone of the first meeting was reestablished safely by casually, comfortably stating, “Hell no, you damn fool, we got work to do.” The sigh of relief and the physical relaxation that followed this seemingly impolite and unprofessional reply attested to his need, and it easily shifted his attention to the purpose expressed in the italicized words and relieved him of an inner anxiety which was actually a probable threat to continuance of therapy.

As he relaxed the casual statement was made, “Just close your eyes, take a deep breath, and now let’s get at that work we got to do.” By the time the author had finished this statement, the patient was in a profound somnambulistic trance, and thereafter merely sitting down in that chair induced a trance. When the therapist did not wish him to develop a trance, he was simply asked to sit in another chair.

At the fourth session (a trance) he asked, “Is it all right to like you?” He was told, “Next time you come, sit in the straightback chair and the question and answer will come to you.” (Note sharing in the description of the technique.)

At the next session he “spontaneously” sat in the straightback chair, looked startled, and declared, “Hell yes, I can do any damn thing I want to.” The reply was made, “Slow learner, huh?” To this he answered, “I’m doing O.K.” and arose, sat in the regular chair and went into a trance. (He didn’t want any “baloney” about a “transference” and its “resolution,” but he could do “any damn thing” he “wanted to do.” Thus he recognized a certain emotional reaction, admitted it to himself, and then disposed of it by “going to work” and wasting no time in some laborious attempt at “analyzing his transference neurosis.” Instead he was solely interested in what he had previously said in the word of “get going.”

Therapy was less than 20 hours, each interview was highly productive with ever-increasing “sharing. “Ten years later he is still well-adjusted and a warm friend of the author, though our meetings are infrequent.

The technique described above has been used many times over a long period of years with minor variations. Various patients have contributed to its development by presenting opportunities for the author to introduce new suggestions and additional indirect communications and various types of double binds. As given above, it is in essence complete and has been extensively used in this form with only the modifications required
by the patient’s own intelligence and attitudes. To write this paper old records were consulted, and the technique itself was written out first as a separate item. Then for this paper it was rewritten with parenthetical inserts and explanatory paragraphs for an exposition of the technique. In the field experiments that follow below, not originally even considered, the copy of the technique without inserts was employed to permit a smoother and easier use with those patients.

**FIRST FIELD EXPERIMENT**

This paper had been typed in final form up to this point and it had been carefully reviewed that same evening. The next morning a most fortunate coincidence occurred. A new patient, 52 years old, a successful upper-social-class businessman, entered the office. He was shamefaced, embarrassed, and in apparently severe emotional distress. He pointedly looked at the state license to practice medicine in Arizona posted on the wall in accord with Arizona law, read the certificate from the American Board of Psychiatry and Neurology qualifying the author as a diplomate of that board, picked up the Directory of Medical Specialists from the dictionary stand, read the author’s qualifications there, picked up the Psychological Directory and read the author’s qualifications there, went to the bookcase and selected the books, *The Practical Applications of Medical and Dental Hypnosis and Time Distortion in Hypnosis*, pointed to the author’s name on the dust jackets, and remarked caustically, “So you fool around with that stuff!” The author agreed casually but (to add further fuel to the patient’s fire) added, “And just last night I finished writing a paper on hypnosis, and I am also the editor of *The American Journal of Clinical Hypnosis*.” The reply was, “Yes, I’ve heard plenty about you being a crackpot, but I’m in trouble (noting that the author was writing down each of his statements, the patient spontaneously slowed his speech to accommodate the author’s writing speed, but otherwise continued uninterruptedly with his complaints), and I need help.”

“And it’s getting worse. It began about eight years ago. I’d be driving to work and I would go into a panic and would have to park the car at the curb. Maybe a half-hour later I could drive the rest of the way to the office. Not constantly, but slowly it increased in frequency until one day it changed. I couldn’t park by the curb. I had to drive home. Sometimes it happened on my way home from the office and I’d have to drive back there. Then maybe after an hour, sometimes only a half-hour later, I could go to the office or home with no difficulty. My wife tried to drive me there to save me from these panic states. That just made things worse. I’d be sure to get a panic and yell at her to speed up. I tried taxicabs. That didn’t work. The taximen thought I was off my rocker because I would suddenly yell at them to turn around and try to make them break the speed laws getting back home or getting back to the office. I tried a bus once and I thought I’d go crazy. The bus driver wouldn’t let me off until he reached the next bus stop. I nearly killed myself running back home. It didn’t happen every day at first, but it kept getting more frequent until three years ago it was every day I was late to the office and late back home. I had to take a lunch with me. I would get a panic going to or coming back from lunch.”
“Three years ago I went into intensive therapy with Dr. X. He was trained in psychoanalysis at the Y Clinic for three years and had two years of controlled psychoanalysis himself. I saw him four or five times a week, an hour each time, for two and a half years, but I always had to allow about two hours to get there on time and then two more to get home. I didn’t always need the time. I sometimes arrived way ahead of time, and sometimes I could leave on time. But I just continued to get worse. Then about six months ago the psychoanalyst put me on heavy dosages of tranquilizers because I had made no improvement; but he kept on analyzing me. The analysis didn’t do any good. Some of the drugs would work for a week or even two, but then they would wear out. Most of them did nothing for me. Just name a tranquilizer; I’ve taken it. Pep pills! Sedatives! Extra analytic hours too. Then about a couple of months ago I tried whiskey. I never had done any drinking to speak of, but what a relief that whiskey was. I could take a drink in the morning, put in a day’s work at the office, take a drink and go home feeling fine. With the tranquilizers that worked, I hadn’t been able to do my office work, and even those that didn’t work interfered with my office work terribly. I had had to take a simpler job. For one month I used two drinks of whiskey a day, one in the morning, one at quitting time, and everything was O.K. Then about a month ago I had to double the moaning dosage, then take some at noon, then a double dose to get home. Then I started on triple doses with extra single ones thrown in between times. My home is 20 minutes from here. It took three drinks to get me here, stiff ones. I came early so I would have to wait a couple of hours and sober up, and I sober up fast.

“Just after I began my psychoanalysis I heard and read about hypnosis and heard of you. The psychoanalyst told me frankly what a crackpot you are and that hypnosis is dangerous and useless, but even if you are a crackpot, I know that at least you have proper medical and psychiatric credentials. And no matter how dangerous and useless and stupid hypnosis is, it can’t be as bad as alcohol. The whiskey I have to take each day now is turning me into an alcoholic.”

“Well, you can’t do any worse with hypnosis than what the alcohol is doing. I’m going to try to cooperate with you, but after all I have heard about hypnosis from my psychoanalyst, and all the published stuff denouncing it he gave me, I know nobody in his right mind is going to let himself be hypnotized. But at least you can try.”

This account was given while the newly finished paper on hypnotic techniques for patients uncooperative for various reasons was on the desk in front of the author. This suggested an immediate experiment. It was simply that the patient allow the author to read aloud his newly written paper, not disclosing the intention to use it as a hypnotic-induction technique. The man disgustedly agreed to the request but refused to fixate his gaze on any object. He kept glancing about the room, would not place his hands on his thighs, but did place them on the arms of the chair.

Slowly, carefully, the technique was read almost verbatim, sometimes rereading parts of it as judged best by his facial expression.
Finally the patient began to look first at one hand and then the other. At last his gaze
became fixated on the right hand. The left-index or “no” finger raised slightly, then the
left middle finger. Then the right index finger with jerky, cogwheel movements began
lifting in a perseverative fashion. His left index finger lowered, but the middle finger
remained cataleptic. His head then began a perseverative affirmative nodding that lasted
until he was interrupted by the induction of catalepsy in both hands. His eyes had closed
spontaneously when the left index finger was lowered.

He was allowed to remain in the trance, and the technique was again slowly, emphatically
read to him.

He was allowed to continue in the trance for an additional 30 minutes while the author
left the room briefly, came back, checked on the continued maintenance of his cataleptic
position, and then worked on this manuscript additionally.

Finally the patient was aroused from his apparently deep trance by reiteration of the
remark about reading the manuscript. He aroused slowly, shifted his position, and again
remarked that it (hypnosis) wasn’t any more harmful than alcohol. Suddenly he noticed
the clock with a startled reaction and immediately checked it with his own watch and
then the author’s. His startled comment was, “I came in here half an hour ago. The clock
and our watches say I’ve been here over two hours—nearly two and a half. I’ve got to
leave.”

He rushed out of the door, came rushing back, and asked how soon he could have another
appointment as he shook the author’s hand. He was given an appointment for three days
later and told, “Be sure to bring a full bottle of whiskey.” (He could not recognize the
implications of this but he replied that he would, that the one in his hip pocket was nearly
empty although it had been full that morning when he left the house.) He then departed
from the waiting room, came back, and again shook hands with the author, stating simply
that he had forgotten to say good-bye.

Three days later he entered the office smilingly, made a few casual remarks about current
events, sat down comfortably in the chair, and offered a compliment on a paperweight.
He was asked what had happened during the last three days. His eloquent reply was,
“Well, I’ve been wondering about that problem I came to you about. I was pretty hot
under the collar and I had plenty to say and I said it and you wrote it down word by word.
I kept trying to figure out what it was costing me per word to let you take your time just
writing it down. It irritated me quite strongly, and when I noticed I had been here two and
a half hours just to let you write down verbatim what I had to say, I made up my mind
that I would pay you for one hour only and let you argue about the rest. Then when you
told me to bring a full bottle of whiskey the next time I came, I felt just as I did about
those useless tranquilizers and I had half a mind not to come back. But after I got outside,
I realized I was feeling unusually free from tension even though I was late for a business
appointment, so I came back to say goodbye. [The reader will note that this is not the
exact chronological sequence recorded above.] Then I forgot to take a drink in order to
drive to my appointment, maybe because I was irritated about your mention of a full bottle of whiskey.

“Then the next day before I knew it, I was at the office on time, felt fine, put in a good day’s work, went out to lunch, and drove home. Same thing the next day. Then this morning I remembered I had an appointment with you today. I was still angry about that ‘full bottle’ you mentioned, but I got one out to put in my pocket. I took a small drink out of another bottle, but forgot to put the full bottle in my pocket. I suppose you will interpret that as resistance or defiance of authority. I say I intended to and simply forgot. I was on time at the office, put in a good day’s work, but at noontime an old-time friend dropped in unexpectedly and I had a long lunch with him along with a bottle of beer. Then I went back to work and just managed to remember my appointment in time to get here. So it’s beginning to look as if you might be able to help me if you get around to starting instead of just writing down what I say. That’s what took so long last time. I didn’t need that drink this morning, but I couldn’t come to you under false pretenses so I took one. A cocktail at dinner is O.K., but a morning drink is just no good. Somehow I don’t feel bad about your taking your time to write down everything I say.”

There was some casual discussion of current events, and the author offered the unexpected comment to the patient, “Well, let’s see. You were once an editorial writer on a large metropolitan newspaper, and editorials are supposed to mold the opinions of the masses. Tell me, is the opinion molded in the conscious mind of the person; and what is your definition of the ‘conscious mind’ and the ‘unconscious mind’?” He replied, “You don’t go through two and a half years of psychoanalysis with wholehearted cooperation and then get brainwashed for another half-year with tranquilizers plus analysis, without learning a lot and losing a lot. All I can give you is an ordinary lay definition, namely, your conscious mind is the front of your mind and your unconscious mind is the back of your mind. But you probably know more about that than I do or Dr. X.” He was asked, “And is it possible that ever the twain shall meet?” His answer was, “That’s an odd question, but I think I get what you mean. I think that the unconscious mind can tell the conscious mind things, but I don’t think the conscious mind can either tell the unconscious mind anything or even know what is in the unconscious. I spent plenty of time trying to excavate my unconscious mind with Dr. X and getting just nowhere, in fact getting worse.” Another question was put to him, “Shall I discuss the conscious mind and the unconscious mind with you some time?” His answer was, “Well, if you keep on writing down everything I say and everything you say, and I have all the luck with my problem that I had when you spent the whole time just writing down my complaints the way you did last time—by the way, I had a wonderful afternoon playing golf yesterday with a client, first good game in years and no drinking either—well, go right ahead and discuss the conscious mind, the unconscious mind, politics, hypnosis, anything you wish.”

He was asked why he had made that reply. His answer was, “Well, this is a bit embarrassing. I’m 52 years old and I am just bubbling over inside like a little boy, and the feeling is one I would call faith and expectancy, just like a little kid who is dead
certain he is going to have his most hopeful dreams about going to the circus fulfilled. Sounds silly, doesn’t it, but I actually feel like a hopeful, happy, expectant little boy.”

The reply was made by asking, “Do you remember the position you sat in in that chair?” Immediately he uncrossed his legs, dropped his hands on his lap, closed his eyes, slowly lowered his head, and was in a deep trance in a few moments’ time.

The rest of the hour was spent in an “explanation of the importance of reordering the behavior patterns for tomorrow, the next day, the next week, the next year, in brief, of the future, in order to meet the satisfactory goals in life that are desired.” This was all in vague generalities, seemingly explanations but actually cautious posthypnotic suggestions, intended to be interpreted by him to fit his needs.

He was aroused from the trance by remarking casually, “Yes, that is the way you sat in the chair last time,” thereby effecting a reorientation to the time just previous to this second trance. As he aroused and opened his eyes, the author looked pointedly at the clock. The patient was again startled to find that time had passed so rapidly, asked for another appointment in three days but agreed to wait five days. On the way out of the reception room he paused to look at some wood carvings and commented that he was intending without delay to do some woodwork long postponed.

Five days later the man came in smilingly, sat down comfortably in his chair, and presented a conversational appearance. He was asked what had happened over the weekend and the other three days. His reply, given slowly and patiently as it was recorded by the author, was most informative.

“I’ve seen you twice. You haven’t done a darn thing for me or my problem, and yet something is going on. I had trouble with my problem three times. I was going to the City A to dine with friends, my wife was in the front seat but I was driving. I felt the old panic coming on but I didn’t let my wife know it. I haven’t driven that road for years, and the last time I did, I got a panic at the same place that this new one seemed about to develop. That time I stopped the car, pretended to examine the tires, and then I asked my wife to drive. This time nothing could stop me from continuing to drive and the panic went away, but just when, I don’t remember. We all had a nice time and I drove back without remembering the near panic I had on the way out. Then this noon I went to a hotel where I haven’t eaten for years because of panics, and just as I was leaving, an old friend came up to greet me and to tell me a long-winded, boring story and I got mad at him—I wanted to get back at the office. I was just mad, not panicky. Then when I left the office to come here, a client nabbed me at the door and told me a joke, and I got mad because he was delaying my trip to your office. When I did get away, I realized that I had had only one slight panic that I handled all by myself, and what you might call ‘two mads’ because I was delayed by someone interfering with my going where I should go. Now you will have to tell me what’s going on here. Oh yes, my wife and I had two drinks one night before dinner. She said a couple of mixed drinks would taste good and they did.”
“But what is going on? You sit and write down what you and I say. You don’t hypnotize me, you aren’t doing any psychoanalysis. You talk to me but you don’t say anything in particular. I suppose when you get around to it you will hypnotize me, but what for I don’t know. That problem I came in with, psychoanalyzed without results for two and a half years and brainwashed with tranquilizers and psychoanalysis for another half-year, and now in two hours without you doing anything, I’m pretty sure I’m over my problem.”

A casual reply was made that therapy usually takes place within the patient, that the therapist is primarily a catalyst. To this he answered, “Well, ‘catalyst’ when you get ready. If I can waste three years on psychoanalysis and tranquilizers and just get worse it’s wonderful to go to the office and home and to lunch again and it was good to meet that old friend at the hotel, and that story our client told me wasn’t half bad. When is my next appointment?”

He was instructed to come in a week’s time and to let his unconscious mind work on his problem “as needed.”

A week later the man entered the office and inquired with some bewilderment, “Things are happening all right. I’ve had panics all week, not bad ones, puzzling ones. They were all in the wrong places. I do my regular work in the way I want to, I’ve increased my workload. I go back and forth to my office O.K. But what happens is something silly. I put on one of my shoes perfectly comfortably, but as I reach for the other, my panic hits me hard for a moment, then disappears, and I put on the other shoe comfortably. I drive into the garage, turn off the ignition, get out of the car, lock the garage door, and a sudden panic hits me, but by the time I’ve put my car keys in my pocket, the panic is gone. What’s more, every panic I get makes me more amused, it’s so silly and so short. I don’t even mind them. It’s funny how a man can get so panicky and suffer the way I did for so long when now it is so brief and so amusing.”

“I wonder if the reason for these panics isn’t my wife’s irritation with me. She has always wanted me to see things her way, and it always made me mad. So I wonder if I get into these panics because they irritate the hell out of her. You know. I think that’s the underlying cause. What I suspect is that somehow you are making me tear up the old problem and scatter it around like confetti. I wonder if that’s what I’m doing, tearing up my problem and just throwing it to the wind. I wonder why in three years I never told my analyst about my wife’s antagonism. Four or five or more hours a week for three years ought to drain dry every idea a man has. Why did I tell you? You never asked! Oh yes, I played two days of golf the way I like to play, no drinking, no panics. Then on the way here I got a panic as I stepped outside the office building, and so I went into the [adjacent] bar, ordered three double shots of whiskey, paid for them, looked at them all lined up for me and never saw a sillier thing in my life. So while the bartender just stared at me and the untouched drinks, I walked out. I didn’t have a panic.”

“Now you have been writing about half-hour on what I’ve been telling you, and that clock there says its half-past the hour and I’m willing to bet the next time I look at it, it will be on the hour.” (The implications of this remark are obvious.)
Slowly, gravely, the answer was given, “You are entirely right. “ Immediately his eyes closed, and a deep trance ensued at once. He was promptly asked to review the progress he had made and the account of the current interview was read slowly to him. As he listened, his head slowly nodded perseveratively in an affirmative fashion.

Exactly on the hour he was told, “It’s just as you said, it’s exactly the hour by the clock.” He awoke, stretched, yawned, and asked, “How about next week, same time?”

The appointment was made.

As he left the office, he remarked, “I’m reading this (taking from his jacket pocket) delightful book. Would you like to read it when I’m finished?” He was assured that it would be a pleasure.

The next meeting was most enlightening. As he entered, he remarked, “I’m enjoying these conversations. I’m understanding. For years I have unconsciously resented my wife in one way only. Her father died when she was an infant, and her mother swore she would be a father to the little baby. She was. She still is, and my wife is like her mother. She wears all the pants in the home. Mine, and my son’s too. She is completely the man in the house in every way. But we are so compatible in every other way, and we are deeply in love with each other, and she always decides things the right way. The thing is, I would like permission from her to make the decision she is going to make anyway. No, that’s wrong. I want no permission, I just want to make decisions and let her agree with them because my decision is right, instead of my agreeing with her decisions because they happen to be the ones I would make. Funny, I never even talked about all this in the three years’ time in psychoanalysis; now I wonder why I have told you all this when I didn’t even think highly of hypnosis. And last Sunday I laughed to myself. My wife announced that she was taking me and the kids to an entertainment that I wanted to attend, and she knew it. But I decided I would just stay home and I told her so. I really enjoyed doing it and I felt greatly amused. It was worth missing it. I just felt like a happy little boy who had successfully asserted himself.”

“Now with your permission I’m going to—no, I don’t want your permission because I decided to do it and I’ve been doing it for almost a week. What I do is this. The first day I got in my car, I deliberately had a short panic after the first block or two, and then drove on to the office comfortably. The next day I drove still further and deliberately had another brief panic and drove on. The same thing is done when I go home. I’ve only got about enough distance left for about four or five more short panics. Then I’ll be through. But I’m not going to stop seeing you. It’s worth it to have a conversation with you once a week if you don’t mind, and I expect to be charged for it.”

Therapy has continued in this fashion; at first a simple report by the patient of his “own behavior” with no expectation of any comment from the author and a general conversation on various related topics. Thus did the patient take over the responsibility of his own therapy, doing it in his own way at his own speed.
He is still continuing his weekly visits, sometimes on a purely social level, sometimes discussing the teenage behavior of his children not as a problem but as an interesting contrast to his own. His own problem has vanished so far as any personal difficulties are concerned. That he is willing to pay a psychiatric fee for social visits suggests that unconsciously the man wants the assurance of a continued friendship for some length of time from one who aided him to achieve a satisfying sense of masculine dominance without compelling him to go through a long, dependent, submissive, and fruitless relationship in search of therapy, but who instead simply placed the burden of responsibility for therapy upon him and his own unconscious mind. However, as the weeks go by the evidence is building that he will soon be reducing the frequency of his visits. Early summer plans have been repeatedly mentioned and these, as they are outlined, will make visits impossible. Thus, his unconscious mind is informing the author of the impending termination. Invariably he goes into a spontaneous trance of five to ten minutes' duration as the end of the hour approaches. In this trance he remains silent, and so does the author.

Similar therapeutic procedures have been employed in the past, not exactly in this fashion but in a decidedly comparable manner. One patient will make an appointment phrasing his request, “so that I can have my batteries recharged” (meaning a trance, sometimes with helpful suggestions, sometimes merely a trance). Other patients come in seemingly for no more than a “casual” conversation, eventually discontinuing this practice. In the past such therapeutic procedures have sufficed to achieve long-term satisfactory results, as witnessed by follow-up inquiries five and ten years later.

**SECOND FIELD EXPERIMENT**

Another unexpected opportunity arose to test the above technique. A 24-year old-girl who became acutely disturbed in 1961 by visual and auditory hallucinations of a persecutory character developed many persecutory delusions, became antagonistic (she was the youngest) toward her two siblings and her parents, and finally had to be hospitalized on an emergency basis where her case was diagnosed as schizophrenia, paranoid type, with a doubtful prognosis.

“Psychodynamically oriented” psychotherapy was undertaken by various psychoanalytically trained psychiatrists. The girl, a college student of decidedly superior intelligence, made mockery of them, ridiculed psychoanalytic concepts, placed the psychoanalysts in a self-defensive position, or else angered them and was regarded by them as “not amenable to any kind of psychotherapy.” Electroshock therapy was recommended but refused possibly by both the relatives as well as by the patient. (The father, a dentist, had sought counseling on the matter from two other psychiatrically trained psychotherapists who had advised against it as too soon to be warranted. Hence it is not known whether the father or the patient refused, or both, the patient stating very simply, “I would not tolerate having my brains scrambled for thumbpushes on a button at $30 a push”).
She was asked what she wished of the author. Her statement was, “I have a family that think you can hypnotize me into sanity, as they call it. God, how I hate them. So they just signed me out of the state hospital and brought me here willy-nilly. Now what kind of an ass are you going to make of yourself?”

“None at all, I hope, regardless of my potentialities. I’m not going to psychoanalyze you, I’m not going to take your history, I don’t care about your Oedipus complex or your anal phase, I’m not going to Rorschach you or T.A.T. you. I’m going to show you a letter from your father (which reads in essence ‘My college daughter 22 years old is very disturbed mentally. Will you accept her for therapy?’) and my answer to him (which reads in essence ‘I shall be glad to see your daughter in consultation.’). I do have one question to ask you, What did you major in?”

She answered, “I was going to major in psychology, but things began to go wrong so I just switched in my junior year to English, but I’ve read a lot of that crap called psychology. And I am fed up to the ears with psychoanalysis.”

“Good, then I won’t have to waste your time or mine. You see, all I want to do is to find out if we can understand each other. Now be patient with me and let me ramble on. You’re here on a two-hour appointment and as long as you’re going to be bored, let it be as boresome as can be.”

Promptly she said, “Well, at least you are honest; most psychiatrists think they are interesting.”

Very rapidly the author then explained that he was going to read to her a paper he had just written (she interjected, “Do anything to get an audience, wouldn’t you?”) and immediately he had, as in the preceding case, asked her to put both feet on the floor, her hands on her thighs, to stare steadily at the clock, being sure that she just “plain resented” the boredom “instead of going to sleep.” (She knew that the author employed hypnosis, and this precluded her from thinking hypnosis would be used.)

Systematically the technique described above was used again almost verbatim. The only difference was that the author proceeded more slowly, and at first there was much repetition by varying slightly the words but not the essence of their meaning.

At first her expression was one of scornful mockery, but she suddenly declared in amazement, “My right hand is lifting, I don’t believe it, but it is and I’m not in a trance. Ask a different kind of question.”

She was asked if her unconscious mind thought it could communicate with me. In astonishment she declared, “My head is nodding ‘yes’ and I can’t stop it, my right hand is lifting up and I can’t stop it, and my right index finger is also lifting too. Maybe my unconscious mind can communicate with you, but make them stop moving.”
“If your unconscious mind wants to stop them, it will do so itself” was the answer given to her.

Almost at once she said, “Oh, they’ve all stopped, so now maybe if you just ask me the questions, I can get at some stuff that I know I’ve repressed. Will you please go ahead?”

Her eyes closed, a spontaneous trance developed, therapeutic rapport was well-established before the two hours were up, and their girl is now a most eager, cooperative, and thoroughly responsive patient, making excellent progress.

This was but another impromptu field experiment prompted by the overt hostility of the opening of the session. She had been seen for less than 10 hours when her family expressed the belief that she was better than she was at anytime previously in her life. She, however, laughingly stated, “You don’t live with mixed-up ideas such as I had so long as I did without learning that there is a terrific interweaving in all of your thinking. I want to stay in therapy and just keep on learning to understand myself.”

Following the first 10 hours she enrolled in college where she is making an excellent adjustment seeing the author once a week. She discusses objectively, well, and understandingly her past symptomatic manifestations as emotionally violent experiences belonging to the past and usually terminates the therapeutic hour with a 15- to 20-minute trance.

**THIRD FIELD EXPERIMENT**

Before this paper had been typed in final form a third patient with a totally different type of resistance came into the office. She walked with a controlled rigidity of her body, stepping softly. The right side of her face was one of obviously controlled frozen immobility; she spoke clearly and lucidly, with a patterned left-sided mouthing of her words; her right eye blink was markedly reduced; her right arm movements were constrained and hesitant, and when she moved her hand toward the right side of her face, such movement was slower and definitely guarded in comparison with her left-arm movements, which were free and easy and decidedly expressive.

To spare the patient she was asked immediately, “How long have you had trigeminal neuralgia? Answer in the fewest possible words and slowly, since I do not need too much history to begin your therapy.”

Her reply was “Mayos’, 1958, advised against surgery, against alcohol injections, told there was no treatment, have to put up with it and endure it all my life, (tears rolled down her cheeks), a psychiatrist friend said maybe you help.”

“You working?”

“No, leave of absence, psychiatrist friend say see you—get help.”
“Want help?”

“Yes.”

“No faster than I can give it?” (That is, would she accept help at the rate I considered best. I wanted no expectation of a “miracle cure.”)

“Yes.”

“May I start work on you now?”

“Yes, please, but no good, all clinics say hopeless, painful. Everybody enjoy himself but I can’t. I can’t live with my husband, nothing, just pain, no hope, doctors laugh at me see you for hypnosis.”

“Anyone suspect psychogenic origin of pain?”

“No, psychiatrists, neurologists, Mayos’—all clinics say organic, not psychogenic.”

“And what advice do they give you?”

“Endure; surgery, alcohol, last resort.”

“Do you think hypnosis will help?”

“No, organic disease, hypnosis psychological.”

“What do you eat?”

“Liquid.”

“How long does it take to drink a glass of milk?”

“Hour, longer.”

“Trigger spots?”

In a gingerly fashion she pointed at her cheek, nose, and forehead.

“So you really think hypnosis won’t work! Then why see me?”

“Nothing helps, one more try only cost a little more money. Everybody says no cure. I read medical books.”

This was far from a satisfactory history, but the simplicity and honesty of her answers and her entire manner and behavior were convincing of the nature of her illness, its acute
and disabling character, the reality of her agonizing pain, and her feeling of desperation. Her pain was beyond her control, it did not constitute a condition favorable to hypnosis; she was well-conditioned over a period of 30 to 40 out of 60 months (as was afterward learned) by the experience of severe uncontrollable pain with occasional brief remissions, and all respected medical authorities had pronounced her condition as incurable and had advised her “to learn to live with it and only as a last resort to try surgery or alcoholic injections.” She had been informed that not even surgery was always successful, and surgical residuals were often troublesome. One man only, a psychiatrist who knew the author, advised her to try hypnosis as a “possible help.”

In view of this well-established background of learning and conditioning based upon long experience direct hypnosis was regarded as inviting a probable failure. Accordingly the technique for resistant patients was employed. She was allowed to sit and watch the author, which she did with desperate attention. No suggestion of any sort was offered except the statement, made with marked firmness of tone of voice, “Before I make any beginning of any sort, I want to offer you some general explanation. Then we can begin.” Very gently she nodded her head affirmatively.

The author proceeded at once with the technique described above, referring openly to the typed manuscript to make the repetition of it as verbatim as possible.

She responded to the technique with remarkable ease, demonstrated ideomotor movements of her head and arm catalepsy.

There was added to the technique the additional statements that an inadequate history had been taken, that her unconscious mind would search through all of its memories, and that she would communicate freely (to do so “freely” would imply “comfortably”) any and all information desired, there should be a careful search of her unconscious mind of all possible ways and means of controlling, altering, changing, modifying, reinterpreting, lessening, or in any other way doing whatever was possible to meet her needs. She was then given the posthypnotic suggestion that she would again sit in the same chair and depend upon her unconscious mind to understand the author and his wishes. Slowly, perseveratively, she nodded her head in the affirmative.

She was aroused from the trance by saying, “As I just said, ‘Before I make any beginning of any sort, I will want to offer you some general explanation. Then we can begin.’” To this was added with a pointed inflection, “Is that all right with you?” Slowly, over a period of two minutes, she opened her eyes, shifted her position, wiggled her fingers, twisted her hands, and then answered very easily and comfortably in marked contrast to her previous labored and guarded answers, “That will be perfectly all right.”

Immediately, in a most startled fashion, she exclaimed, “Oh my goodness, what happened? My voice is all right and it doesn’t hurt to talk.” With this she gently closed her mouth and slowly tightened the masseter muscles. Promptly she opened her mouth and said, “No, the neuralgia is there just as severe as ever, but I’m talking without any pain. That’s funny. I don’t understand. Since this attack began, it’s been almost impossible to talk, and I don’t feel the air on my trigger points.” She fanned her cheek,
nose, and right forehead, then gently touched her nose with a resulting spasm of extreme pain.

When this had subsided she said, “I’m not going to try the other trigger spots even if my face does feel different and I have normal speech.”

She was asked, “How long have you been in this room?” Wonderingly she replied, “Oh, five minutes, at the very most 10, but not really that long.” The face of the clock was turned toward her (its position had been carefully changed during her trance). In utter bewilderment she exclaimed, “But that’s impossible. The clock shows more than an hour!” Pausing, she slid her watch from under her sleeve and said again (since her watch and the clock agreed) “But that’s utterly impossible,” to which the author said with great intensity, “Yes, it is quote utterly impossible unquote but not in this office.” (The indirect hypnotic suggestion is obvious to the reader but it was not to the patient.)

She was given an appointment for the next day and rapidly ushered out of the office.

Upon entering the office she was asked before she took her seat, “And how did you sleep last night. Did you dream?”

“No, no dreams, but I kept waking up over and over all night long, and I kept having the funny thought that I was waking up to take a rest from sleeping or something.”

She was told, “Your unconscious mind understands very well and can work hard, but first I want a fully history on you before we work, so sit down and just answer my questions.”

Searching inquiries revealed a well-adjusted parental home, a happy childhood, and excellent college, marital, economic, social, and professional adjustments. It was also learned that her first attack had begun in 1958, had lasted continuously for 18 months during which time she had futilely sought medical or surgical aid from various well-known clinics, had undergone psychiatric examinations to rule out possible psychogenic factors, and had consulted various prominent neurologists. She was a psychiatric social worker and had a cheerful habit of softly whistling merry tunes almost continuously while at work or even walking down the street. She was exceedingly well-liked by her colleagues and explained that she had been referred to the author by an old-time friend of his, but that all others had commented most unfavorably about hypnosis. To this she added, “Just meeting a medical man who uses hypnosis has already helped me. I can talk easily, and this morning when I drank my glass of milk I did it in less than five minutes, and it usually takes an hour or more. So it wasn’t a mistake to come here.”

The reply was given, “I’m glad of that.” Her eyes glazed, and spontaneously she developed a deep trance.

The details of the indirect suggestions to the effect that her unconscious could do what it desired will not be given. Partial remarks, remarks with implications, double binds, and making one thing contingent upon something entirely unrelated when read seem much
too meaningless to report. When spoken, the intonations, the inflections, the emphases, the pauses, and all the varying implications and contingencies and double binds that could thus be created set into action a wealth of activities for which variously disguised instructions could be given. For example one statement was that the cracking of a Brazil nut with her teeth on the right side of her mouth would really be most painful, but, thank goodness, she had better sense than to try to crack Brazil nuts or hickory nuts with her teeth, especially on the right side of her mouth for the reason that it would be so painful and not at all like eating. The implication here is most emphatically that eating is not painful. Another was, “It’s just too bad that that first bite of filet mignon will be so painful when the rest of it will be so good.” Again the implication could not be fully recognized, since the author immediately digressed to some other type of suggestion.

She was aroused from the trance state by the simple remark, “Well, that’s all for today.” Slowly she awakened and looked expectantly at the author. Pointedly he directed her attention to the clock. She exclaimed, “But I just got here and told you about the milk, and [looking at her watch] a whole hour has gone by! Where did it go?” Airily, flippantly (so that she could not suspect the reply) the author said, “Oh, the lost time has gone to join the lost pain,” and she was handed her appointment card for the next day and quickly ushered out of the office.

The next day she entered the office to declare, “I had filet mignon last night and the first bite was awful agony. But the rest of it was wonderful. You can’t imagine how good it was, and the funny thing is that when I combed my hair this morning, I got a silly urge to jerk locks of it here and there. It made me feel so foolish but I did it, and I was watching my strange behavior and I noticed my hand resting on my right forehead. It isn’t a trigger spot any more. See [demonstrating], I can touch it anywhere.”

At the end of four hour-long sessions her pain was gone, and she raised the question at the fifth, “Maybe I ought to go back home.” In a jocular manner the author said, “But you haven’t learned how to get over the recurrences!”

Immediately her eyes glazed, closed, a deep trance ensued, and the author remarked, “It always feel so good when you stop hitting your thumb with a hammer.”

A pause, then her body stiffened in a sudden spasm of pain, and then almost as quickly relaxed, and she smiled happily. Flippantly the author said, “Oh, phooey, you need more practice than that, work up a sweat with a half dozen, that will really make you realize that you’ve had excellent practice.” (Flippancy does not belong in a dangerous or threatening situation, only where the outcome is certain to be pleasing.) Obediently she did as asked, and beads of perspiration formed on her forehead. When she had finally relaxed, the comment was made, “Honest toil brings beads of perspiration to the brow—there’s a box of tissue there, why not dry your face.” Taking her glasses off, and still in the trance, she reached for a sheet of tissue and mopped her face. She dried her right cheek and her nose as briskly as she had the painless left side of her face. No mention of this was made directly, but the seemingly irrelevant comment was made, “You know, it’s nice to do things remarkably well and yet not know it.” She merely looked puzzled.
except for an odd little smile of satisfaction. (Her unconscious was not yet “sharing” the loss of the trigger spots of her cheek and nose.)

She was aroused with the statement, “And now for tomorrow,” handed her appointment card, and promptly dismissed.

As she entered the office at the next appointment, she remarked, “I just am at a loss about everything today. I don’t need to come, but I’m here and I don’t know why. All I know is the steak tastes good and I can sleep on my right side and everything is all right, but here I am.” The answer given was, “Certainly you are here; just sit down and I’ll tell you why.

Today is your ‘doubt day,’ since anybody who has lost that much trigeminal neuralgia so fast is entitled to some doubts. So, slap your left cheek hard.” Promptly she administered a swift, stinging slap, laughed, and said, “Well, I’m obedient, and that slap really stung.”

With a yawn and a stretch the author said, “Now slap your right cheek the same way.” There was marked hesitation followed by a quick slapping movement, the force of which was greatly reduced at the last fraction of a second. The author promptly remarked rather mockingly, “Pulled your punch, pulled your punch, had a doubt, didn’t you, but how does your face feel?” With a look of astonishment she answered, “Why, it’s all right, the trigger point is gone and there is no pain.” “Right. Now do as I told you and no more pulling your punch.” (One does not yawn and stretch and speak mockingly to a patient who might have agonizing pain, but she could not analyze this.)

Very quickly and forcibly she slapped her right cheek and nose with a stinging blow and remarked, “I did have a doubt the first time but I haven’t got any now, not even about my nose because I hit that too, but I didn’t have that in mind.” Thoughtfully she paused and then struck her forehead hard with her fist. She remarked, “Well, there’s the end of doubts,” her tone of voice both jocular and yet intensely pleased. In a similar manner the author remarked, “Astonishing how some people have to have a little understanding literally pounded into their heads.” Her immediate reply was, “It’s obvious there was room for it.” We both laughed and then, with a sudden change of manner to one of utter intentness and gravity, she was told with slow heavy emphasis, “There is one thing more I want to tell you.” Her eyes glazed, a deep trance ensued. With careful, impressive enunciation she was given the following posthypnotic suggestion. “You like to whistle, you like music, you like meaningful songs. Now I want you to make up a song and a melody using the words ‘I can have you anytime I want you, But, Baby there ain’t never gonna be a time when I want you,’ and forever and always, as you whistle that tune you will know, and I do not need to explain, since you know! “Slowly, perseveratively, her head nodded affirmatively. (The burden of responsibility was hers, the means was hers.)

She was aroused by the simple statement, “Time really travels fast, doesn’t it?” Promptly she awakened and looked at the clock and said, “I’ll never understand it.” Before she could proceed, she was interrupted with, “Well, the deed is done and cannot be undone, so let the dead past bury its dead. Bring me only one more good tomorrow and you will go home tomorrow with another good tomorrow and another and another, and all the
other good tomorrows are forever yours. Same time” (meaning appointment for the next
day at the same hour). She left the office without delay.

The final interview was simply one of a deep trance, a systematic, comprehensive review
by her within her own mind of all of her accomplishments and the gentle request to
believe with utter intensity in the goodness of her own body’s potentials in meeting her
needs and to be “highly amused when the skeptics suggest that you have had remissions
before followed by relapses.” (The author is well aware of the deadliness of skeptical
disparaging remarks and of the engendering of iatrogenic disease.) Correspondence
received since her return home has confirmed her freedom of pain and also that a
neurologist, antagonistic toward hypnosis, offered her a long argument to the effect that
the relief she experienced would be most transient and that there would be a relapse (an
unwitting effort to produce iatrogenic disease). She related this, stating that his argument
had made her feel “highly amused,” thereby quoting directly from the author’s own
posthypnotic suggestion.

**DISCUSSION AND COMMENTS**

In previous publications this author has repeatedly indicated indirectly or directly that the
induction of hypnotic states and phenomena is primarily a matter of communication of
ideas and the elicitation of trains of thought and associations within the subject and
consequent behavioral responses. It is not a matter of the operator doing something to
subjects or compelling them to do things or even telling them what to do and how to do it.
When trances are so elicited, they are still a result of ideas, associations, mental processes
and understandings already existing and merely aroused within the subjects themselves.
Yet too many investigators working in the field regard their activities and their intentions
and desires as the effective forces, and they actually uncritically believe that their own
utterances to the subject elicit, evoke, or initiate specific responses without seeming to
realize that what they say or do serves only as a means to stimulate and arouse in the
subjects past learnings, understandings, and experiential acquisitions, some consciously,
some unconsciously acquired. For example the affirmative nodding of the head and the
negative shaking of the head are not deliberate, intentional, supervised learning, and yet
become a part of verilized or nonverbalized overt communication, or an expression of
the mental processes of the person, who thinks he is merely listening to a lecturer
addressing an audience, which is unrecognized by the self but visible to others. Then, too,
as another example, one learns to talk and to associate speech with hearing, and we need
only to watch the small child learning to read to realize that the printed word, like the
spoken word, becomes associated with lip movements and, as experiments have shown,
with subliminal laryngeal speech. Hence when a severe stutterer endeavors to talk,
definite effort is required by listeners to keep their lips and tongue from moving and to
refrain from saying the words for the stutterer. Yet there never was any formalized or
even indirect teaching of the listeners to move their lips, their tongue, or to speak the
words for the stutterer. Nor does the stutterer want any other person to do it; he even
resents it strongly. But this experiential learning is unconsciously acquired and is elicited
by stimuli not even intended to do so but which set into action mental processes which
the listener at an involuntary level, often uncontrollable and even known to be likely to
incur bitter resentment on the part of the stutterer. The classic joke in this connection is
that of the stutterer who approached a stranger and stammered painfully a request for
directions. The stranger pointed to his ears and shook his head negatively, and the
stutterer made his inquiry again of another bystander, who gave the directions. Thereupon
the bystander asked the man who had indicated that he was deaf why he had not replied,
and received the badly stuttered reply of, “Do you think I wanted my head knocked off?”
His reply disclosed eloquently his full knowledge of his own intense resentments when
somebody tried to “help” him to talk or seemed to mock him.

Yet the stutterer has not asked directly or indirectly for the other person to say his words
for him; the listeners know it will be resented and do not want to do it, yet the distressing
stimuli of stuttered words elicit their own long established patterns of speech. So it is
with the stimuli, verbal or otherwise, employed in induction techniques, and no one can
predict with utter certainty just how a subject is going to use such stimuli. One names or
indicates possible ways, but the subjects behave in accord with their learnings. Hence the
importance of loosely organized, comprehensive, permissive suggestions and the relative
unimportance of ritualistic, traditional techniques blindly used in rote fashion.

On several occasions this author has had opportunity to do special work with congenitally
deaf people and those who had acquired nerve deafness in childhood, one an instance of a
man who acquired nerve deafness after the age of 40. All of these people had been
trained in “lip reading,” although most of them explained to the author that “lip reading”
was “face reading,” and all of them could do sign language. To prove this one of these
deaf people took the author to listen to a Sunday sermon by a heavily bearded minister
and, by sign language, “translated” to show that he was “face reading,” since the author
then could read sign language. Further experimentation with this deaf man disclosed that
if the minister spoke in a monotone or whispered, his face could not be “read.”

With these deaf people an experiment was done in which it was explained that an
assistant would write on a blackboard various words and that several adults (college
level) would face the blackboard and merely silently watch the writing, making no
comment of any sort. It was also explained to these adults that, separately, strangers
would be brought in and placed in a chair facing them with their backs to the blackboard
and continuing to face them as the assistant did the writing. They were not told that the
strangers were deaf and could “lip read.”

The deaf persons were fully aware that they were, to “read the faces” before them and
that they would be reading silently what the assistant was writing, but one additional fact
was not disclosed.

In beautiful Spencerian script in large letters the assistant wrote words of varying
numbers of syllables. What only the author and the assistant knew was that the words
were written to form designs of a square, a diamond, a star and a triangle by the process
of placing the words at the strategic points of the angles of the figures. A circle (the last
figure) had been previously written on a black cardboard and was hung up on the
blackboard. This latter was formed by the fewest possible and shortest words to permit
easier reading as well as the design recognition.

The deaf persons were sitting behind a barrier just high enough to conceal their hands. As
the assistant wrote, the author sat so he could see only the deaf persons’ hands. The
author could not see the blackboard nor did he know the order of the designs or what the
words were. He did know that a list of possible words had been made by him and the
assistant but that only about a third of them would be required and that the assistant
would make his own choices. Furthermore for each deaf person each design except the
circle would be in a different sequential order.

One subject (the deaf woman who had acquired nerve deafness after the age of 40) made
a perfect score. Not only were the written words “read” by her in the faces of the adults
watching the writing, but so were the identities of the designs. Moreover she told the
author in sign language that there was “something wrong” with the words “square,”
“diamond,” and “triangle” and something was “a little bit funny” about the word “star,”
and something “very funny” about the word “circle.” One must add, however, that this
woman was exceedingly paranoid, psychotically so. None of the others had a perfect
record. One man gave all the replies except “circle.” He “sign languaged” that the last
series of words was written differently, but he could not explain how he identified all of
the written words forming the circle. The other subjects all identified the written words,
experienced some mild confusion about the words forming the circle, and missed “star”
and “circle.” This group all felt that they had missed two of the “words.” All except the
paranoid psychotic patient were allowed to see the blackboard, and the observers all were
surprised to find that the strangers had read their facial expressions for both the design
recognition as well as the written words.

This experiment was long in the author’s mind in relation to the development of his own
personal approach to the induction of hypnosis. Therefore, keeping well and clearly in
mind his actual wishes, the author casually and permissively (or apparently permissively)
presents a wealth of seemingly related ideas in a manner carefully calculated to hold or to
fixate the subject’s attention rather than the subject’s eyes or to induce a special muscle
state. Instead every effort is made to direct the subject’s attention to processes within
himself, to his own body sensations, his memories, emotions, thoughts, feelings, ideas,
past learnings, past experiences, and past conditions, as well as to elicit current
conditionings, understandings and ideas.

In this way, it is believed by the author, hypnosis can be best induced and a good
hypnotic technique so organized can be remarkably effective even under seemingly
highly adverse circumstances. However, the author has so far always failed with behavior
merely personally objectionable to the subject but entirely legitimate. An account of an
instance of this is given in this volume, (See “Another example of confusion in trance
induction”), and more than one otherwise compliant subject has “shut off my hearing,” or
awakened.
In this particular paper a total of four subjects were dealt with by a single technique with only slight modifications to meet the requirements of sex, intelligence, and educational level. All four represented different types of resistance, different backgrounds, and different types of problems. One was a rather severely maladjusted person, the second was unhappily governed by peculiar, circumscribed, uncontrollable maladjustments, the third had a long history of general maladjustment eventuating in a state hospital commitment with a diagnosis of “psychosis, paranoid type, probably schizophrenic,” and the fourth was a patient diagnosed repeatedly at competent clinics and by competent neurologists and psychiatrists as suffering from a hopeless organic condition characterized by occasional brief remissions and treatable only in a partially satisfactory manner by organic measures entailing undesirable results. Five years’ experience of excruciating pain had firmly convinced and conditioned this last patient to the understanding that the condition was untouchable by psychological measures, and only hopeless desperation led to the seeking of hypnotherapy.

The technique employed so successfully upon four such diverse patients was essentially a rigid arresting and fixation of their attention and then placing them in a situation of extracting from the author’s words certain meanings and significances that would fit into the patterns of their own thinking and understandings, their own emotions and wishes, their own memories, ideas, understandings, leanings, conditioning, associational, and experiential acquisitions, and into their own patterns of response to stimuli. The author did not really instruct them. Rather he made statements casually, repetitiously, permissively, yet authoritatively, but in a manner so disguised that their attention was not directed away from their own inner world of experience to the author but remained fixated upon their own inner processes. Consequently a hypnotic trance state developed, one in which they were highly receptive to any general ideas that might be offered to them to examine and to evaluate and to discover for themselves any applicability to their problems. For example the second patient was not told to develop his brief and “silly” panics, nor was he told what plan to work out governing his control of his daily trips. Nor was the origin of his condition ever asked for; his intelligence told him it had an origin, and there was no need to tell him to search for it.

As for the patient with trigeminal neuralgia, neither analgesia nor anaesthesia was suggested. Nor was there a detailed personal history taken. She had been repeatedly diagnosed by competent clinics, neurologists, and psychiatrists as suffering from an organic painful disease, not a psychogenic problem. She knew these facts, the author could understand without any further mention or repetition. Neither was she offered a long and “helpful” discussion of what pain was and various methods of lessening or minimizing, altering or reconditioning her suffering. No matter what the author said, she was dependent upon her own resources only.

Hence no more than was necessary was said to initiate those inner processes of her own behavior, responses, and functionings which would be of service to her. Therefore direct mention was made that the first bite of the filet mignon would be painful but that the rest of it would be so very good. Out of this simple yet really involved statement she had to abstract all the meanings and implications, and in the process of so doing she was forced
into an unwitting and favorably unequal comparison of many long years of comfortable and satisfying eating free from pain, with only a few years of painful eating.

To summarize, in the therapeutic use of hypnosis one primarily meets the patients’ needs on the terms they themselves propose; and then one fixates the patients’ attention, through adequate respect for and utilization of their method of presenting their problem, to their own inner processes of mental functioning. This is accomplished by casual but obviously earnest and sincere remarks, seemingly explanatory but intended solely to stimulate a wealth of the patients’ own patterns of psychological functioning, so that they meet their problems by use of their learnings already acquired, or that will develop as they continue their progress.
Pantomime Techniques in Hypnosis and the Implications

Milton H. Erickson


In the early experiments done by this author on hypnotic deafness, verbal communication having been lost as a result of the induced deafness, the value of pantomime was recognized, used, and then replaced by written communications as easier.

The Pantomime Technique as a hypnotic technique complete in itself resulted from an invitation to address an affiliated society of American Society of Clinical Hypnosis, the Grupo de Estudio sobre Hipnosis Clinica y Experimental, in Mexico City in January, 1959.

Just before the meeting the author was informed that he was to demonstrate hypnosis as the introduction to his lecture by employing as a subject a nurse they had selected who knew nothing about hypnosis nor about the author and who could neither speak nor understand English—they already knew that I could not speak nor understand Spanish. They had explained privately to her that I was a North American doctor who would need her silent assistance and they informed her of our mutual language handicaps and assured her that she would be fully respected by me. Hence she was totally unaware of what was expected of her.

This unexpected proposal to the author led to rapid thinking about his past partial uses of pantomime by gesture, facial expressions, etc. This lead to the conclusion that this unexpected development offered a unique opportunity. A completely pantomime technique would have to be used, and the subject’s own state of mental uncertainty and eagerness to comprehend would effect the same sort of readiness to accept any comprehensible communication by pantomime as is effected by clear-cut definite communications in the Confusion Technique (“The confusion technique in hypnosis” this volume, Section 2). She was then brought through a side door to confront me. Silently we looked at each other, and then—as I had done many times previously with seminarists in the United States in seeking out what I consider clinically to be “good responsive” subjects before the beginning of a seminar and hence before I was known to them—I walked toward her briskly and smilingly and extended my right hand, and she extended hers. Slowly I shook hands with her, staring her fully in the eyes even as she was doing to me, and slowly I ceased smiling. As I let loose of her hand, I did so in an uncertain, irregular fashion, slowly withdrawing it, now increasing the pressure slightly with my thumb, then with the little finger, then with the middle finger, always in an uncertain, irregular, hesitant manner, and finally so gently withdrawing my hand that she would have no clear-cut awareness of just when I had released her hand or at what part of her
hand I had last touched. At the same time I slowly changed the focus of my eyes by altering their convergence, thereby giving her a minimal but appreciable cue that I seemed to be looking not at but through her eyes and off into the distance. Slowly the pupils of her eyes dilated, and as they did so, I gently released her hand completely, leaving it in midair in a cataleptic position. A slight upward pressure on the heel of her hand raised it slightly. Then catalepsy was demonstrated in the other arm also, and she remained staring unblinkingly.

Slowly I closed my eyes, and so did she. I immediately opened my eyes, stepped behind her, and began explaining what I had done in English, since most of the audience knew English fairly well. She made no startle response, and did not even seem to hear me. I gently touched her ankle and then gently lifted her foot, leaving her to stand cataleptically on one leg. One of the doctors knew I had a smattering of German and held up his fist, opened it, saying questioningly, “die Augen.” Gently I touched her closed lids and gave a slight upward pressure. She slowly opened them and looked at me with her pupils still dilated. I pointed to my feet, then to her upraised cataleptic foot, and signalled a downward movement. She frowned in puzzlement apparently at seeing both her hands and her foot uplifted, then smiled at my downward signal toward her foot only, and she put her foot down with what appeared to me to be an expression of some slight embarrassment or bewilderment. The arm catalepsy remained unchanged.

Several of the doctors called her by name and spoke to her in Spanish. She merely looked at me attentively, making no involuntary head or eye movements so common when addressed from some distance away by someone else, nor did she seem to pay any further attention to her hands.

I was asked in English if she could see the audience, since apparently she could not hear them. I moved her hands up, down, and across while she seemed to watch them and my eyes alternately. Then I pointed to my eyes and to her eyes by bringing my fingers close to them; than I made a futile, hopeless sweeping gesture of my right hand toward the audience as I assumed a look of blank surprise and wonderment as I faced the audience as a pantomime of not seeing anybody. She did likewise, showed a startled reaction and asked in Spanish, as I was told later, “Where are they? The doctors are supposed to be here?” Several of the doctors spoke to reassure her, but she merely continued to look frightened.

I promptly attracted her attention by putting my fingers close to her eyes, then to mine, then I lifted her hand and looked with a pleased smile at the ring on her hand as if I admired it. Her fright vanished apparently.

One of the audience asked me how I would awaken her. I showed her the second hand on my watch, marked out 10 seconds of time by synchronizing a finger movement with the second hand movement. She watched intently. Then I had her watch me close my eyes, beat out about 10 seconds, and then I opened my eyes with an upright alert jerk of my head. Then I smiled and with a nod of my head and a movement of my hand I indicated that she was to do likewise. As she did so, I stepped back rapidly, and when she opened
her eyes she saw me at the far end of the platform. I immediately walked forward briskly with a pleased smile and extended my hand in greeting. This re-established the original way in which we had met and she awakened immediately and shook hands with me as she looked me over. I bowed and said, “Thank you very much. I am most appreciative,” as if dismissing her. One of the doctors translated my remarks; I repeated myself and again shook hands in a dismissal fashion. She looked puzzled and uncertain, so one of the group told her she could now leave. She left the room in what to me seemed a most puzzled fashion.

Later I was informed that she had developed a total amnesia for the entire experience, and had expressed wonderment at my immediate dismissal of her when she was supposed to assist me. She also expressed disbelief in hypnosis but volunteered as a subject, promptly developed a profound trance, recalled all of the events of her experience with the author including the “departure [negative hallucination] of the audience” and her “puzzlement” when dismissed, but when aroused from this trance, she again manifested a complete amnesia for both trances. She was subsequently used extensively by members of that group as an assistant and as an experimental and instructional subject.

The second unexpected, completely pantomime induction was done in January of 1961 during a visit to Caracas, Venezuela. I had been invited to tour the Hospital Concepcion Palacios during which I was asked to address the staff on the use of hypnosis in obstetrics at an impromptu meeting in the conference room. One of the audience suggested that I demonstrate as I discussed the phenomena of hypnosis. Remembering my experience in Mexico City I asked if I might work with some young woman who did not know the purpose of my visit there, who did not understand English, and who had had no experience in hypnosis of any sort. Three young women were brought in, and I looked them over and selected the one who gave me a clinical impression of what I term “responsive attentiveness.” I asked that the others be dismissed and that she be told that I wished her cooperation while I lectured. Very carefully my translator so informed her without giving her any more information, and she nodded her head affirmatively.

Stepping over to her and standing face to face with her, I explained in English for those who understood it that they were to watch what I did. My translator kept silent, and the young lady eyed me most attentively and wonderingly.

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, attentive, 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 recognize, startled her, and as her pupils dilated, I so touched her wrist with a suggestion of an upward movement that her arm began rising, so gently discontinuing the touch that she did not notice the tactile withdrawal, and the upward movement continued. Quickly shifting my fingertips to hers, I varied the touches to direct in an unrecognizable fashion a full upward turning of her palm, and then other touches on her fingertips served to straighten some fingers, to bend others, and a proper touch on the tip of the straightened fingers 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 with my fingers her visual attention and directed her attention to my eyes. I focussed 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 and commands given in English.

I asked for her name, and one of the staff gave it to me in rapid Spanish, the translator repeated it, laboriously enunciating the name so that I could grasp the phonetics. She made no response to anything the staff or the translator said or did, merely standing passively. When someone tried to push her, she became actively rigid but made no other response. I led her about the room, touching her eyelids to indicate that she was to open them, and then indicated a chair, in which she seated herself. Even with her eyes open, she seemed oblivious to everyone there and to all auditory stimulation.

I learned that she was a resident physician and that she had not yet been introduced to hypnosis. While she sat with her eyes open and apparently unseeingly and unhearingly, I discussed hypnosis.

At the close of my remarks I awakened her by turning to her and indicating she was to stand. Then, with the gesture of brushing my palms across each other as if the task were all done, I smiled at her and bowed. The hypnotic facial expression disappeared, she looked about the room and asked, as I was told later, “What am I to do?” while I, not understanding, bowed and said “Gracias, Senorita.” She looked puzzled, my translator explained her task was done, and she left in a puzzled manner. I then began to answer questions from the audience.

The following August of the same year—that is, six months later— I visited there and again lectured to the staff. My former subject was present in the audience, and when I beckoned to her to come up on the platform, she did so in a pleased fashion but developed spontaneously a deep trance just before she reached the desk at which I sat.
She had in the meantime not only been a hypnotic subject for others but had also used it on her patients. As a result, despite the author’s linguistic handicap, she could anticipate some of the phenomena that the author wished to demonstrate. In addition a translator conveyed his requests to her after rapport was transferred to him. This transfer of rapport was effected by the process of pointing to my right hand, then to hers, shaking hands with her, then withdrawing my hand, indicating it, reaching over and shaking hands with my translator while I indicated to her with my left hand that she was to see the translator and to do likewise, and as they shook hands they exchanged greetings in Spanish.

The next unexpected completely pantomime initial induction was done in Venezuela that same month before the Medical Society in Caracas. Just as I was about to begin my lecture I was courteously interrupted by the officers and the explanation was offered that many of the doctors present did not believe in hypnosis, that there was much conviction that I had a confederate with whose aid I would perpetrate a hoax. They were obviously most distressed to tell me this but explained that as the officers of the society they had been delegated to ask me to demonstrate hypnosis by maintaining a complete silence and to select someone from the large audience for whom they could secure a valid identification. I replied that I hoped the subject I secured would not be able to understand English.

In the rear of the auditorium I saw a woman about 30 years old who gave every evidence of what I term that “responsiveness,” which I personally consider a most helpful indication of hypnotisability. I pointed the woman out to my translator, she was questioned for her identity, was discovered to be the wife of a physician who did not believe in hypnosis, and that she too did not believe in it and had never seen it. However, she readily came to the platform, differing from the Mexico City nurse in that she knew hypnosis was under consideration. As she approached me, I asked, “And if you please, what is your name?” She turned to the translator and asked him what I had said and this was broadcast by the public address system present. Thus the point was made that she did not understand English.

Essentially the same technique as was used in Mexico City was employed with the same hypnotic results. However, one addition was made. I patted the back of my hand gently during the demonstration and smiled as if I liked the sensation. I did likewise to her hand, and she too smiled.

Then I brushed off the back of my hand as if I were brushing away all sensation. I then pinched and twisted the skin of my hand in an obviously painful fashion but wore a look of profound astonishment and wonderment as if I felt nothing and then smiled happily. I reached for her hand, did likewise, and in astonishment she turned to my translator who, ill at ease on my account, had assured her as she came to the platform that he would remain on the platform as would the officers, and she should feel free at any time to speak to him.

As I forcibly pinched and twisted the skin of her left hand, the officers crowded around, did likewise, and the woman also tested her hand. She then asked the officers what had
happened to her hand and asked if it (her hand) were dead, speaking in what the translator later reported as a tone of distress. A doctor in the audience and several others in the audience reassured her. She did not seem to hear them, and a negative hallucination of the audience, visual and auditory was spontaneously manifested. But the translator’s explanation was readily heard by her, as were those of the officers on the platform. In other words she had interpreted the platform situation initially as signifying rapport with those who were there but not with the audience, even though her husband was in the audience.

A doubting Thomas in the audience declared in Spanish that he was fully convinced of the validity of hypnosis and asked the officers of the society if he could volunteer as a subject. This request was translated to me. Keeping the woman still there, I accepted his offer, and results similar to those with the woman were secured. However, he aroused from the trance state with a total amnesia and asked the translator to tell me to begin the hypnosis, a request that was broadcast by the public address system. He was reinduced, and the translator told him in Spanish, “After awakening, remember all.” Upon awakening from the trance, he was most effervescent in his excited pleasure, and the woman too was much impressed by what she had seen occur with the Spanish physician. In each instance the awakening of the subjects was done by grasping their hands firmly, and since both had their eyes open, shaking their hands briskly and shaking my head briskly as if arousing and clearing my mind. Since the doctor had seen this manoeuvre with the woman, he responded more quickly than she had.

In brief, hypnosis is a cooperative experience depending upon a communication of ideas by whatever means available, and verbalized, ritualistic, traditional rote-memory techniques for the induction of hypnosis are no more than one means of beginning to learn how to communicate ideas and understandings in a joint task in which one person voluntarily seeks aid or understandings from another.

In two experiences in hypnotizing deaf-and-dumb persons sign language was employed with the added pantomime of listlessness and fatigue of movement in making the sign language. With these two subjects rapport was lost if they closed their eyes, and resort had to be made to a sharp shaking of them by the shoulder to awaken them, such a cue having been incorporated into the trance-inducing suggestions originally. When the measure of suggesting that they keep their eyes open in the deep trance was used, their peripheral vision greatly decreased and became so central in character that perhaps only one finger of a letter sign would be seen unless instructions to the contrary were given. However, a total of four trances with two such subjects is only adequate to state that the usual hypnotic trance and attendant phenomena can be induced in the neurologically deaf-and-dumb by sign language, but that there appears to be a profound loss of peripheral vision with a consequent loss of some rapport. This raises an intriguing question of why a trance should cause, in such subjects who are so dependent upon sight, a much greater loss of peripheral vision than this writer has encountered in trances in many thousand of people with normal speech and hearing, where a more limited loss of peripheral vision is very common. If, however, in such subjects a trance is induced by pantomimed instructions to keep their eyes open and to read lip movements, there is no
such loss of peripheral vision even though they had previously spontaneously seen only one digit of a three-finger sign. In explanation of this finding one of the subjects explained, “Lip reading is really face reading; sign language is reading one sign.”

Similarly, if during the induction sign language instructions are given that after a trance is developed they are to receive instruction through written communication, the loss of peripheral vision is minimal. This was explained by the same subject as, “In reading you see the paper or the blackboard too.” Unfortunately the data on these subjects are insufficient to warrant further discussion.

The first and only previous report on the subject of deaf-mute induction of which this author is aware was presented by Dr. Alfredo Isasi of Barcelona, Spain at the Fifth European Congress of Psychosomatic Medicine in April 1962, and published in September 1962 in *La Revista Latino-Americana de Hipnosis Clinica* (Vol. 3, pp. 92-94.) It is entitled “Dos casos de sofrosis en sordomundos—(Two cases of sophrosis (hypnosis) in deaf-mutes.” In this report a technique of inducing hypnosis in deaf mutes, a demonstration of which has been filmed, is described in detail. After the initial communication by sign and gesture the hypnotic state was induced through stroking and gentle pressure on the forehead, eyelids, and jaw line, and tested by raising the arms gently and releasing them. Relaxation, analgesia, and control of bleeding enabling successful dental work in previously apprehensive, fearful, uncooperative patients was achieved. Two case records of young men deaf-mutes were presented in detail.

**COMMENTS**

Perhaps the most pertinent aspect of this matter of trance induction by a Pantomime Technique is the ease with which a communication of ideas and understandings can be effected without verbalization and in situations in which the subject may be totally uninformed as to the nature of the proposed task being done by two people of different cultures, languages, social usages, and customs. If then one thinks of the many so-called controlled studies and reports found in the hypnotic literature in which two homogenous groups, one called “experimental,” one called “control,” are handled by the same experimenter who uses slightly different words but has a full knowledge of what results he expects to secure, one can well wonder just how “controlled” are these experiments.

But when “control subjects” have been previously hypnotized by the experimenter or others or have watched hypnotic inductions and experiments of others by the experimenter, (who, of course, knows that he expects to duplicate hypnotic behavior in the “waking state” of the “control subjects”), one does more than wonder about the experimenter’s scientific acumen. To this author both the intelligence and the scientific integrity on the part of the experimenter are in question—seriously so!

In the late 1920’s, 30’s, and 40’s this author did some research involving the comparison of the dream symbolism of Hindu mentally ill patients with that of native-born Massachusetts and Michigan patients, using information obtained from Drs. Lalkaka and Govindaswamy, respectively of Bombay and Mysore, India. Similarly he then used
recently drawn pictures of newly admitted mentally ill American patients, which were compared with those collected by Hans Prinzhorn in “Bildnerei Der Geisteskranken” (Verlag, Berlin, 1923) of mentally ill Germans. The similarities were amazing, until one realizes that the dreams and the pictures come from essentially similar human minds even though from different mental states and cultures. In this regard, in a report published in January 1940 in *The Psychoanalytic Quarterly* (V. 9, No. 1, pp. 51-63) this author in association with Lawrence S. Kubie, M.D., commented upon the possible correspondence or homogeneity of unconscious understandings in two people of the same culture. In this report one subject offered a slightly differing wording but precisely the same content as had been worked out independently by the subject who did the original cryptic writing in a deep hypnotic trance with no apparent conscious knowledge of its content. The experimenter himself did not know the content of the cryptic writing.

Thus the common dream symbolism of the mentally ill patients of India and of the United States; the common symbolism in the artwork of mentally ill German patients of an earlier era and those of newly admitted mentally ill patients in the United States; the translation of cryptic automatic writing by one hypnotic subject of another subject; along with this report on the Pantomime Technique in hypnosis, all suggest the following: That a parallelism of thought and comprehension processes exists which is not based upon verbalizations evocative of specified responses, but which derives from behavioral manifestations not ordinarily recognized or appreciated at the conscious level of mentation.

In brief, this report on the Pantomime Technique in hypnosis indicates that adequate hypnotic suggestions can be given intentionally without verbalization. It seems reasonable to infer that similar suggestions can also be unintentionally given in pantomime unwittingly to elicit complicated hypnotic phenomena from a subject unacquainted in any way with hypnosis, comparable to the way in which suggestions can be given when the subjects’ language and cultural and social usages are unknown to the experimenter, even as the subjects are unacquainted with those of the experimenter.

Hence true experimentation in hypnosis should take into consideration far more than the selected items usually tested. When control measures are devised, it should be held constantly in mind that their purpose is to isolate the selected items so that their effect may be evaluated without distortion by factors which may not have even been considered or identified, let alone eliminated or controlled.
Interspersal Hypnotic Technique for Symptom Correction and Pain Control

Milton H. Erickson


Innumerable times this author has been asked to commit to print in detail the hypnotic technique he has employed to alleviate intolerable pain or to correct various other problems. The verbal replies made to these many requests have never seemed to be adequate since they were invariably prefaced by the earnest assertion that the technique in itself serves no other purpose than that of securing and fixating the attention of patients, creating then a receptive and responsive mental state, and thereby enabling them to benefit from unrealized or only partially realized potentials for behavior of various types. With this achieved by the hypnotic technique, there is then the opportunity to proffer suggestions and instructions serving to aid and to direct patients in achieving the desired goal or goals. In other words, the hypnotic technique serves only to induce a favorable setting in which to instruct patients in a more advantageous use of their own potentials of behavior.

Since the hypnotic technique is primarily a means to an end, while therapy derives from the guidance of the patient’s behavioral capacities, it follows that, within limits, the same hypnotic technique can be utilized for patients with widely diverse problems. To illustrate, two instances will be cited in which the same technique was employed, once for a patient with a distressing neurotic problem and once for a patient suffering from intolerable pain from terminal malignant disease. The technique is one that the author has employed on the illiterate subject and upon the college graduate, in experimental situations and for clinical purposes. Often it has been used to secure, to fixate, and to hold the attention of difficult patients and to distract them from creating difficulties that would impede therapy. It is a technique employing ideas that are clear and comprehensible, but which by their patent irrelevance to the patient-physician relationship and situation distract the patient. Thereby the patients are prevented from intruding unhelpfully into a situation which they cannot understand and for which they are seeking help. At the same time a readiness to understand and to respond is created within the patient.

Thus, a favorable setting is evolved for the elicitation of needful and helpful behavioral potentialities not previously used, not fully used, or perhaps misused by the patient.

The first instance to be cited will be given without any account of the hypnotic technique employed. Instead, there will be given the helpful instructions, suggestions, and guiding ideas which enabled the patient to achieve his therapeutic goal and which were interspersed among the ideas constituting the hypnotic technique. These therapeutic ideas will not be cited as repetitiously as they were verbalized to the patient for the reason that
they are more easily comprehended in cold print than when uttered as a part of a stream of utterances. Yet, these few repeated suggestions in the hypnotic situation served to meet the patient’s needs adequately.

The patient was a 62-year-old retired farmer with only an eighth-grade education, but decidedly intelligent and well read. He actually possessed a delightful, charming, outgoing personality, but he was most unhappy, filled with resentment, bitterness, hostility, suspicion, and despair. Approximately two years previously, for some unknown or forgotten reason (regarded by the author as unimportant and as having no bearing upon the problem of therapy), he had developed a urinary frequency that was most distressing to him. Approximately every half-hour he felt a compelling urge to urinate, an urge that was painful, that he could not control, and that would result in a wetting of his trousers if he did not yield to it. This urge was constantly present day and night. It interfered with his sleep, his eating, and his social adjustments, and compelled him to keep within close reach of a lavatory and to carry a briefcase containing several pairs of trousers for use when he was “caught short.” He explained that he had brought, into the office a briefcase containing three pairs of trousers, and he stated that he had visited a lavatory before leaving for the author’s office, another on the way, and that he had visited the office lavatory before entering the office, and that he expected to interrupt the interview with the author by at least one other such visit.

He related that he had consulted more than 100 physicians and well-known clinics. He had been cystoscoped more than 40 times, had had innumerable X-ray pictures taken and countless tests, some of which were electroencephalograms and electrocardiograms. Always he was assured that his bladder was normal; many times he was offered the suggestion to return after a month or two for further study; and “too many times” he was told that “it’s all in your head,” that he had no problem at all, that he “should get busy doing something instead of being retired, and to stop pestering doctors and being an old crock.” All of this had made him feel like committing suicide.

He had described his problem to a number of writers of syndicated medical columns in newspapers, several of whom offered him in his stamped self-addressed envelope a pontifical platitudinous dissertation innovative upon his problem, stressing it as one of obscure organic origin. In all of his searching not once had it been suggested that he seek psychiatric aid.

On his own initiative, after reading two of the misleading, misinforming, and essentially fraudulent books on “do-it-yourself hypnosis,” he did seek the aid of stage hypnotists—in all, three in number. Each offered him the usual blandishments, reassurances, and promises common to that type of shady medical practice, and each failed completely in repeated attempts at inducing a hypnotic trance. Each charged an exorbitant fee (as judged by a standard medical fee, and especially in relation to the lack of benefit received).

As a result of all this mistreatment, the medical no better than that of the charlatans and actually less forgivable, he had become bitter, disillusioned, resentful, and openly hostile,
and he was seriously considering suicide. A gas station attendant suggested that he see a psychiatrist and recommended the author on the basis of a Sunday newspaper article. This accounted for his visit to the author.

Having completed his narrative, he leaned back in his chair, folded his arms, and challengingly said, “Now psychiatrize and hypnotize me and cure this—bladder of mine.”

During the narration of the patient’s story the author had listened with every appearance of rapt attention except for a minor idling with his hands, thereby shifting the position of objects on his desk. This idling included a turning of the face of the desk clock away from the patient. As he listened to the patient’s bitter account of his experiences, the author was busy speculating upon possible therapeutic approaches to a patient so obviously unhappy, so resentful toward medical care and physicians, and so challenging in attitude. He certainly did not appear to be likely to be receptive and responsive to anything the author might do or say. As the author puzzled over this problem, there came to mind the problem of pain control for a patient suffering greatly in a terminal state of malignant disease. That patient had constituted a comparable instance where a hypnototherapeutic approach had been most difficult, yet success had been achieved. Both patients had in common the experience of growing plants for a livelihood, both were hostile and resentful, and both were contemptuous of hypnosis. Hence, when the patient issued his challenge of “psychiatrize and hypnotize me,” the author, with no further ado, launched into the same technique employed with that other patient to achieve a hypnototherapeutic state in which helpful suggestions, instructions, and directions could be offered with reasonable expectation that they would be accepted and acted upon responsively in accord with the patient’s actual needs and behavioral potentials.

The only difference for the two patients was that the interwoven therapeutic material for the one patient pertained to bladder function and duration of time. For the other patient the interwoven therapeutic instructions pertained to body comfort, to sleep, to appetite, to the enjoyment of the family, to an absence of any need for medication, and to the continued enjoyment of time without concern about the morrow.

The actual verbal therapy offered, interspersed as it was in the ideation of the technique itself, was as follows, with the interspersing denoted by dots.

You know, we could think of your bladder needing emptying every 15 minutes instead of every half . . . . hour . . . . Not difficult to think that . . . . A watch can run slow . . . . or fast . . . . be wrong even a minute . . . . even two, five minutes . . . . or think of bladder every half hour . . . . like you’ve been doing . . . . maybe it was 35, 40 minutes sometimes . . . . like to make it an hour . . . . what’s the difference . . . . 35, 36 minutes, 41, 42, 45 minutes . . . . not much difference . . . . not important difference . . . . 45, 46, 47 minutes . . . . all the same . . . . lots of times you maybe had to wait a second or two . . . . felt like an hour or two . . . . you made it . . . . you can again . . . . 47 minutes, 50 minutes, what’s the difference . . . . stop to think, no great difference, nothing important . . . . just like
50 minutes, 60 minutes, just minutes . . . anybody that can wait half an hour can wait an hour . . . I know it . . . you are learning . . . not bad to learn . . . in fact, good . . . come to think of it, you have had to wait when somebody got there ahead of you . . . you made it too . . . can again . . . and again . . . all you want to . . . hour and 5 minutes . . . hour and 5½ minutes . . . what’s the difference . . . or even 6½ minutes . . . make it 10½ hour and 10½ minutes . . . one minute, 2 minutes, one hour, 2 hours, what’s the difference . . . you got half a century or better of practice in waiting behind you . . . you can use all that . . . why not use it . . . you can do it . . . probably surprise you a lot . . . won’t even think of it . . . why not surprise yourself at home . . . good idea . . . nothing better than a surprise . . . an unexpected surprise . . . how long can you hold out . . . that’s the surprise . . . longer than you even thought . . . lots longer . . . might as well begin . . . nice feeling to begin . . . to keep on . . . Say, why don’t you just forget what I’ve been talking about and just keep it in the back of your mind. Good place for it—can’t lose it. Never mind the tomato plant—just what was important about your bladder—pretty good, feel fine, nice surprise—say, why don’t you start feeling rested, refreshed right now, wider awake than you were earlier this morning [this last statement is, to the patient, an indirect, emphatic, definitive instruction to arouse from his trance]. Then [as a dismissal but not consciously recognizable as such by the patient], why don’t you take a nice leisurely walk home, thinking about nothing? [an amnesia instruction for both the trance and his problem, and also a confusion measure to obscure the fact that he had already spent 1½ hours in the office]. I’ll be able to see you at ten A.M. a week from today [furthering his conscious illusion, resulting from his amnesia, that nothing yet had been done except to give him an appointment].

A week later he appeared and launched into an excited account of arriving home and turning on the television with an immediate firm intention of delaying urination as long as possible. He watched a two-hour movie and drank two glasses of water during the commercials. He decided to extend the time another hour and suddenly discovered that he had so much bladder distension that he had to visit the lavatory. He looked at his watch and discovered that he had waited four hours. The patient leaned back in his chair and beamed happily at the author, obviously expecting praise. Almost immediately he leaned forward with a startled look and declared in amazement, “It all comes back to me now. I never give it a thought till just now. I plumb forgot the whole thing. Say, you must have hypnotized me. You were doing a lot of talking about growing a tomato plant and I was trying to get the point of it and the next thing I knew I was walking home. Come to think of it I must of been in your office over an hour and it took an hour to walk home. It wasn’t no four hours I held back, it was over six hours at least. Come to think of it, that ain’t all. That was a week ago that happened. Now I recollect I ain’t had a bit of trouble all week—slept fine—no getting up. Funny how a man can get up in the morning, his mind all set on keeping an appointment to tell something, and forget a whole week has went by. Say, when I told you to psychiatrize and hypnotize me, you sure took it serious. I’m right grateful to you. How much do I owe you?”
Essentially, the case was completed, and the remainder of the hour was spent in social small talk with a view of detecting any possible doubts or uncertainties in the patient. There were none, nor, in the months that have passed, have there occurred any.

The above case report allows the reader to understand in part how, during a technique of suggestions for trance induction and trance maintenance, hypnotherapeutic suggestions can be interspersed for a specific goal. In the author’s experience such an interspersing of therapeutic suggestions among the suggestions for trance maintenance may often render the therapeutic suggestions much more effective. The patients hear them and understand them, but before they can take issue with them or question them in any way, their attention is captured by the trance-maintenance suggestions. And these in turn are but a continuance of the trance-induction suggestions. Thus, there is given to the therapeutic suggestion an aura of significance and effectiveness deriving from the already effective induction and maintenance suggestions. Then again the same therapeutic suggestions can be repeated in this interspersed fashion, perhaps repeated many times, until the therapist feels confident that the patient has absorbed the therapeutic suggestions adequately. Then the therapist can progress to another aspect of therapy using the same interspersal technique.

The above report does not indicate the number of repetitions for each of the therapeutic suggestions for the reason that the number must vary with each set of ideas and understandings conveyed and with each patient and each therapeutic problem. Additionally, such interspersal of suggestions for amnesia and posthypnotic suggestions among the suggestions for trance maintenance can be done most effectively. To illustrate from everyday life: A double task assignment is usually more effective than the separate assignment of the same two tasks. For example, a mother may say, “Johnny, as you put away your bicycle, just step over and close the garage door.” This has the sound of a single task, one aspect of which favors the execution of another aspect, and thus there is the effect of making the task seem easier. To ask that the bicycle be put away and then to ask that the garage door be closed has every sound of being two separate, not to be combined, tasks. To the separate tasks a refusal can be given easily to one or the other task or to both. But a refusal when the tasks are combined into a single task means what? That he will not put away the bicycle? That he will not step over to the garage? That he will not close the garage door?

The very extent of the effort needed to identify what one is refusing in itself is a deterrent to refusal. Nor can a refusal of the “whole thing” be offered comfortably. Hence Johnny may perform the combined task unwillingly but may prefer to do so rather than to analyze the situation. To the single tasks he can easily say “later” to each. But to the combined task he cannot say “Later” since, if he puts away the bicycle “later,” he must “immediately” step over to the garage and “immediately” close the door. This is specious reasoning, but it is the “emotional reasoning” that is common in daily life, and daily living is not an exercise in logic. As a common practice the author says to a patient, “As you sit down in the chair, just go into a trance.” The patient is surely going to sit down in the chair. But going into a trance is made contingent upon sitting down, hence a trance state develops from what the patient was most certainly going to do. By combining
psychotherapeutic, amnestic, and posthypnotic suggestions with those suggestions used first to induce a trance, and then to maintain that trance, constitutes an effective measure in securing desired results. Contingency values are decidedly effective. As a further illustration, more than once a patient who has developed a trance upon simply sitting down has said to the author, “I didn’t intend to go into a trance today.” In reply the author has stated, “Then perhaps you would like to awaken from the trance and hence, as you understand that you can go back into a trance when you need to, you will awaken.” Thus the “awakening” is made contingent upon “understanding,” thereby ensuring further trances through association by contingency.

With this explanation of rationale the problem of the second patient will be presented after a few preliminary statements. These are that the author was reared on a farm, enjoyed and still enjoys growing plants, and has read with interest about the processes of seed germination and plant growth. The first patient was a retired farmer. The second, who will be called “Joe” for convenience, was a florist. He began his career as a boy by peddling flowers, saving his pennies, buying more flowers to peddle, etc. Soon he was able to buy a small parcel of land on which to grow more flowers with loving care while he enjoyed their beauty which he wanted to share with others, and in turn, to get more land and to grow more flowers, etc. Eventually he became the leading florist in a large city. Joe literally loved every aspect of his business and was intensely devoted to it but he was also a good husband, a good father, a good friend, and a highly respected and valued member of the community.

Then one fateful September a surgeon removed a growth from the side of Joe’s face, being careful not to disfigure Joe’s face too much. The pathologist reported the growth to be a malignancy. Radical therapy was then instituted, but it was promptly recognized as “too late.”

Joe was informed that he had about a month left to live. Joe’s reaction was, to say the least, unhappy and distressed. In addition he was experiencing much pain—in fact, extremely severe pain.

At the end of the second week in October a relative of Joe’s urgently requested the author to employ hypnosis on Joe for pain relief since narcotics were proving of little value. In view of the prognosis that had been given for Joe the author agreed reluctantly to see him, stipulating that all medication be discontinued at 4:00 A.M. of the day of the author’s arrival. To this the physicians in charge of Joe at the hospital courteously agreed.

Shortly before the author was introduced to Joe, he was informed that Joe disliked even the mention of the word hypnosis. Also, one of Joe’s children, a resident in psychiatry at a well-known clinic, did not believe in hypnosis and had apparently been confirmed in this disbelief by the psychiatric staff of the clinic, none of whom is known to have had any firsthand knowledge of hypnosis. This resident would be present, and the inference was that Joe knew of that disbelief.
The author was introduced to Joe, who acknowledged the introduction in a most courteous and friendly fashion. It is doubtful if Joe really knew why the author was there. Upon inspecting Joe, it was noted that much of the side of his face and neck was missing because of surgery, ulceration, maceration, and necrosis. A tracheotomy had been performed on Joe, and he could not talk. He communicated by pencil and paper, many pads of which were ready at hand. The information was given that every four hours Joe had been receiving narcotics (¼ grain of morphine or 100 milligrams of Demerol) and heavy sedation with barbiturates. He slept little. Special nurses were constantly at hand. Yet Joe was constantly hopping out of bed, writing innumerable notes, some pertaining to his business, some to his family, but many of them were expressive of complaints and demands for additional help. Severe pain distressed him continuously, and he could not understand why the doctors could not handle their business as efficiently and as competently as he did his floral business. His situation enraged him because it constituted failure in his eyes. Success worked for and fully merited had always been a governing principle in his life. When things went wrong with his business, he made certain to correct them. Why did not the doctors do the same? The doctors had medicine for pain, so why was he allowed to suffer such intolerable pain?

After the introduction Joe wrote, “What you want?” This constituted an excellent opening, and the author began his technique of trance induction and pain relief. This will not be given in its entirety since a large percentage of the statements made were repeated, not necessarily in succession but frequently by referring back to a previous remark and then repeating a paragraph or two. Another preliminary statement needed is that the author was most dubious about achieving any kind of success with Joe since, in addition to his physical condition, there were definite evidences of toxic reactions to excessive medication. Despite the author’s unfavorable view of possibilities there was one thing of which he could be confident. He could keep his doubts to himself and he could let Joe know by manner, tone of voice, by everything said that the author was genuinely interested in him, was genuinely desirous of helping him. If even that little could be communicated to Joe, it should be of some comfort, however small, to Joe and to the family members and to the nurses within listening distance in the side room.

The author began:

Joe, I would like to talk to you. I know you are a florist, that you grow flowers, and I grew up on a farm in Wisconsin and I liked growing flowers. I still do. So I would like to have you take a seat in that easy chair as I talk to you. I’m going to say a lot of things to you, but it won’t be about flowers because you know more than I do about flowers. That isn’t what you want. [The reader will note that italics will be used to denote interspersed hypnotic suggestions which may be syllables, words, phrases, or sentences uttered with a slightly different intonation.]

Now as I talk, and I can do so comfortably, I wish that you will listen to me comfortably as I talk about a tomato plant. That is an odd thing to talk about. It makes one curious. Why talk about a tomato plant? One puts a tomato seed in the ground. One can feel hope that it will grow into a tomato plant that will bring satisfaction by the fruit it has. The seed soaks up water, not very much difficulty in
doing that because of the rains that bring peace and comfort and the joy of growing to flowers and tomatoes. That little seed, Joe, slowly swells, sends out a little rootlet with cilia on it. Now you may not know what cilia are, but cilia are things that work to help the tomato seed grow, to push up above the ground as a sprouting plant, and you can listen to me, Joe, so I will keep on talking and you can keep on listening, wondering, just wondering what you can really learn, and here is your pencil and your pad, but speaking of the tomato plant, it grows so slowly. You cannot see it grow, you cannot hear it grow, but grow it does—the first little leaf-like things on the stalk, the fine little hairs on the stem, those hairs are on the leaves, too, like the cilia on the roots, they must make the tomato plant feel very good, very comfortable if you can think of a plant as feeling, and then you can’t see it growing, you can’t feel it growing, but another leaf appears on that little tomato stalk and then another. Maybe, and this is talking like a child, maybe the tomato plant does feel comfortable and peaceful as it grows. Each day it grows and grows and grows, it’s so comfortable, Joe, to watch a plant grow and not see its growth, not feel it, but just know that all is getting better for that little tomato plant that is adding yet another leaf and still another and a branch, and it is growing comfortably in all directions. [Much of the above by this time had been repeated many times, sometimes just phrases, sometimes sentences. Care was taken to vary the wording and also to repeat the hypnotic suggestions. Quite some time after the author had begun, Joe’s wife came tiptoeing into the room carrying a sheet of paper on which was written the question, “When are you going to start the hypnosis?” The author failed to cooperate with her by looking at the paper and it was necessary for her to thrust the sheet of paper in front of the author and therefore in front of Joe. The author was continuing his description of the tomato plant uninterruptedly, and Joe’s wife, as she looked at Joe, saw that he was not seeing her, did not know that she was there, that he was in a somnambulistic trance. She withdrew at once.] And soon the tomato plant will have a bud form somewhere, on one branch or another, but it makes no difference because all the branches, the whole tomato plant will soon have those nice little buds—I wonder if the tomato plant can, Joe, feel really feel a kind of comfort. You know, Joe, a plant is a wonderful thing, and it is so nice, so pleasing just to be able to think about a plant as if it were a man. Would such a plant have nice feelings, a sense of comfort as the tiny little tomatoes begin to form, so tiny, yet so full of promise to give you the desire to eat a luscious tomato, sun-ripened, it’s so nice to have food in one’s stomach, that wonderful feeling a child, a thirsty child, has and can want a drink, Joe, is that the way the tomato plant feels when the rain falls and washes everything so that all feels well. [Pause.] You know, Joe, a tomato plant just flourishes each day just a day at a time. I like to think the tomato plant can know the fullness of comfort each day. You know, Joe, just one day at a time for the tomato plant. That’s the way for all tomato plants. [Joe suddenly came out of the trance, appeared disoriented, hopped upon the bed, and waved his arms; his behavior was highly suggestive of the sudden surges of toxicity one sees in patients who have reacted unfavorably to barbiturates. Joe did not seem to hear or see the author until he hopped off the bed and walked toward the author. A firm grip was taken on Joe’s arm and then immediately loosened. The nurse was
summoned. She mopped perspiration from his forehead, changed his surgical dressings, and gave him, by tube, some ice water. Joe then let the author lead him back to his chair. After a pretense by the author of being curious about Joe’s forearm, Joe seized his pencil and paper and wrote, “Talk, talk.”] “Oh yes, Joe, I grew up on a farm, I think a tomato seed is a wonderful thing; think, Joe, think in that little seed there does sleep so restfully, so comfortably a beautiful plant yet to be grown that will bear such interesting leaves and branches. The leaves, the branches look so beautiful, that beautiful rich color, you can really feel happy looking at a tomato seed, thinking about the wonderful plant it contains asleep, resting, comfortable, Joe. I’m soon going to leave for lunch and I’ll be back and I will talk some more.”

The above is a summary to indicate the ease with which hypnotherapeutic suggestions can be included in the trance induction along with trance-maintenance suggestions, which are important additionally as a vehicle for the transmission of therapy. Of particular significance is Joe’s own request that the author “talk.” Despite his toxic state, spasmodically evident, Joe was definitely accessible. Moreover, he learned rapidly despite the absurdly amateurish rhapsody the author offered about a tomato seed and plant. Joe had no real interest in pointless, endless remarks about a tomato plant. Joe wanted freedom from pain, he wanted comfort, rest, sleep. This was what was uppermost in Joe’s mind, foremost in his emotional desires, and he would have a compelling need to try to find something of value to him in the author’s babbling. That desired value was there, so spoken that Joe could literally receive it without realizing it. Joe’s arousal from the trance was only some minutes after the author had said so seemingly innocuously, “want a drink, Joe.” Nor was the reinduction of the trance difficult, achieved by two brief phrases, “think, Joe, think” and “sleep so restfully, so comfortably” imbedded in a rather meaningless sequence of ideas. But what Joe wanted and needed was in that otherwise meaningless narration, and he promptly accepted it.

During lunchtime Joe was first restful and then slowly became restless; another toxic episode occurred, as reported by the nurse. By the time the author returned Joe was waiting impatiently for him. Joe wanted to communicate by writing notes. Some were illegible because of his extreme impatience in writing. He would irritatedly rewrite them. A relative helped the author to read these notes. They concerned things about Joe, his past history, his business, his family, and “last week terrible,” “yesterday was terrible.” There were no complaints, no demands, but there were some requests for information about the author. After a fashion a satisfying conversation was had with him as was judged by an increasing loss of his restlessness. When it was suggested that he cease walking around and sit in the chair used earlier, he did so readily and looked expectantly at the author.

“You know, Joe, I could talk to you some more about the tomato plant and if I did you would probably go to sleep, in fact, a good sound sleep. [This opening statement has every earmark of being no more than a casual commonplace utterance. If the patient responds hypnotically, as Joe promptly did, all is well. If the patient does not respond, all you have said was just a commonplace remark, not at all noteworthy. Had Joe not gone
into a trance immediately, there could have been a variation such as: “But instead, let’s talk about the tomato flower. You have seen movies of flowers slowly, slowly opening, giving one a sense of peace, a sense of comfort as you watch the unfolding. So beautiful, so restful to watch. One can feel such infinite comfort watching such a movie.”]

It does not seem to the author that more needs to be said about the technique of trance induction and maintenance and the interspersal of therapeutic suggestions. Another illustration will be given later in this paper.

Joe’s response that afternoon was excellent despite several intervening episodes of toxic behavior and several periods where the author deliberately interrupted his work to judge more adequately the degree and amount of Joe’s learning.

Upon departure that evening, the author was cordially shaken by hand by Joe, whose toxic state was much lessened. Joe had no complaints, he did not seem to have distressing pain, and he seemed to be pleased and happy.

Relatives were concerned about posthypnotic suggestions, but they were reassured that such had been given. This had been done most gently in describing so much in detail and repetition the growth of the tomato plant and then, with careful emphasis, “You know Joe,” “Know the fullness of comfort each day,” and “You know, Joe, just one day at a time.”

About a month later, around the middle of November, the author was requested to see Joe again. Upon arriving at Joe’s home, he was told a rather regrettable but not actually unhappy story. Joe had continued his excellent response after the author’s departure on that first occasion, but hospital gossip had spread the story of Joe’s hypnosis, and interns, residents, and staff men came in to take advantage of Joe’s capacity to be a good subject. They made all the errors possible for uninformed amateurs with superstitious misconceptions of hypnosis. Their behavior infuriated Joe, who knew that the author had done none of the offensive things they were doing. This was a fortunate realization since it permitted Joe to keep all the benefits acquired from the author without letting his hostilities toward hypnosis interfere. After several days of annoyance Joe left the hospital and went home, keeping one nurse in constant attendance, but her duties were relatively few.

During that month at home he had actually gained weight and strength. Rarely did a surge of pain occur, and when it did it could be controlled either with aspirin or with 25 milligrams of Demerol. Joe was very happy to be with his family, and there was considerable fruitful activity about which the author is not fully informed.

Joe’s greeting to the author on the second visit was one of obvious pleasure. However, the author noted that Joe was keeping a wary eye on him, hence great care was taken to be completely casual and to avoid any hand movement that could be remotely misconstrued as a “hypnotic pass” such as the hospital staff had employed.
Framed pictures painted by a highly talented member of his family were proudly displayed. There was much casual conversation about Joe’s improvement and his weight gain, and the author was repeatedly hard pushed to find simple replies to conceal pertinent suggestions. Joe did volunteer to sit down and let the author talk to him. Although the author was wholly casual in manner, the situation was thought to be most difficult to handle without arousing Joe’s suspicions. Perhaps this was an unfounded concern, but the author wished to be most careful. Finally the measure was employed of reminiscing about “our visit last October.” Joe did not realize how easily this visit could be pleasantly vivified for him by such a simple statement as, “I talked about a tomato plant then, and it almost seems as if I could be talking about a tomato plant right now. It is so enjoyable to talk about a seed, a plant.” Thus there was, clinically speaking, a recreation of all of the favorable aspects of that original interview.

Joe was most insistent on supervising the author’s luncheon that day, which was a steak barbecued under Joe’s watchful eye in the backyard beside the swimming pool. It was a happy gathering of four people thoroughly enjoying being together, Joe being obviously most happy.

After luncheon Joe proudly displayed the innumerable plants, many of them rare, that he had personally planted in the large backyard. Joe’s wife furnished the Latin and common names for the plants, and Joe was particularly pleased when the author recognized and commented on some rare plant. Nor was this a pretense of interest, since the author is still interested in growing plants. Joe regarded this interest in common to be a bond of friendship.

During the afternoon Joe sat down voluntarily, his very manner making evident that the author was free to do whatever he wished. A long monologue by the author ensued in which were included psychotherapeutic suggestions of continued ease, comfort, freedom from pain, enjoyment of family, good appetite, and a continuing pleased interest in all surroundings. All of these and other similar suggestions were interspersed unnoticeably among the author’s many remarks. These covered a multitude of topics to preclude Joe from analyzing or recognizing the interspersing of suggestions. Also, for adequate disguise, the author needed a variety of topics. Whether or not such care was needed in view of the good rapport is a debatable question, but the author preferred to take no risks.

Medically, the malignancy was continuing to progress, but despite this fact Joe was in much better physical condition than he had been a month previously. When the author took his departure, Joe invited him to return again.

Joe knew that the author was going on a lecture trip in late November and early December. Quite unexpectedly by the author, a long distance telephone call was received just before the author’s departure on this trip. The call was from Joe’s wife, who stated, “Joe is on the extension line and wants to say ‘hello’ to you, so listen.” Two brief puffs of air were heard. Joe had held the telephone mouthpiece over his tracheotomy tube and had exhaled forcibly twice to simulate “hello.” His wife stated that both she and Joe extended
their best wishes for the trip, and a casual conversation among friends ensued with Joe’s wife reading Joe’s written notes.

A Christmas greeting card was received from Joe and his family. In a separate letter Joe’s wife said that “the hypnosis is doing well, but Joe’s condition is failing.” Early in January Joe was weak but comfortable. Finally, in his wife’s words, “Joe died quietly January 21.”

The author is well aware that the prediction of the duration of life for any patient suffering from a fatal illness is most questionable. Joe’s physical condition in October did not promise very much. The symptom amelioration, abatement, and actual abolishment effected by hypnosis, and the freedom of Joe’s body from potent medications, conducive only of unawareness, unquestionably increased his span of life while at the same time permitting an actual brief physical betterment in general. This was attested clearly by his improved condition at home and his gain in weight. That Joe lived until the latter part of January despite the extensiveness of his malignant disease undoubtedly attests to the vigor with which Joe undertook to live the remainder of his life as enjoyably as possible, a vigor expressive of the manner in which he had lived his life and built his business.

To clarify still further this matter of the technique of the interspersal of therapeutic suggestions among trance induction and trance maintenance suggestions, it might be well to report the author’s original experimental work done while he was on the Research Service of the Worcester State Hospital in Worcester, Massachusetts in the early 1930s.

The Research Service was concerned with the study of the numerous problems of schizophrenia and the possibilities of solving some of them. To the author the psychological manifestations were of paramount interest. For example, just what did a stream of disconnected, rapidly uttered incoherencies mean? Certainly, such a stream of utterances must be most meaningful to the patient in some way. Competent secretaries from time to time had recorded verbatim various examples of such disturbed utterances for the author’s perusal and study. The author himself managed to record adequately similar such productions by patients who spoke slowly. Careful study of these verbal productions, it was thought, might lead to various speculative ideas that in turn might prove of value in understanding something about schizophrenia.

The question arose of whether or not much of the verbigeration might be a disguise for concealed meanings, fragmented and dispersed among the total utterances. This led to the question of how the author could himself produce a series of incoherencies in which he could conceal in a fragmented form a meaningful message. Or could he use the incoherencies of a patient and intersperse among them in a somewhat orderly fashion a fragmented, meaningful communication that would be difficult to recognize? This speculation gave rise to many hours of intense labor spent fitting into a patient’s verbatim, apparently meaningless utterances a meaningful message that could not be detected by the author’s colleagues when no clue of any sort was given to them. Previous efforts at producing original incoherencies by the author disclosed a definite and
recognizable personal pattern indicating that the author was not sufficiently disturbed mentally to produce a bonafide stream of incoherent verbigerations.

When a meaning was interspersed in a patient’s productions successfully, the author discovered that his past hypnotic experimentation with hypnotic techniques greatly influenced the kind of a message he was likely to intersperse in a patient’s verbigerations. Out of this labor came the following experimental and therapeutic work.

One of the more recently hired secretaries objected strongly to being hypnotized. She suffered regularly upon the onset of menstruation from severe migrainous headaches lasting three to four or even more hours. She had been examined repeatedly by the medical service with no helpful findings. She usually retired to the lounge and “slept off the headache,” a process usually taking three or more hours. On one such occasion she had been purposely and rather insistently forced to take dictation by the author instead of being allowed to retire to the lounge. Rather resentfully she began her task, but within 15 minutes she interrupted the author to explain that her headache was gone. She attributed this to her anger at being forced to take dictation. Later, on another such occasion, she volunteered to take certain dictation which all of the secretaries tried to avoid because of the difficulties it presented. Her headache grew worse, and she decided that the happy instance with the author was merely a fortuitous happenstance. Subsequently she had another severe headache. She was again insistently requested by the author to take some dictation. The previous happy result occurred within 10 minutes. Upon the occurrence of another headache she volunteered to take dictation from the author. Again it served to relieve her headache. She then experimentally tested the benefits of dictation from other physicians. For some unknown reason her headaches only worsened. She returned from one of these useless attempts to the author and asked him to dictate. She was told he had nothing on hand to dictate but that he could redictate previously dictated material. Her headache was relieved within eight minutes. Later her request for dictation for headache relief was met by some routine dictation. It failed to have any effect.

She came again, not too hopefully, since she thought she had “worn out the dictation remedy.” Again she was given dictation with a relief of her distress in about nine minutes. She was so elated that she kept a copy of the transcript so that she could ask others to dictate “that successful dictation” to relieve her headaches. Unfortunately, nobody seemed to have the “right voice,” as did the author. Always, a posthypnotic suggestion was casually given that there would be no falling asleep while transcribing.

She did not suspect, nor did anybody else, what had really been done. The author had made comprehensive notes of the incoherent verbigeration of a psychotic patient. He had also had various secretaries make verbatim records of patients’ incoherent utterances. He had then systematically interspersed therapeutic suggestions among the incoherencies with that secretary in mind. When this was found to be successful, the incoherent utterances of another patient were utilized in a similar fashion. This was also a successful effort. As a control measure, routine dictation and the dictation of “undoctored incoherencies” were tried. These had no effect upon her headaches. Nor did the use by
others of “doctored” material have an effect, since it had to be read aloud with some
degree of expressive awareness to be effective.

The question now arises, why did these two patients and those patients used
experimentally respond therapeutically? This answer can be given simply as follows:
They knew very well why they were seeking therapy; they were desirous of benefiting;
they came in a receptive state, ready to respond at the first opportunity, except for the
first experimental patient. But she was eager to be freed from her headache and wished
the time being spent taking dictation could be time spent getting over her headache.
Essentially, then, all of the patients were in a frame of mind to receive therapy. How
many times does a patient need to state his complaint? Only that number of times
requisite for the therapist to understand. For all of these patients only one statement of the
complaint was necessary, and they then knew that the therapist understood. Their intense
desire for therapy was not only a conscious but an unconscious desire also, as judged
clinically, but more importantly, as evidenced by the results obtained.

One should also give recognition to the readiness with which one’s unconscious mind
picks up clues and information. For example, one may dislike someone at first sight and
not become consciously aware of the obvious and apparent reasons for such dislike for
weeks, months, even a year or more. Yet finally the reasons for the dislike become apparent to the conscious mind. A common example is the ready hostility frequently
shown by a normal heterosexual person toward a homosexual person without any
conscious realization of why.

Respectful awareness of the capacity of the patient’s unconscious mind to perceive
meaningfulness of the therapist’s own unconscious behavior is a governing principle in
psychotherapy. There should also be a ready and full respect for the patient’s unconscious
mind to perceive fully the intentionally obscured, meaningful therapeutic instructions
offered them. The clinical and experimental material cited above is based upon the
author’s awareness that the patient’s unconscious mind is listening and understanding
much better than is possible for his conscious mind. It was intended to publish this
experimental work, of which only the author was aware. But sober thought and awareness of the insecure status of hypnosis in general, coupled with that secretary’s
strong objection to being hypnotized—she did not mind losing her headaches by “taking
dictation” from the author—all suggested the inadvisability of publication.

A second secretary, employed by the hospital when this experimental work was nearing
completion, always suffered from disabling dysmenorrhea. The “headache secretary”
suggested to this girl that she take dictation from the author as a possible relief measure.
Most willingly the author obliged, using “doctored” patient verbigeration. It was
effective.

Concerned about what might happen to hypnotic research if his superiors were to learn of
what was taking place, the author carefully failed with this second secretary and then
again succeeded. She volunteered to be a hypnotic subject, and hypnosis, not “dictation,”
was then used to meet her personal needs. She also served repeatedly as a subject for
various frankly acknowledged and “approved” hypnotic experiments, and the author kept his counsel in certain other experimental studies.

Now that hypnosis has come to be an acceptable scientific modality of investigative and therapeutic endeavor and there has developed a much greater awareness of semantics, this material, so long relegated to the shelf of unpublished work, can safely be published.

**SUMMARY**

Two case histories and a brief account of experimental work are presented in detail to demonstrate the effective procedure of interspersing psychotherapeutic suggestions among those employed to induce and to maintain a hypnotic trance. The patients treated suffered respectively from neurotic manifestations and the pain of terminal malignant disease.
II. Facilitating New Identity Creation

The papers in this section deal with what we may regard as one of the highest and most complex functions of the psychotherapist—facilitating the creation of new consciousness and identity. The cases discussed herein span 50 years of Erickson's experience in exploring the delicate balances between polar opposites of different psychotherapeutic approaches: Provoking and facilitating, directing and nondirecting, the authoritarian and the permissive. His approaches range from the apparently gross and professionally questionable technique of having a patient get drunk in order to tell off his overprotective mother, to utilizing the most delicate sensitivities in perceiving the nuances of relationship involved in a case he describes as "The Identification of a Secure Reality" where a new foundation is created for the total personality.

My first paper on Erickson’s use of psychological shocks and creative moments in psychotherapy was my introduction to his innovative approaches to facilitating new patterns of identity, behavior, and social interactions, particularly in couples and the family (Rossi, 1973, see volume two of this series). Psychological shocks can come naturally with the unexpected happenings of everyday life or from those normal developmental stages that are characteristic of the process of personality maturation. When a normal developmental process does not take place because the patient is too fixated at an earlier or less adequate stage, a psychological shock tends to break the old frame of reference and initiate a search for new consciousness development, identity, and lifestyle. This search for new consciousness and adaptation is described as “the birth of the hero” in my theology, or a “spiritual quest” in the classical literature of the humanities.

Our new neuroscience perspectives on Erickson’s work are more or less apparent in all these case examples. More than technique or theoretical principles are involved, however. Wisdom and a deep appreciation of life processes underlay and enrich the therapeutic principles. Erickson recognizes each case as unique in the creative interplay that emerges between the psyches of therapist and patient.
Facilitating a New Cosmetic Frame of Reference

Milton H. Erickson

Unpublished manuscript, 1927.

A sophomore in college, majoring in home economics, sought therapy because of “awful inferiority feelings” that seriously restricted and hampered her daily adjustments. The essential facts of her history were few and easily understandable. She had experienced no personality difficulties until the onset of puberty. At that time, during a pleasure drive in the family automobile, an accident had caused her to be thrown out of the car. The only injury she had suffered was a “gashing of the right side of my mouth, which caused awful scarring. That’s why I keep the right side of my mouth covered with my hand, or I turn my head away so that you can’t see that side of my face.” This mannerism had been noted as constantly present. She was unwilling to exhibit the scar to the writer, insisting that it would “disgust” him if he were to see it.

Additional inquiry disclosed that, although she was right-handed, she had learned to eat left-handedly in order to keep the scar covered while eating. Only in the family circle would she briefly discontinue her hiding behavior. She tolerated no mention of her disfigurement, however, by anyone. On the street, in social gatherings, or in the classroom she kept the right side of her mouth covered. She had escaped physical education in high school and college by means of a medical excuse from the family physician.

Because of her need to hide the scar, she was handicapped in numerous other ways. She could not drive a car because that would leave her face uncovered. Neither could she swim except in privacy. Everything she did was governed by her compulsive need to keep the right side of her mouth covered by either her left or her right hand. Even her association with men was markedly limited, despite her actual attractiveness. In fact, her social engagements with men were limited to walking on the man’s right side in the dark. On such walks she would not smoke, although she enjoyed smoking, for fear that the glowing of the cigarette would light up her face. However, she would permit kissing, which she enjoyed very much, providing the darkness was deep enough.

Many efforts had been made to have her wear special cosmetics, since she was “so sensitive about a little scar.” This she refused to do; why, she did not know. On her own initiative she had visited a number of plastic surgeons, since her parents had “always taken a completely unreasonable attitude” about the scar. However, all three plastic surgeons had taken “the same unreasonable and unsympathetic attitude my parents took.” The result was that she had intensely hostile feelings toward the medical profession.

The rest of her history was not indicative of any other problems, although it illustrated many more of her handicaps in daily behavior. Essentially, her situation was that of a
young girl with one arm paralyzed and held in an awkward position covering her scar. Her object in seeking therapy was to learn how to adjust to her handicap without correcting her behavior. She was not receptive to any ideas about the possibility of altering her understandings about the “awful scar.”

Not until the third interview would she permit the writer to see the scar. It was examined at great length but without comment. Finally, her extreme tension was relieved by telling her that she might again cover it with her hand and keep it covered.

**CONCRETE DISPLACEMENT OF SYMPTOM**

During the taking of her history it had been learned that she had considerable talent in sketching, in which she took a great deal of pride. Accordingly, she was given the assignment of going home and, in the privacy of her room, making a life-size sketch of her face, showing the exact position, shape, and size of the scar. This was to be done with every possible attention to the minutest details, and the sketch was to be “true to life and scientifically accurate.”

When she succeeded in producing a sketch that she was confident was “accurate and true,” she was to bring it to the writer. If she wished, she could bring it in a sealed envelope that would not be opened until she was sure that she was willing for the writer to examine it. She spent the rest of that day and a good share of the night perfecting the sketch, which she brought to the writer in a large, unsealed manila envelope. Since she expressed full willingness, a hasty glance was taken at the sketch, and it was then replaced in the envelope and filed in her case history folder. It was noted that she still kept the scar hidden but that she was much less tense and anxious. Instead, she appeared much bewildered and puzzled.

**TRANCE INDUCTION AND POSTHYPNOTIC SUGGESTION**

She had previously refused to permit hypnosis, but she now readily accepted the suggestion that a trance should be induced so that she could be given a new, different, and unrelated assignment. A fairly deep trance was readily induced, during which she kept her left hand over the scar. Her next assignment, she was told, was twofold. She was to visit the college library, consult her mother, inquire of fashion experts, or consult any possible source she could discover to learn everything possible about the old-time practice of applying “beauty patches.” This done, she was to make a series of sketches of women’s faces showing the various shapes and locations of beauty patches. All of this was to be done in the waking state, but with no conscious awareness of why she was doing it. Nevertheless, she should know that she was doing it and wonder why. When the task was comprehensively done, she would decide to show the sketches to the writer. Each sketch would be similar to the self-portrait she had executed, and each would illustrate the use of a single beauty patch. She was then awakened with an amnesia for the trance events.
SHOCK AND SURPRISE: CONFLICTING FRAMES OF REFERENCE

About two weeks later she appeared with a collection of sketches amply illustrating shapes, sizes, and locations of beauty patches. She was intensely puzzled and curious about the overwhelming interest she had experienced in executing this assignment. She was asked to exhibit the sketches and to discuss them. Fortunately, all these sketches were on sheets of paper the same size as her first drawing, and all the feminine faces she had drawn were similar in outline to her self-portrait.

Advantage was taken of this to run hastily through the drawings, asking a simple question concerning each, and then to slip into the pile her self-portrait. She was then asked to scatter them over the table and to identify each particular type of beauty patch, whether a crescent, a star, a diamond, or whatever, and to give the reason for the site of application.

So engrossed did she become in this that she failed to recognize immediately the self-portrait. Instead, she described the scar as a six-pointed-star-shaped beauty patch applied to the corner of the mouth to attract attention to that feature as one most attractive. The fact that it was six-pointed instead of five-pointed puzzled her, and she expressed her surprise because she was certain she had only drawn five-pointed stars. As she puzzled over and examined the drawing further, she finally recognized it, with a sense of shock, as the self-portrait. For the next five minutes she faltered in her speech and stammered fragmentary utterances as she strove to integrate two conflicting frames of reference—the one centering about her “awful, disfiguring scar,” and the other, her six-pointed-star-shaped beauty patch properly placed in relation to her definitely attractive mouth.

REINFORCING THE NEW FRAME OF REFERENCE

Finally, as she sat there, helpless in the face of her new understanding of her scar, she was told:

Your parents, your brother, your friends were all so “unreasonable” as to think that your scar was just a beauty patch. The plastic surgeons thought so, too, and brushed you off as a silly girl who refused to recognize the scar for what it was. I, too, am sufficiently unreasonable as to see that scar as a little white star-shaped beauty patch at the corner of a very pretty mouth. And you yourself—in fear, distress, abhorrence—drew your portrait accurately and well, and without knowing it you portrayed that scar for what it was, a beauty patch which, unguardedly, you recognized correctly.

Now, let’s be scientific about this. Beauty patches are intended to draw attention to the most attractive feature. You have pretty eyes, you have a pretty dimple in your left cheek, you have a pretty mouth. You like to be kissed, and a number of boys have kissed you. Go out with them again, one by one. Let them kiss you goodnight under the porch light. Make a mental note of where they kiss you, on the left side of your mouth, full face, or on the right side. I think they will kiss the side with the beauty patch. You will find out.
Now, go home, take these sketches—all of them—with you. You did them carefully and well. You learned a tremendous amount from them. You can keep the sketches, or you can give them away. But what you learned from them you will always keep.

**SYMPTOM RESOLUTION AND SIX-YEAR FOLLOW-UP**

Subsequently, she reported that she was invariably kissed on the right side of her mouth. (The objectivity of this report is open to serious question, however.) Moreover, she rapidly freed herself from the habit of covering her mouth and lost her feelings of inferiority. She married two years later and now has four children.
The Ugly Duckling: Transforming the Self-Image

Milton H. Erickson

Unpublished manuscript, 1933.

Two young women, high school classmates but not friends, were in love with the same young man. One girl was rigid and prudish; the other girl, was decidedly permissive. When the latter was about three months pregnant, she and the young man were married. Three years later the man divorced his wife for adequate reasons, and two years later he married the other girl. A baby girl was born to them two years later, much to the father’s delight.

The marriage continued reasonably happy with one exception. The mother was much too puritanical with the daughter, who at the age of 25, became the writer’s patient. The daughter sought psychiatric help because her marriage of four years’ duration was becoming seriously unhappy. Her story was to the effect that her husband was an “intolerable, unspeakable liar,” and had been since she first met him. She had excused him during their courtship and for the first year of married life because “you have to take what a man says when he is in love with lots of salt.” Now, however, because her son was almost three years old and beginning to understand many things, she did not want his father “constantly telling lies.”

Many times she had tried to discuss the lying with her husband but found herself unable to do so because he was “so sweet and loving” and because “I suppose I wish his lies were true. I can’t help it.” Nevertheless, within the past year she had become so tense and so irritable and so unable to discuss anything with her husband that she had been resorting to unprovoked temper tantrums, outbursts of screaming, threats of divorce, and ideas of suicide. At no time had she been able to discuss her husband’s lying with anybody, and only his insistence that she consult a psychiatrist resulted finally in her call on the writer.

A previous visit from her husband disclosed him to be much alarmed about his wife’s mental state, since he could only describe her sudden outbursts of violent temper and hex bouts of weeping, which she apparently could not explain to him. He knew of no provocation whatever and considered the marriage otherwise a happy one.

The patient was most unwilling to reveal what lies her husband told so repetitiously, insisting that the writer need only instruct her husband to tell the bare, simple truth. Finally, after extensive persuasion, she agreed to inform the writer. In effect, her husband, because he was in love with her as a person, out of the mistaken goodness and greatness of his love, insisted on telling her that she was pretty, that she was cute, that her hair was lovely, that he liked the tilt of her nose, “and all those silly things that men, when they fall in love, say.”
She went on to state that ever since she was a tiny child her mother had “daily” told her that she was homely and unattractive, that her lack of beauty was a cross she would have to bear cheerfully and gladly. In addition, it would be only right and good for her to develop a charming personality, since that would last a lifetime, while beauty always faded away.

As a small child she had not been much concerned about her looks. In high school she had developed considerable self-consciousness, but had finally resigned herself to her fate and enjoyed “exercising her personality.” She seldom accepted a second or third invitation from the high school boys because they “lied” to her about her looks. Following graduation she had obtained a secretarial job, which she continued until her marriage.

Her first social engagement with the man she married had impressed her indelibly. He had told her then that she had the most charming personality that he had ever encountered. This had been reiterated during subsequent engagements, and not until later had he told her how pretty she was. She had accepted these compliments then because he was in love with her and because they were in accord with his response to her personality. Therefore, his “lies” could be forgiven as emotional exaggerations.

With the advent of pregnancy, however, her nipples had become very deeply pigmented. Her mother had informed her that child-bearing always cost a woman whatever little beauty she had. The daughter’s reaction was one of acceptance of “that fact” and strong resentment toward her mother. Thereafter, visits at the maternal home became much less frequent, and finally, they were limited to holidays and family anniversaries.

Her husband, however, had not manifested any dislike for the nipple pigmentation. In fact, he had “falsely acted pleased” about it. This, coupled with his continued expressions of his regard for her “beauty,” had placed her in the unbearable situation of being constantly reminded by his compliments of her misfortune and his mendacity. She felt that a solution to her problem would be a straightforward, open, honest recognition of the fact of her unloveliness. Then the question could be dropped, and no further references need ever be made to her looks.

A careful attempt was made to get her to evaluate her features one by one, since, to the writer as well as to her husband, her features were better than averagely attractive. Her ideas were rigidly fixed, however, and she promptly accused the writer of trying to gloss over her lack of beauty to pacify her. Accordingly, the effort was abandoned. Despite her impatience about the writer’s interest in “irrelevant matters,” inquiry disclosed no other significant problem. Her son was described as the “spitting image” of his father. “You can tell them apart because Johnny doesn’t have a moustache.”

When questioned about the possibility that her husband might actually believe that she were pretty, since “people often tell lies until they actually believe them,” she was rather nonplussed. After some thinking she stated that, if such were the case, therapy might help
her to tolerate the situation better, so that she would not lose her temper and become so depressed by his mistaken beliefs.

**THERAPEUTIC TRANCE, EXPECTANCE, AND INNER SEARCH**

Since she was aware, through another patient, of the writer’s use of hypnosis, it was a relatively easy task to interest her in hypnotherapy. She was a good subject, required little training, and was most cooperative. As the first measure, although extensive inquiries had been made previously of her husband, she was asked to list the various nursery tales she read to her son and to the six-year-old neighbor girl for whom she often cared on weekends. Among the tales was one she read with great frequency, “The Ugly Duckling.”

She was asked to recite in the trance state a number of the stories, among them “The Ugly Duckling.” No special attention was apparently given the story by the writer. However, her husband stated that she had read the “Ugly Duckling” story to her son frequently since about his second birthday.

At the next session she was told in the trance state to discuss her husband’s heavy, dark-brown moustache. She expressed great admiration for it, repeated how she insisted that he grow one, since it would make him look distinguished, and had refused to let him shave it off. During their courtship she had insisted that he grow one, and he had done so.

Still in the trance state, she was instructed as a posthypnotic task to take a heavy, dark-brown eyebrow pencil and to paint a moustache on her son as a practical joke on her husband. Then, after they had finished laughing at it, she was to examine it and her husband’s moustache and to learn to understand something of great importance to her. What this was she would not know at first, but at the right time it would become fully understood—with tremendous force.

At the next session she was to relate her reaction to the moustache on her son. In effect, she described it as a “hideous thing” since it did not “fit” on Johnny’s face, even though a moustache looked so well on his father, and despite the practically identical facial appearance of father and son. She also expressed feelings of a vague inner unrest, as if she were trying to understand something she already knew.

She was then hypnotized deeply and told that her unconscious was to remember a nursery tale and to think that tale over without letting her conscious mind know about it in any way. This nursery tale would be selected by her unconscious because it would apply to her in a most peculiar way and would fulfill her need to understand adequately certain things she had to know about herself. Furthermore, she would have to search through the nursery tales with which she was acquainted, that none of them would seem to her the right one, but that she would finally give up the task of searching and just take the handiest one, hoping that it would be the right one. Several days would have to be spent by her unconscious in its study of the tale. Also, she would probably dream about it, happy dreams, but she would not remember her dreams. Neither would her unconscious let her know what it was thinking about. Nevertheless, she would be consciously aware that something was happening within her, altering her attitudes and understandings.
At the same time, in some way, the moustache painted on her son’s face, so hideous to her and so out of keeping with his face, and her husband’s moustache, so attractive on him, would fit into the nursery tale in some way that would clarify all of her thinking and establish those attitudes she so greatly wanted.

Finally, just before her next session, she was to be unconsciously impelled to do something that would inform the writer, immediately as she entered the office, that her unconscious had completed its tasks adequately. Then, during the session, either in the waking or the trance state, she would begin to discuss with increasing understanding her new, altered, unconscious understandings, and thus make them a part of her total life reactions and attitudes.

She was seen five days later. She apologized as she entered the office for being late, explaining that she had been detained at the beauty shop where she had “blown the works.” She added that in the past she disliked going to beauty shops and had never had more than a permanent wave, but this time she had had everything they could offer. No comment was made except to state that she really could “follow orders.” This puzzled her, but she began a casual conversation, suddenly interrupting to state that she wanted to talk about the moustache she had painted on her son and about her husband’s moustache.

She was told to think over the topic carefully and to organize her thoughts. After a few minutes she began, explaining in effect that she had duplicated on her son’s face a replica of her husband’s moustache, in smaller size but of the same dark-brown color and shape. The effect had been grotesque and hideous because it did not “fit.” The boy was too small, his appearance was too young, and hence, despite his extreme resemblance to his father, the result was a distasteful mockery. Only when he became old enough and mature enough would the dark-brown color on his upper lip be attractive.

She paused, blushed, and impulsively declared, “It’s just like nipples.” A further pause, “A girl’s nipples should look young, but when she has matured and been pregnant, they really should look different. Why, it would be like a grownup man who had a boy’s skin on his face. It wouldn’t look good.” After a pause she added, “Maybe I better stop trying to look at myself as if I was a little girl. My husband sees me grown up.”

This observation elicited a startled silence in her. Then again she began, “I’ve just thought of ‘The Ugly Duckling’ story. All my life I’ve read that story over and over. I never knew why. And the last few days I’ve been so absentminded. I’ve just been keeping that story in the back of my mind. Do you know, I bet those old ducks still think that that swan is ugly. It had to join the swans to find out that it was beautiful.”

Reply was made, “The old mother duck will always think the young swan is ugly, but what will the other young swans think? And what will the young swan really know about itself?” Before she could reply, she was told emphatically, “You know and you will always know.”
“And now, when your husband comes home tonight, why don’t you cuddle up to him at the door and ask him simply, immediately, ‘Don’t you want to take a pretty girl out to dinner tonight?’”

“Your next appointment will be in one week’s time at the same hour.”

Thereupon she was summarily dismissed.

Her husband was seen before she was. He reported that she had obeyed instructions exactly and that he had been so astonished that he had forgotten a business appointment and enthusiastically agreed to her suggestion. He was most emphatic about the transformation in his wife, expressed curiosity about what had happened, but agreed to await such time as she chose to discuss the events of therapy.

At her interview the discussion was kept on a vague, casual level. About three months later she asked for an appointment. The purpose was to discuss any possible need to inform her husband of her original “silly ideas.” Inquiry disclosed that he had apparently lost all curiosity. A year has passed. They were seen again because they brought to the writer a young couple, intimate friends of theirs, who were considering divorce because of marital problems, and they wished the writer to handle that problem as well as he had handled hers. Inquiry disclosed them to have been adjusting most happily.
A Shocking Breakout of a Mother Domination

Milton H. Erickson

Previously unpublished manuscript, circa 1936.

Dr. X received over 300 hours of intensive psychoanalytic therapy by the past president of the American Psychoanalytic Association and of the International Psychoanalytic Association. This therapy had been without any therapeutic results. He was then taken over as a patient by another past president of the American Psychoanalytic Association and underwent another 300 hours of intensive psychoanalytic therapy with no results. He was then referred to the author.

CONSCIOUS LIMITATIONS AND HYSTERICAL DEAFNESS

About six hours were spent determining the fact that there was no approach to him to be made at the conscious level. He could narrate his obsessional fears, doubts, and compulsions, but if any comment of any sort were made to him during the hour, his eyes would glaze over, and it was entirely obvious that he would develop a hysterical deafness. This was tested by sounds that should have elicited startle reactions. Apparatus had been rigged so that a sound could be produced behind him, so there would be no possible visual awareness of what was about to happen. He made no startle or response of any kind to these unexpected sounds. It was found, however, that he would maintain sufficient visual awareness and sufficient selective hearing that he could hear and understand when the author was not speaking about him as a patient.

TRANCE INDUCTION AND TRAINING FOR POSTHYPNOTIC SUGGESTION

Having made these determinations, in the next two hours he was given the explanation that he would be hypnotized, and no effort of any sort would be made to do therapy, that every effort would be spent in training him to be a good hypnotic subject. To this he agreed readily in the same passive, accepting manner in which he had come for therapy. He entered into a deep somnambulistic trance quite readily, and a considerable amount of time was spent in teaching him to experience the various hypnotic phenomena, particularly the execution of posthypnotic suggestion. These were of great variety, but there was a careful avoidance of anything that might be construed as therapeutic. At a later date, during a three-hour session, a deep somnambulistic trance was induced, and there was a systematic presentation to him of a long series of posthypnotic suggestions. These were explained as suggestions that he would not have to execute during the trance; that they would be without therapeutic effect in the trance; that they were posthypnotic suggestions that would be carried out at a later date in a situation far removed from the author’s office and at a time when he and all others would recognize him as in the
conscious state. Interwoven with these suggestions was the reassurance that he need not be afraid of listening to these posthypnotic suggestions, that he could comfort himself by knowing that, as he listened to them, they were without effect upon him as a person and as a personality; that they could have no significance until some time in what would seem to be the remote future. An example was drawn for him to the effect that he could readily accept the suggestion here and now; that two weeks from now, on a specified date, he would eat a beefsteak and that in no way need he reject that possibility. Similar parallels were drawn to ensure his full understanding that he could accept all posthypnotic suggestions and merely thoughtlessly postpone their effectiveness to what would seem to him to be the remote future.

These posthypnotic suggestions had been worked out with a great deal of care, and they were developed on the basis of the information given to the author by the patient’s wife, an intelligent, cooperative, long-forebearing person who had endured her unhappy lot without complaint.

In essence the situation was that he was completely ruled by his mother. He and his wife had been married 15 years. The parents had given him and his wife a house alongside of theirs. The bride and groom had not been permitted to go on a honeymoon. His mother had insisted that he take two weeks off from his practice and honeymoon in their new home. To the bride’s horror the groom’s mother showed up in her kitchen the next morning to prepare breakfast. She had decided on the menu, and the bride and groom had to eat what she cooked. Mother also prepared lunch and the evening meal, besides telling them when to go to bed and when to get up. This type of behavior on the part of the husband’s mother had continued for the entire 15 years of their marriage. Mother took them to church and made them sit in the pew with the young husband next to his mother and separated from his wife by his father. Mother took them out to dinner at her favorite places. Mother took them to her choice of places of entertainment. In brief, in the entire 15 years of that marriage the mother had dominated every detail of their home.

Mother belonged to the Woman’s Christian Temperance Union and during medical school when he lived in the fraternity house, Sonny had imbibed alcoholic beverages. He had never dared tell his mother, and at least once a week she delivered a sermon on the evils of alcohol. Neither was he allowed to drink soft drinks, tea, or coffee. He had once ventured to request the privilege of drinking buttermilk, but his mother had expounded on the virtues of drinking only water and pasteurized milk.

Mother picked out his shirts, his ties, his shoes, and his underwear; she specified every change of clothing down to which suit he was to wear on which occasion. Mother did permit him to go to the office unescorted. But on any other trips away from home she went with him and handled him as if he were around the age of three or four years. Initially in his married life he had walked to his office; Mother said the exercise was good. But after the first year he began to leave early in the morning to avoid having people see him alone on the streets. His mother approved of long hours spent in the office, and he began working late at night in order to avoid being seen; this was not too effective, however so he began coming home by way of alleys.
In his practice of medicine he was engaged in a specialty that permitted the minimum of contact with his patients, most of whom were seen by his office help and technicians. His mother insisted that he go to medical meetings, but she always escorted him there and back. Very promptly he became too self-conscious to participate in any activities of the county medical society. In fact, he began avoiding speaking to his fellow physicians. After 12 years of this he sought therapy, and his parents begged for a special, private room at the institution where he was treated. His mother took lodgings nearby, was permitted to visit him daily and took him for walks, so that he did not participate in any of the institutional activities for patients. Since he made no improvement after over 300 hours, his mother decided to seek another therapist; she escorted him to that therapist’s office and accompanied him back home. This the therapist permitted.

When Sonny was brought to the author for therapy, Mother was told in most emphatic terms that she could not accompany him to the office, that she would have to delegate that responsibility to his wife. The author finally succeeded in conveying to the mother the idea that forcing the wife to bring her husband to therapy would be an appropriate punishment for the wife, and that she in her earnest solicitude for her son’s welfare should see to it that his wife undertook the punitive duty of bringing her husband for therapy.

The interview with the wife after this hoax had been perpetrated upon the mother was most delightful. She was an intelligent, capable young woman who felt herself hopelessly lost in dealing with her mother-in-law and incapable of weaning her husband away from her. It was possible to talk to her freely and frankly and to secure her promise of secrecy about the author’s plans. In fact, she was most delighted with the author’s intentions and most enthusiastic about cooperating. She was told to let Mother continue her domination unabated but to look forward with mirthful anticipation to what was going to happen to Mother.

The posthypnotic suggestion given to the patient in the deep trance had been worked out in extensive detail, and the patient’s wife had been consulted extensively to ensure its completeness. The explanation was given to the wife that the patient could not accept therapy in the ordinary waking state and that he did not accept it in the trance state. The approach employed was to use hypnosis to impress thoroughly upon the patient’s mind all the things that would lead to therapy in the trance state, but with the suggestion that they would be inoperative in that trance state. He was told that all therapeutic suggestions would become uncontrollably effective at a specified date in the future when he was in the state of full conscious awareness. In other words, the therapy was given in the trance state but remained inoperative until some later time of full conscious awareness, at which point it would become compulsively effective.

**A SHOCKING BREAKOUT OF A MOTHER DOMINATION**

When all of the posthypnotic suggestions had been completed, a specific date and a specific hour was set; namely, 10:00 A.M. on Sunday morning, the hour at which the
mother always came to take her son, his wife, and their two children to church. That morning mother had already prepared breakfast for her son and his family and had gone home to dress for church. Her son and his wife and family had also dressed for church. The mother came in, and her son greeted her as usual; then as related by his wife, in full agreement with posthypnotic suggestion, the son said, “Mother, would you please come into the kitchen for a minute?” His mother wonderingly followed him. He walked over to one of the kitchen shelves, took down a bottle of whiskey that was only partially corked so that he could remove the cork easily, and poured out a glassful while his mother stood in shocked, silent horror; then, with a stream of profane and obscene expletives, he declared his intention to get drunker than a lord, and that she was to haul her f—a—to church without him—whereupon he promptly drank six ounces of straight whiskey. What the patient did not remember was that immediately after breakfast he had gone to the bathroom, had inserted his finger in his throat, and had vomited up his entire breakfast. The impact of the six ounces of straight 100 proof whiskey was most startling, and it was added to by the posthypnotic suggestion. He collapsed on the floor; his wife and his mother undressed him and put him to bed, while he sang some unexpurgated songs dating back to his fraternity days; then he collapsed in a drunken stupor. His mother was so horrified that she went home and took a bath, having missed church for the first time in many many years.

She remained in bed until the next morning, when she came over to fix breakfast. As she came in, she found her son awaiting her in the breakfast room. He greeted her most profanely and obscenely, explaining, “I have been waiting for you because I am thirsty for another drink of whiskey,” and thereupon he drained a glass of what appeared to be whiskey. Actually, it was tea prepared by his wife to look like whiskey. Having drained the glass, he said, “Now I had better stagger off to bed,” and he began singing, “Drunk today, drunk tonight, drunker than I have ever been before.” His mother left in tears and went to bed for the day and night. As soon as his mother was safely out of the house, one of the children kept watch in case the mother or father should appear. The man’s wife prepared the first breakfast she ever had in 15 years of their married life. The patient notified his office that he was indisposed and he would not be in that day. At noon the patient’s wife prepared lunch, and that evening, the dinner. They went to bed at the hour of their choosing. In all of this the patient’s wife played a passive, submissive role in relation to her husband just as she had to her husband’s mother, and in response to posthypnotic suggestion the husband began to rejoice in his wife’s attitude toward him. The next morning the mother stalked into the house and said she was going to clean it out. She saw the whiskey bottle actually filled with tea and dumped it into the sink. She found another bottle of whiskey that had not been opened, and she rejoiced mightily in opening it and draining it down the sink. Then she ordered her son to march into the living room to listen to her while she “explained a few things.” She also demanded that his wife and children do likewise. Very meekly the patient did as told, and as the mother began, “Now you listen to me,” her son pulled out a half-pint flask of actual whiskey and drained it before his mother recovered her poise sufficiently to rush at him and take it away. The wife had immediately seized the two children aged 12 and 10 and rushed them out of the room. The patient profanely and obscenely told his mother that if she ever again came into the house without an invitation, he would promptly get
drunk, and that he might even ask his wife to get drunk with him. He then ordered her with much vulgar language to get out of the house, saying that if she dared to call any physicians or any friends to come to see him, he would take extremely unpleasant measures against her.

Mother left rather frightened. For the next three months she did not appear, but her son noted that she was watching out of an upstairs window to see if he went to the office and if he was walking home. During those three months the man and his wife established a good understanding of the total situation. Also, during those three months the patient came alone to see the author to have his posthypnotic suggestions reinforced and still further elaborated. At the end of three months a new set of instructions was given the patient. He was to locate a house that he would like to live in; to make arrangements either to rent or purchase it; and then to make arrangements with the moving company to be completely moved into the new home on the other side of town during one of his parent’s periodic day-long visits to an out-of-town relative.

The patient and his wife spent six weeks locating a desirable house and making appropriate arrangements with the moving company. Upon the mother’s return in the evening of the day of the moving, she was utterly astonished to find a vacant house where her son had lived.

She appeared at the office the next day to find out the location of his new home. He told her coldly that he did not think she should know, and if she tried in any way to find out, he and his wife and her grandchildren would never again visit her. Greatly subdued, the mother left and made no further attempts to intrude upon her son’s life.

A year later the son and his wife made a formal call on his parents, and good family relations were established. At Thanksgiving dinner the mother started to tell him what he should have on his plate and to her utter horror she saw her son, her daughter-in-law, and their two children leave the table and go home. However, they appeared for Christmas dinner, and the mother behaved herself. Thereafter good family relations were established, which the son carefully tested by offering his mother a glass of whiskey—which she politely refused—while he and his wife drank in her presence.

All together a total of not over 20 hours were spent working with this patient. (The author did not find that the previous 600 hours of psychoanalytic therapy had aided the patient’s breakout in any way.) In addition to his healthy family adjustment, the patient began to participate in county medical society meetings, was elected president of the county medical society, was elected president of the state medical society, and later was elected to office in the national society of his specialty.
Shock and Surprise Facilitating a New Self-Image

Milton H. Erickson

Unpublished manuscript, circa 1930s.

The purpose of psychotherapy is to enable a patient to achieve a legitimate personal goal as advantageously as is possible. Properly, it is not a matter of advancing particular schools of thought or of attempting to substantiate interpretative psychological theories, but simply a task of appraising a patient’s problem or problems in terms of the reality in which the patient lives and in the terms of the realities of the patient’s continuing future as he or she may reasonably hope for it to be.

The author is well aware that this brief formulation of psychotherapy and its purposes is in marked contrast to those schools of psychotherapy which insist that, as a prerequisite for future adjustment, a painstaking, laborious one-to-three-year-or-more minute scrutiny and analysis be made of the long-dead and unchangeable past before even touching upon the patient’s actual present and future needs, understandings, capabilities, and possibilities.

Yet one may consider the few troubled people who are benefited by psychotherapy of all kinds and the countless numbers who, while also having problems, still succeed without therapy in achieving goals that they and others regard as constituting real personal and social success. Thus, after such consideration, one may well wonder at the self-reassuring dogmatism of the many self-styled “the one-and-only right” schools of interpretative, speculative psychotherapy.

After this somewhat acrimonious introduction the author wishes to present a case history in which there was employed successful psychotherapy caustically described by some colleagues as “unorthodox and not in accordance with established rules of psychotherapy.” The fact that the patients had benefited was not considered to be pertinent to the issue by those critics.

CASE 1

The first patient was a 35-year-old professionally trained woman with a master’s degree. She was very slightly overweight but otherwise was decidedly attractive, graceful, and possessed of a most pleasing personality. Her major defect can be summarized in the outraged statement of an unmarried man of her own age, holder of a doctoral degree in a field of work related to hers: “If that damned girl would comb her hair, wash her ears and neck, put on a dress that didn’t look like an ill-fitting gunnysack, straighten her stockings, and polish her shoes, I could get seriously interested in her.”
In summary, her appearance epitomized her problem, and the above outraged statement described her appearance very well. Yet Ann was a highly intelligent young woman, and in the author’s six months of professional contact with her, he had been much impressed with the clarity and lucidity of her thinking and with her ability in the comprehensive appraisal of problems. The author had also developed an earnest respect for her competence as revealed in staff conferences; however, it was also noted that Ann had neither casual nor intimate friends, with the exception of one exceedingly competent, very friendly older woman who was quite obese and who suffered from arthritis.

Finally this older woman approached the author and explained that Ann was seriously depressed and definitely suicidal despite her outward facade of a comfortable, businesslike adjustment. She explained that for a long time she had attempted to coax Ann to seek therapy, and that only recently had Ann rather unwillingly agreed to see the author—but only briefly since, to quote her friend, “The darned idiot sees no hope for herself, and I want you to take her by the scruff of the neck and shove her face into a mirror and make her take a good look at herself as a real person of value. Nobody, just nobody—not even me—can talk to her; Ann just freezes and gets deaf and blind, and you lose all contact with her. But I finally have managed to make her listen long enough so that she has agreed to see you for a ‘few times,’ if you are willing. Please, for my sake, see her because I’m frightened by Ann’s desperation.”

**PREPARATION FOR TRANCE INDUCTION**

Ann appeared for her appointment with obvious reluctance. She was asked to take a seat beside the office door while the author sat on the opposite side of the room. She was told: “As you know, Ann, I’m very definitely crippled by anterior poliomyelitis, and anytime you want to escape from this office, you can get out of the door long before I can cross the room. Therefore you can feel safe here. And if you decide to develop hypnotic trances here, you will still have time to arouse from the trance state and get out of the office before I can cross the room. At the staff lecture on hypnosis, and at the demonstration which I gave recently and which you attended, I mentioned that several persons had unwittingly gone into and come out of hypnosis, and I refused to identify them. You, Ann, were one of those persons. Hence, I am delighted to see you here, and I hope you have come for the therapy that both Agnes and I think you need. However, therapy will not be forced on you. Agnes made this appointment for you. It will be used only to outline the situation. Your appearance here indicates that you recognize your need for therapy.

“Next, Agnes has told me that despite your salary and lack of any dependents you have so misused your income that in 12 years time you have saved only $700, and hence you are convinced that you cannot afford therapy. Let’s correct your ideas on that at once. There is no charge for this interview. It is a courtesy to our friend Agnes, not a debt incurred by you.

“Subsequent interviews with you, if any, will be therapeutic, and they are to be paid for on my terms, and my terms only. These terms are absolute, full, and complete obedience
in relation to every instruction I give you regardless of what I order or demand. Your one and only protection from this arbitrariness on my part is that you are free to relate everything or anything you wish to Agnes first before you act upon my instructions. If she approves, you then have no choice but to obey.

“You have told Agnes you have no time for therapy. I shall, therefore, expect the most expeditious of responses from you. No dilly-dallying, no shilly-shallying. You will be told what to do, and you will do it. That’s it! If I tell you to resign your position, you will resign. If I tell you to eat fresh garlic cloves for breakfast, you will eat them. I have spoken clearly and understandably. Just as clearly do I want it understood that in psychotherapy for you, I want action and response—not words, ideas, theories, concepts. I want responses, desirable, good, informative responses of action and change, not contemplation of change, but change and action of a constructive sort. If this is understood by you, let me know and I will continue.

Ann meekly nodded her head affirmatively.

“Fine! Now listen and listen well. Think over all I have said carefully for the next three days. Understand well that for the next three long days you are to think over everything that I have said to you. If I tell you to go into a hypnotic trance, you will do so. And you and I both know, I from observation, you from your unconscious learnings and actual responses in a recent staff situation, that you can respond most adequately hypnotically. I do not care if you like that frank statement of fact or not. But you want therapy, and you have so indicated in many ways, especially to Agnes.

“After the three days you are, if you decide affirmatively for therapy, to return here for that therapy best suiting you as a potentially happy, well-adjusted person. Come at this hour prepared to stay as long as I wish, and bring your checkbook with you. Discuss this entire matter with nobody, not even Agnes, who has been told to discuss your therapeutic wishes no longer. Come prepared for and committed to therapy and to the loss of your bank account and your personality problems, but don’t come back if you are not so committed. The decision must be entirely yours.

“Bear in mind that therapy is going to meet your wishes, but it will not always be comfortable and easy. You want it done rapidly, and it will be done rapidly and thoroughly. Once you come, you are committed to therapy, and your bank account belongs to me as does the registration certificate for your car, whether in my possession or not. I will tell you what to do and how to do it, and you are to be a most obedient patient, learning fully to put into action all the ideas presented by you.

“Now go home; you have a vital decision to make. Do it by yourself. If in the affirmative, return in three days at this hour, with your time my time. Goodbye.

Agnes reported that Ann went through a remarkably silent, distraught three days and that her work suffered greatly.
A SURPRISING AND RAPID TRANCE INDUCTION

Ann returned at the appointed time, entered the office hesitantly and tremulously, and stood waiting for the author to speak. She was told, “Close the door, sit down in that chair near the door, and in the process of doing those two tasks develop a deep somnambulistic trance in which you will give me your full attention mentally as well as visually and auditorily. Nod your head when you feel that you are ready for me to begin.”

Moments after she seated herself, Ann began nodding her head in the typical perseverative fashion of the deep trance, her gaze fixed rigidly on the author. Her blink and swallowing reflexes were absent, and her rigid facial expression was characteristic of the somnambulistic state.

“That’s fine, Ann. Continue to remain in the trance as you are now. Be receptive of everything I say. Remember you are at liberty to question Agnes on any detail that you wish, but otherwise what I say remains confidential. What I am going to say to you is not something you will expect. It will be helpful, drastically so. I will outline a course of behavior for you, and this you are to execute without fail. Do you give me your absolute promise?”

Slowly, perseveratively, Ann nodded her head.

“Are you afraid?”

Ann nodded her head affirmatively.

“You need not be afraid. I’m going to startle you greatly, and I am going to give you sharp psychological pain. Both experiences will be almost paralyzingly unpleasant, and then, as you incorporate the understandings that they signify, the pain and distress will disappear. Are you ready?”

Ann nodded her head. She was told to stand with her feet close together and her hands at her side and not to move unless there arose a good indication for moving.

As she stood waiting expectantly, the author stated, “Ann, you are 35 years old; you look at least five years or more younger than you are; you are definitely attractive in appearance; you have not had a date for at least 14 years despite your pleasing appearance, personality, and good intelligence; you are five feet three inches tall, and you weigh about 130 pounds; you have trim ankles, an excellent figure, a beautiful mouth and beautiful eyes. All this you can verify yourself.”

Then in a tone of voice of utter intensity, in the manner of conveying a vitally important message, she was asked the following question: “Ann, did you know that you have a pretty patch of fur between your legs?”

For some minutes Ann stood staring at the author, blushing deeply and continuously, apparently too cataleptic to close her eyes or to move in any way.
“You really have, Ann, and it is definitely darker than the hair on your head. Now at least an hour before your bedtime, let us say at nine o’clock tonight, after you take your shower, stand in the nude before the full-length mirror in your bedroom. Carefully, systematically, thoroughly examine your body from the waist down. Be pleased with your belly button, curious about that pad of fat between your belly button and your pretty pubic hair.

“Try to realize how much you would like to have the right man caress your pretty pubic hair and your softly rounded belly. Think of how you would like to have him caress your thighs and hips. Stand there in front of the mirror and keep standing there until you have realized all of this. Then, as you become pleas ingly tired physically, go to bed happy, blushingly happy, knowing that you do have a pretty piece of fur between your legs, and fall restfully into physiological sleep, and sleep restfully the whole night. You do not need to remember your dreams, nor will they disturb your sleep; but the next day, outwardly calm and composed but inwardly warm and happy, work well and comfortably.

“Do you understand all of this instruction, and are you prepared to do it as I have outlined it? Nod your head affirmative if you understand fully:”

Slowly Ann nodded her head, continuing to blush constantly and to breathe irregularly.

“Now listen carefully, Ann. Shortly you are to awaken from your trance. You are to have a complete amnesia for all that has happened here, has been said here, has been experienced by you here. Go home, take your tub bath or shower early, dry yourself, then suddenly find yourself standing in front of your full-length mirror, staring at yourself from the waist down, and then remember in full detail everything that was said to you here, every comment, every instruction; and, Ann, execute them fully. This you will do to the full satisfaction of my instructions and to the full satisfaction of your needful understandings of the therapeutic advances you need to make.

“Then tomorrow, at this same hour, come for your second appointment. Come dressed as you are today, in the same dress, outwardly appearing exactly as you do today. Now arouse from your trance with the total amnesia I have asked for and go about your duties, unconsciously awaiting the right time tonight. And in the process of arousing gently, sit down comfortably in the chair there and then become fully alert but not curious because I dismiss you.”

Ann sat down, obviously aroused from her trance state, and looked expectantly at the author. She was told not to be curious about the passage of time (she had looked at her watch and had showed marked astonishment), that all was well and that she would, without further instruction, keep her next appointment. With a most puzzled look she departed.
She appeared a half-hour early for her next appointment, but spent that extra time pacing back and forth in front of the office as if attempting to make up her mind whether or not to keep her appointment. Exactly on time she entered the office, her face bursting red with blushes. Precipitously she declared, “I remember everything. I don’t know what to say.”

“Just close the door and sit down in that chair.”

She did so, immediately developed a profound trance, and sat looking wide-eyed at the author, still blushing.

“I see that you want therapy and that you did as you were instructed.”

Blushing more deeply she nodded her head perseveratively.

“Now stand up in the same way as you did yesterday. Thank you! Now listen to me well, carefully, thoughtfully. Yesterday, quite drastically, in a fashion which you could not avoid understanding and which precluded any possibility of suppression or repression, I asked you to become fully aware of the badge of femininity which you wear, a badge of femininity which you should rightly treasure in all ways.

“But that is not all of which you are to become aware. Tonight, even as last night, in the same sequence of events as I described yesterday, find yourself unexpectedly in the nude in front of the mirror, then suddenly recall all the instructions I have already given you here in the office and which I will give you today.

“Tonight, as you stand in the nude in front of the mirror, look at your badge of femininity, be pleased with it, even blush, and then suddenly, as if it were for the first time that you saw them, look well at the two emblems of womanhood you wear on your chest.

“Examine them carefully, both visually and tactually, thinking over carefully all the things that you know I could tell you to think—all of the things I could tell you to think over. Is it necessary for me to elaborate?”

She slowly shook her head.

“Will you do it even more elaborately than you think I would order you to do the task?”

Ann began blushing in waves as she tried to turn her head aside, and then, yielding, she nodded her head affirmatively.

She was then instructed to return the next day and to appear in the same dress and outwardly unchanged. Next, she was told to sit down, to arouse from hypnosis with a complete amnesia for everything until the crucial moment before the mirror that night.
As she aroused from the trance, she was told, “That’s all for today.” Her face expressed bewilderment, she looked at her watch in a most puzzled fashion, but she departed without saying anything.

She appeared on time the next day, blushing deeply as she entered the office. Without any hesitation she promptly closed the door, sat down in the chair, and immediately developed a profound somnambulistic trance; her blushes disappeared.

She was immediately asked, “Do you want to say something?”

She nodded her head.

“All right, say it now to your full satisfaction.”

Promptly she stated, “I did all you said, I did it better, I think, than you could have asked.” Then with many blushes she asked, “Do I have to tell you?”

“No, Ann, the fact that you have obeyed instructions fully, even better than I could expect, and since your question implies your willingness to cooperate in therapy by relating things you reasonably can expect me not to know, your progress is entirely satisfactory.”

Ann ceased blushing and waited expectantly.

“Did you remember everything both times upon awakening, yet handle your awarenesses well throughout the following day?”

Ann nodded affirmatively.

“Now stand up as before, beside your chair. Today’s task is much harder, much, much harder, much more troublesome, much more painful. Upon leaving here you will notify your office that you will not be there the rest of the day. You will leave here with an amnesia for what I am about to say to you, but still fully consciously aware of the learnings you have acquired the past two nights.

“Listen well! You have heard how many a mother gets her small child neat and clean and declares that it seems to her that in only a few moments’ time he becomes unbelievably untidy. Now listen, Ann! This is the third day you have been in the office. It is not the first time you have worn a dress three days in succession. I merely ensured no accidental change of dress. Now listen carefully, storing every word in your unconscious mind for sudden, full conscious memory when you find yourself in front of your mirror promptly upon returning to your apartment after leaving this office. Do you understand?”

Ann nodded her head slowly, apparently bewildered by the author’s rather sharp tone of voice.
“Ann, our dress looks horrible. It’s saggy and baggy and it fits you like any old potato sack, and it is wrinkled and perspiration-stained, and you don’t have a decent-fitting, decent-looking dress in your entire wardrobe. Every one is an insult to the eye. No taste, wrong colors, wrong everything, and yet you wear them to the office, on the street. When you find yourself in front of the mirror today, with full conscious memory of all that I have said and will say in this office today, examine each and every dress you have, model it, note the ill fit, the sweat stains, spots, rips, loose buttons on blouses—see how competently you dress to be an eyesore.

“And worse, Ann. Look at your hair. Never have I seen it properly combed in the six months I have known you. Always at least a couple of snarls, and that parting of your hair, how do you make it so outrageously crooked? Take a hand mirror and use it to help you to see in the large mirror. A woman’s hair is ‘her crowning glory’ or, in your case, Ann, your crowning disgrace.

“More yet! Have you a personal prejudice about washing your ears and behind them? Don’t answer, but look in the mirror and get an answer then! And your neck! You take a shower or a tub bath, but how do you forget to wash your neck? It must be an art, an undesirable art. Who would want to neck with a dirty-necked girl, a dirty-necked girl like you?

Shudder about that a bit as you look in the mirror. If you want feminine corroboration of all I’m saying, get Agnes to let loose some of her suppressed feelings. You will like them less that what I am saying to you. “How often do your fingernails go into mourning with that line of black dirt under your poorly trimmed fingernails? Do you think it is pleasing to hold hands with a girl whose fingernails are in mourning? Don’t answer. The questions are rhetorical. For six months I have known you with mussy hair, dirty ears and neck, displeasing, disgusting fingernails, and ill-fitting, untidy dresses, wrinkled stockings—take a look at those, too, tonight. What a slob you are outwardly!

“You have $700 in the bank. You can borrow money. Go downtown to Department Store X. Seek out Miss Y. I know her; Agnes knows her; I’ve spoken to her sufficiently about your needs. Tell her that you want her to teach you that vast amount of learning you lack but which every woman should have as second nature. Miss Y will be reasonable; accept instruction fully, buy everything you need, get some pretty dresses that fit you, some deodorants and antiperspirants, learn to comb your hair—say a happy goodbye to your $700 and what more you borrow. Arrange for time off work—this I know is possible. There is more I could say, but it really isn’t necessary to elaborate.

There is just one question that intrigues me, but do not answer. It is, where did you get the good sense to go to the dentist to keep your teeth in such good shape, or do you just naturally have such beautiful teeth? Well, use them to sink into the task before you.

“Now you are to leave here with a total amnesia for all that has occurred today in this office. For any reason that comes to mind, notify the office of your absence for the rest of the day. Go to your apartment. Look around happily. It is neat and tidy. Agnes has told
me so. Feel pleased with it. Then step to the mirror and let the ‘horror show’ begin, and stay to the bitter end and then realize what happiness can be yours.

“A closing remark to you is this: awaken and leave promptly upon grasping the meaning of what next I say. Let me see no more of you until you keep your next appointment as a ‘vision of delight.’ Now get out of here and close the door from the other side.”

She left hurriedly in puzzled bewilderment.

A month passed, and late one afternoon Ann entered the office blushing furiously, smiling happily but embarrassingly, most beautifully gowned. She explained that she was going to a very “special” dinner and dance with a very “special boy friend” and that she would tell the author all about it later, as indeed she did, and she added with much self-consciousness that she hoped she was a “vision of delight.”

Within a year Ann was engaged to a physician; she married him shortly thereafter and moved to another part of the country. Occasional news was received about her. At the age of 45 Ann was encountered unexpectedly while she and her family were on a vacation trip. She was the mother of four children; she appeared to be not over 40 years of age, and she was exceedingly happy. Her husband had achieved marked recognition in his specialty, and the entire family was obviously happy and well-adjusted. One careful comment was made by Ann to the effect that, bit by bit, as her daughter grew old enough to understand each item, she intended to teach the child progressively “how to be a vision of delight.”
Correcting an Inferiority Complex

Milton H. Erickson

Unpublished manuscript, 1937-1938

A 29-year-old man, employed as a clerk, sought therapy in an ambivalent manner. He explained that, while he wanted therapy, he did not amount to enough to warrant anybody wasting time on him. He had sought therapy from other psychiatrists but had always discontinued because the amount of time that seemed indicated for results was so greatly out of proportion to his worth as a person. He always felt the time spent on him could be better spent on less inferior patients. He had come to the writer in the hope that hypnosis would be used and that his therapy could be expedited without depriving more deserving patients of needed time with the writer.

The suggestion was offered that he probably wished limited therapy that would meet his minimal needs. He agreed with as much enthusiasm as he could muster. He also agreed reluctantly to the idea that preliminary interviews would be spent in securing a necessary factual history, but was somewhat reassured by the statement that he could abbreviate the time by giving freely whatever information the writer wished.

His history can be summarized by first giving the recurrent theme of it and listing illustrative items. “I have never done anything very good, no matter what. I’m completely inferior in everything.” He was the only child of shiftless, ne’er-do-well parents. He had failed to attend the eighth grade graduation ceremonies and felt that he had not really graduated. High school required four and a half years because of time spent in changing schools. Even so, he failed to graduate because he lacked one credit. He was always a hanger-on at social activities in school, and his diffidence and lack of self-confidence precluded any active participation. In high school, despite his excellent physique, he succeeded only in being waterboy for a brief time. He was, in his own words, “a wash-out as a waterboy.” In essence, he was one of those “nice fellows” for whom the general tendency of people is to feel contemptuous pity.

His parents died when he was nearly 18. His first employment had been scattered odd jobs at manual labor. Finally, he secured employment washing cars in a large garage and graduated to the position of handyman and errand boy for everything. This led to his placement in the automobile parts department, where he actually manifested good ability. However, his willingness to work hard for a minimal salary earned him only job security and general disrespect.

On inquiring into minute details of what he could do, numerous, consistent items were discovered. A few of these may be listed:

1. He could not knot his tie neatly, nor could he tie his shoestrings neatly.
2. He was invariably five minutes late coming to work and about 20 minutes late in quitting.
3. Time after time he ruined social engagements arranged on a joint basis for him by associates by making some inept remark, such as telling his girl companion, “He [the other man] always gets the prettiest girl.”
4. A final item, which he had mentioned repeatedly in giving his history, was his handwriting. It was practically illegible, and his records at work were a constant source of embarrassment, even though they constituted an insurance against his discharge.
5. One other and highly important theme in his story, reiterated again and again, was “If I could only do one thing good, just one thing, I’d have some pride in myself. Can’t you learn me just one thing good?”

TRANCE INDUCTION UTILIZING THE PATIENT’S INFERIORITY COMPLEX

When he had completed his story, he was told that hypnotherapy would be employed. To accomplish this, it was explained that he would be used as a demonstration subject for the writer’s medical students and that the therapy would be an incidental part of the instruction of the medical students. This type of cavalier offer to help him utilized his need for inferiority even in the therapeutic situation and actually pleased him. His general pattern of submissiveness aided greatly in inducing a deep trance without difficulty. He learned to manifest readily all the general hypnotic phenomena.

Extensive use was made of posthypnotic suggestions to create situations in which his general inept behavior was brought into sharp contrast with the competent behavior of the medical students. In this way an attitude of dependence upon and security in relation to the writer as a completely tolerant, forgiving protector was established to satisfy his neurotic needs.

HYPNOTIC ROLE-PLAYING FACILITATING OBJECTIVE SELF-PERCEPTION

After about 12 hours of this sort of activity, intermingled with instructional work with the medical students, he was deeply hypnotized and depersonalized. He was then induced to assume the identity of that medical student with whom the writer felt he could most easily identify. This accomplished, the selected medical student, who was an amateur actor, was hypnotized deeply and instructed to assume the patient’s identity.

There followed a repetition of various of the procedures previously employed to create special situations with the pseudo-patient duplicating the patient’s previous inept behavior. During this the patient, in his identity as a student, participated in the discussion of the induced behavior portraying himself. Thus he was enabled to see himself in an objective, detached fashion and, from unrecognized inner knowledge, to appreciate exactly what was occurring.
When it seemed that there had been sufficient demonstration of his ineptness, one final item not previously employed was utilized. This was a systematic calling upon various but not all of the medical students, one by one, to write and sign the statement, “This is a beautiful day in June.” In each case the students were urged to write clearly and legibly. Each written production was then critically examined by the entire group, except the pseudo-patient. Among those not called upon to write was the actual patient.

Next the pseudo-patient was asked to write the same sentence. A horribly illegible scrawl with an indecipherable name was produced. (This student had previously been shown the patient’s handwriting and had been asked to study it.) The pseudo-patient was urged again and again to write more legibly, but each production remained illegible.

After discussion of this with the group, the writer explained at length that the “patient” could be taught to write easily and legibly by the utilization of a special technique. Thereupon the medical student, in his role as the patient, was regressed to an earlier childhood level and asked to write simple statements. He did this in a typical childish handwriting, but legibly so. After securing samples of his handwriting at various age levels, he was reoriented to the original trance state. Again he produced illegible scrawls.

**SERIAL POSTHYPNOTIC SUGGESTIONS AND AUTOMATIC WRITING**

He was then given a series of posthypnotic instructions to awaken and, at a specified cue, to write clearly and legibly, “It is not raining tonight” and to sign it with the names of several classmates. This writing, it was explained, would be done automatically, and he would not know who wrote it since it would be written with such legibility. Also, at a second cue he would write the same sentence again with great care and still not know that he had written it. In fact, he would vigorously deny having written either production, insisting that he could not write that legibly.

The pseudo-patient obeyed instructions in full, and his illegible and legible productions were passed around the group for criticism and discussion, while he vigorously claimed that he had not written them, a claim rendered recognizably valid by his posthypnotic amnesia.

Following this, the patient, still in a trance, was reoriented hypnotically and his identity restored. He was immediately regressed to various childhood levels at each of which he was asked to write clearly and legibly the sentence, “This is a beautiful day in June,” signing his name each time and recording his age and the date. At the 14-year level a prolonged series of suggestions was given him to the effect that when he was a grown man, he would be called upon to do the same thing, and a promise was elicited that he would. He was then reoriented to the current situation with an amnesia for trance events, though still in a deep trance.

With great emphasis and care he was given a long series of posthypnotic suggestions to the effect that upon certain specified cues he would, after awakening, write automatically
the sentence, “It is a beautiful day in June,” and sign it with his name. He would not know he was doing this, and he would vigorously deny having written it. Furthermore, while writing it, he would be engaged in discussing with the medical students some topic that would be raised. (The medical students were posted to have in readiness such topics as the city’s population 10 years ago, the street location of some building, etc.)

Additionally, the posthypnotic cue would be repeated a number of times, and each time the writer would raise some question as, “I wonder if the same writing will appear on the next sheet,” or, “I expect the next signature will have the full middle name, instead of the initial.” Each such question was to be responded to by the execution of the implied suggestion.

When it seemed reasonably certain that he understood, he was awakened. After a few casual remarks, at a glance from the writer, one of the students began discussing a topic. The writer drummed briefly on his desk with his fingers. The patient abstractedly picked up a pencil and, while attending to the discussion directed at him, wrote the sentence and signed it with his first and last names and middle initial, all in legible fashion.

This sheet was quietly removed, a new topic raised, the cue given, and the question voiced by wondering if the sentence would be written. The patient responded exactly as he had been instructed. This time his attention was called to the completed writing, and he was asked if he had done it.

There followed his denials and the animated assertions of the students that he had written it. The patient “proved” his contention by copying the same sentence in his usual illegible script underneath his automatic writing. His “proof” was accepted with a show of much reluctance, and the writer took advantage of this development by asking him to scrutinize that page most carefully, to memorize its appearance thoroughly, and to be prepared to recognize it when shown it again. The sheet was then quietly put out of sight along with the first.

He was asked to count the sheets of paper on the desk and to examine them carefully, one by one, to determine if there were any writing on them. When he affirmed that there was none, he was engaged in a new topic of conversation, the cue was given as the writer “wondered” if his name would appear on the uppermost sheet. Automatically his hand wrote legibly without his knowledge.

Again the procedure was repeated, this time the writer wondering if the top sheet would be placed underneath the other sheets and if his full name would be written on the next. Absentmindedly he straightened out the sheets, slipping the top one underneath and writing his full name on the exposed sheet.

The procedure continued with the items listed below written, one by one, clearly and legibly. Repeatedly his attention was called to the fact that everybody was fully 10 feet away from him. The repetition of this puzzled him greatly.
Sheet 3: “My birthday is November 9th. I was born in Lodi.”
4: “Natalie Williams.”
5: “2 3 8 1 9 2 9”
6: “Look on the next sheet for the name of the person writing this sentence.”
7: “John Robert Doe.”
8: “You don’t believe it, do you?”
9: “You will—you really will.”
10: “Didn’t know you could write well, did you, John R. Doe?”
11” “You are about to find out that you can write well, and you will really know it. You will watch yourself writing and you will see it with your own eyes.”

This last sheet was placed at the bottom of the pile. He was then interrupted and asked if any further writing had appeared on the paper since that sentence. He shook his head, remarked that the group was too far away, glanced at the stack of paper, and added that it was ready for writing if anybody wished to do any. He was asked if he still remembered the sheet he had been asked to memorize. He nodded his head, and the writer stepped over and handed it to him. He pointed at the “strange writing” and his own and showed it to each one in the group.

He was asked to be most certain about his statements concerning the writing and to hand it to the writer. While the patient’s attitude was distracted for a moment, the first sheet was substituted and he was again asked if he were certain about the writing. As he asserted he was, the first sheet was extended to him for apparently a reinspection. He was tremendously startled to find that “his writing” had disappeared and that the “strange writing” had moved to a different position on the sheet. Further manipulation of the sheets bewildered him still more, until he declared that he did not know what to think since he knew the author was not a magician. He was assured at once that he would soon know what to think, and he would then be right.

Next he was asked to examine the stack of paper in front of him and to see if there was writing on the various sheets. He asserted that he knew there was none, but upon request he started examining them one by one.

The first few sheets were of course blank. When he came to Sheet No. 3, he commented in astonishment, “That’s the same as my birthday, and I was born in Lodi. That’s funny.” At Sheet No. 4 he was even more startled, commenting in amazement that that was his mother’s maiden name.

Sheet No. 5 bewildered him completely, and he disclaimed any understanding. However, when asked for his present street address and any other past addresses he remembered, he complied and then suddenly recognized the house number where he had lived in 1929. Immediately he looked at the next sheet, hastily read it, and then uncovered Sheet 7. He read his name aloud to himself, declaring that it was his name, that nobody else there knew his middle name, that it was not his writing, which it could not be. He reexamined
the other sheets, including the first two. This discovery of the first sheet and the second as two different written productions confused him still further.

Upon reading Sheet 8 he was too dumbfounded to speak, except to say, “I can’t; I didn’t.” Then, after looking hesitantly around, almost furtively, he looked at Sheet 9, shook his head uncertainly, and slowly lifted the sheet to see No. 10. This he read aloud to himself in a puzzled, bewildered fashion and finally asked, “What is going on? What is happening?”

The reply was offered, “You are learning something most important. Why not look at the next sheet?” Obediently he uncovered the next sheet, read it carefully, and turned to the writer as if waiting.

Immediately, a posthypnotic cue previously employed to induce a trance was given. He developed a deep trance at once and was instructed, “You know unconsciously the whole truth about the writing unconsciously, and you are now ready to know it consciously. You can write well, you can take pride in doing something well, and more than that, you know, really know, that you can do many things well. Only one thing remains to be done before you can use all this understanding to change your ways of doing many things. That one thing that needs to be done will be done shortly.

**VISUAL HALLUCINATIONS TO FACILITATE OBJECTIVE SELF-PERCEPTION**

“I want you to look in that crystal ball right there and see yourself writing in the unhappy, miserable fashion you have for so long. See yourself plainly. Now that that is done, see a second crystal ball alongside that one. In it you now see yourself writing legibly, and as you watch, a tremendous flood of joy and happiness and confidence and pride will well up in you, ready to become shown as soon as you awaken and watch your handwriting, ‘This is a beautiful day in June. Signed: John R. Doe.’ You will watch your hand write this and then write it a second time. Then you will put the sheet away and turn to me and tell me from the bottom of your heart that you can write well and you will show me by writing whatever you wish. And then all the happiness in the world will well up in you, just like in a happy little boy, a growing boy, just like in a teenager who has won first place, like a young man that has succeeded in his first big job. This joy you will really share with everybody, and we will enjoy your happiness because it means everything in so many ways to you. Now awaken and watch first how your hand writes.”

Instructions were followed fully, and the writing he did of his own determining was, “I can really write—I can really do a lot of things I am going to do. John R. Doe.”

Upon reading it through, he leaped to his feet and, at first childishly, then boyishly, then youthfully, demanded over and over that each of the medical students, as well as the writer, read his writing, comment on it favorably, and watch him do further writing. About 15 minutes was spent in this emotional display. Then suddenly he gathered up his papers, handed them to the writer, and said “Thank you.” Turning to the students he said,
“Excuse me a moment, gentlemen,” sat down, undid his knotted shoestrings, and tied them in neat bows.

Straightening up, he addressed them, “I want to thank you gentlemen, too. If you ever need any automobile parts, I’ll give you the best service in the world.” After shaking hands all around, he took his departure, but he was observed entering the men’s room. When he came out, his tie was neatly knotted.

He was seen two weeks later. He reported that he had been working overtime, extensively recopying for his employer all the past records of parts received and sold, so that his employer would have decent records. A month later he had received a promotion and a marked increase in salary. He had developed his social life and had joined an amateur theatrical group and was at the present rehearsing regularly for one of the leading roles. He had also been having social engagements with a young woman of his age.

A year later he was decidedly happy in a minor executive position in a large automobile-accessory firm and was considering marriage. Several years later word was received indirectly that he was happily married and still employed by the same firm.
The Hypnotherapy of Two Psychosomatic Dental Problems

Milton H. Erickson

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In the practice of psychiatry one frequently encounters patients whose problems center around some physical attribute with which they are dissatisfied. Too often they seek help from those trained to deal with such physical aspects of the body, but who have not had the training or the experience necessary to recognize that the primary consideration is the patient’s personality reaction, not the patient’s physical condition.

Consequently, efforts to alter the physical state, regardless of the technical skill employed and the excellence of the results obtained, are not appreciated, since the patient’s hopeful expectations are not limited to the actual possibilities of the physical realities. Particularly is this true in the fields of dentistry and plastic surgery, where sometimes the most skillful work may fail to meet the emotional demands of the patient.

To illustrate this general type of psychosomatic problem in the field of dentistry, two case histories are to be cited below. In each instance the patient seized upon a dental anomaly as the explanation of a definite personality maladjustment. For each, the problem of therapy was not a correction of the dental problem but a recognition of emotional needs.

Several examples of the first type of patient have been seen. Among them was one who underwent an extraction and a fitting with a denture. Her maladjustment continued, increased by her permanent dissatisfaction with the dental work. Another had centered all her life around her neurotic reactions, scorning any type of treatment. A third had been comfortingly told, when she sought dental intervention, that she should take pride in being unique, and so well had the dentist done this that she had adjusted satisfactorily.

Two examples of the second type have been seen. Both of those bitterly resented the dental correction that had been made, since they had been left with their primary personality problem unsolved.

Neither of the writer’s patients reported here had sought correction of their dental anomalies nor had their dentists suggested any need for correction.

While the cases to be cited represent primarily problems best handled by a psychiatrist, there is a need for those in allied fields to be aware of the nature and possible seriousness of seemingly minor psychosomatic reactions and of the opportunities of dealing more adequately with them.
PATIENT A

A high school girl sought psychiatric help because she was failing her Second-year work and because she had barely succeeded in meeting the first year’s requirements. Her reason for coming to the writer was that she knew he was a hypnotist and because she had been much impressed by an extracurricular lecture he had given at the high school. As she entered the office, she remarked that she would probably be hypnotized by a single glance from the writer and that she probably would not even know she was in a trance. No effort was made to disillusion her.

She had come without her parents’ knowledge because she felt that they would not understand her problem. Nor could she go to anybody else she knew because they would only minimize her problem and reassure her “falsely.”

Her complaint was that she was an “absolute freak” in appearance because she had only one double-sized upper incisor tooth. This had not troubled her until the development of physiological maturity and a concurrent change in residence, making necessary admission to a high school where she knew nobody.

Her reaction to her personal and school situation had been one of withdrawal, seclusiveness, and the development of much wishful thinking in which her teeth were “normal.” She found herself extremely self-conscious, was unwilling to eat in the school cafeteria, and avoided smiling or laughing at every cost: her enunciation of words was faulty because of her voluntary rigidity of her upper lip. However, her attitude in the office was one of ease, which she explained was because she was probably hypnotized.

During the interview it was noted that she relied almost exclusively on slang and “jive talk.” Even in making serious remarks, she couched them in extravagances of slang.

For the next two interviews she was encouraged to display her actually extensive knowledge of, and fluency in, past and current slang, and she was delighted to display her ability. Additionally, she was an excellent mimic and had a remarkable command of accents, which she was most ready to display. Accordingly she was asked to demonstrate at length the “choppy” speech of the British and the “bitten off” enunciation of the Scotch. Also, she had an extensive knowledge of popular songs, past and present, comic strips, nursery tales, and light literature of all sorts.

The next interview was devoted to an extensive discussion of the picturesqueness of slang. This conversation unnoticeably and deviously led into a discussion of expressions, such as L’il Abner’s “chompin’ gum,” “what big teeth you have, Grandmother,” “Ol’ Dan Tucker, who died with a toothache in his heel,” “putting the bite on Daddy for more pocket money,” “sinking a fang in a banana split,” and various other expressions or phrases containing references to teeth or dental activity.

She was interested and pleased but also amused by the writer’s effort to talk in “hep” style. She contributed gladly and readily to the discussion by calling upon her extensive
knowledge of references to teeth in popular songs, nursery tales, comics, and slang, without seeming to note the personal implications.

For the next interview she promised to “rattle the ivory” with every reference she could “dig up, from China Choppers to the Elks’ Club.” The next session was fascinating. In response to a request, in rapid-fire fashion, alternating from the British to the Scottish pattern of speech, utilizing slang to do so, she proceeded to give, from song, stories, ditties, doggerel, comics, fables, and slang old and new, innumerable references to teeth.

When she finally began to slow down, the remark was made, “When you put the bite on a job, you really sink your fang into it, but then, you’ve got the really hep accessory for that. Use your choppers now to chop off a bit more of the British and your fang to bite off a bit more Scotch.”

She paused abruptly, apparently suddenly realizing both the personal implications and the fact that teeth could be an interesting, amusing, and pleasingly fascinating subject. Immediately, since she also liked puns immensely, she was reminded of the comic, “That’s my Pop,” and told to go home, look into the mirror, smile broadly, and then say, “That’s my maw.” If she did not understand, she was then to consult a dictionary. At the next interview she was full of smiles and laughter, greeting the writer with a wide grin and saying, “Yes sir, that’s my maw.”

Asked what she had been doing since the last interview, she replied that she had been having a good time “chewing international fat” (talking with various accents), thereby bewildering her teachers and entertaining her schoolmates. Asked if she felt that she were a freak, she stated that she did not but that her instructors surely did when she “chewed the frog, the sauerkraut, or the cornpone” (French, German, and Southern accents).

Subsequently, one of her high school teachers, in discussing pedagogical problems with the author, commented on a remarkable transformation of one of his students. He had first noted her as a shy, withdrawn, and inept student, one whose speech was faulty and whose recitations were unsatisfactory. Then one day she had given a faultless recitation with a strong British accent, repeating the performance on another day with a Scottish accent. Subsequently, he had heard her chattering to a group in the corridor with a Norwegian accent. He regarded her as a decidedly brilliant student, though rather inexplicable in her adolescent behavior.

Still later another instructor, in discussing his Ph.D. thesis on aspects of high school behavior, cited the instance of this same girl’s remarkable transformation and her amazing linguistic abilities, which had rendered her a popular and well-adjusted, competent student.

**PATIENT B**

A 21-year-old girl, employed as a secretary for a construction firm, sought therapy because “I’m too inferior to live, I think. I’ve got no friends, I stay by myself. I’m too
homely to get married. I want a husband, a home, and children, but I haven’t a chance. There’s nothing for me but work and being an old maid, but I thought I’d see a psychiatrist before I committed suicide. I’m going to try you for three months’ time and then, if things aren’t straightened out, that’s the end.”

She was utterly final in this attitude, and consented to only two therapeutic hours a week for three months. She paid in advance and stipulated that she be discharged at the close of the thirteenth interview. (She checked the calendar and counted the number of possible interviews.)

She was not communicative about her past history. Her parents, neither of whom had wanted her, had been unhappy as long as she could remember. They were killed in an automobile accident shortly after her graduation from high school. Since then she had lived in rooming-houses and had worked at various stenographic and secretarial jobs. She changed jobs frequently because of self-dissatisfaction.

Concerning herself and her feelings of inferiority, she listed them bitterly as follows:

1. There is an unsightly wide space between my two upper front teeth. It’s horrible and I don’t dare to smile. (With difficulty she was persuaded to show this. The spacing was about an eighth of an inch.)
2. I can’t talk plain. (From holding her upper lip stiff.)
3. My hair is black, coarse, straight, and too long.
4. My breasts are too small, and my hips are too small.
5. My ankles are too thick.
6. My nose is hooked. (Actually very slightly.)
7. I’m Jewish.
8. I’m an unwanted child, always have been, always will be.

In explaining this list of defects, all emphasis was placed upon the spacing of her upper incisors. To her that was the causation of all her difficulties. She felt that she could adjust to the “other things,” but this “horrible spacing” rendered impossible for her any hope of adjustment.

After her unhappy description of herself, she sobbed and then endeavored to leave, declaring, “Keep the money, I won’t need it where I’m going.” However, she was persuaded to keep to her original plan of three months’ therapy.

Contrary to her description of herself, she was definitely a pretty girl, well-proportioned, and decidedly attractive. She was graceful in her movements and had good posture, except for her downcast head.

Her general appearance, however, was most unattractive. Her hair was straggly, snarled, and uneven in length. (She cut it herself.) The part was crooked and careless. Her blouse lacked a button, there was a small rip in the skirt, the color combination of the blouse and the skirt was wrong, her slip showed on one side, her shoes were scuffed, and her shoestrings were tied in unsightly knots. She wore no makeup, and while her fingernails
were well-shaped, remnants of fingernail polish were on only one hand. (She had started to apply fingernail polish a few days previously but was too discouraged to complete the task or to remove the evidence of her attempt.)

During the next four sessions she was sullen and uncooperative, insisting that the writer earn his fee by doing all the talking.

However, it was learned that she was intensely attracted to a young man two years older than she who also worked at her place of employment. She usually arranged to observe him when he went to the drinking fountain down the corridor, but she ignored him and never spoke to him, although he had made overtures. Inquiry disclosed that the fountain trips were rather numerous. She made it a point to go whenever he did, and apparently he behaved similarly. This had been taking place for the last two months.

She proved to be a rather poor hypnotic subject and only a light trance could be induced. Hence, all these and subsequent interviews were conducted in the light trance.

The next four sessions were primarily devoted to building up the general idea that, by a certain date, she was to acquire a completely new, but quiet and modest outfit of clothes and to have her hair dressed at the beauty shop. Then, at a date set by the writer, she was to go to work in her new clothes. (During this period of time she continued to wear the same clothes she had worn at the first interview). The rationalization was offered her that since she was not optimistic about the future, she might as well have “one last fling.”

The next two sessions were spent on the subject of her “parted teeth.” She was given the assignment of filling her mouth with water and squirting it out between her teeth until she acquired a practiced aim and distance. She regarded this assignment as silly and ridiculous, but conscientiously practiced each evening because “it doesn’t really matter what I do.”

The two following sessions were devoted, first indirectly and then more and more directly, to the idea that she would make use of her newly acquired skill of squirting water as a practical joke at the expense of the desirable young man.

At first she rejected the idea, then accepted it as a somewhat amusing but crude fantasy, and finally she accepted it as a possibility to be definitely executed.

The final plan evolved was that the next Monday, dressed in her new outfit, her nails polished and her hair having been dressed the previous Saturday at the beauty shop, she would await a favorable opportunity to precede the young man to the drinking fountain. There she would await his approach, fill her mouth full of water, and spray him. Then she was to giggle, start to run toward him, turn suddenly and “run like hell down the corridor.”
As was learned later, she carried out the suggestions fully. Late in the afternoon she had seized an opportunity to execute the plan. His look of consternation and his startled exclamation of, “You damn little bitch,” evoked her laughter at him. When she ran, he, quite naturally, pursued her and caught her at the end of the corridor. Upon seizing her he declared, “For that kind of a trick, you’re going to get a good kissing” and suited his action to his words.

The next day, rather timid and embarrassed, she warily went to the fountain for a drink. As she bent over the fountain, she found herself being sprayed with a water pistol by the young man concealed behind a telephone booth. She immediately filled her mouth with water and charged him, only to turn and run wildly as he met her charge head on. Again she was caught and kissed.

The patient failed to keep her next two appointments, and then came in at the next regular time, thoroughly well groomed in appearance.

She gave the foregoing account, and stated that the second episode had resulted in a dinner invitation. This had been repeated two days later. Now she was considering the acceptance of another invitation for dinner and the theater.

She explained further that the outcome of the silly prank suggested to her by the writer had caused her to spend many thoughtful hours “taking inventory of myself.” As a result she had one request to make of the writer—namely, would he coldly, judiciously, and honestly appraise her to detail? When this was done, she would terminate therapy. The smile with which she made this statement was most reassuring.

Accordingly, her request was met by discussing:

1. Her original woebegone, desperate emotional attitude.
2. Her unkempt, frumpish appearance.
3. Her unwarranted derogation of her physical self.
4. Her misconception of a dental asset as a liability.
5. Her sincerity and cooperation in therapy, however bizarre had seemed the ideas presented.
6. The readiness with which she had assumed self-responsibility in reacting to pleasurable life situations.
7. The obvious fact that she now recognized her own personal values.
8. Her need to review her objectives in life as stated in the original interviews.
9. Her personal attractiveness, not as seen only by herself but as appreciated from the masculine point of view.

She listened attentively and, at the close of the interview, thanked the writer graciously and took her departure.

Several months later a marked copy of the local newspaper was received in the mail containing an announcement of her engagement. About six months later an announcement of her marriage to the young man was received. Then, 15 months later, a letter was received containing a snapshot of her home, the announcement of her son’s
birth, and a newspaper clipping announcing her husband’s promotion to junior member of the construction firm. Since then no direct word has been received, but she has referred to the writer several patients who speak glowingly of her.

**DISCUSSION**

Although both of these patients emphasized their dental complaint as the fundamental consideration in their maladjustment, the case histories have been reported without distortion. Instead, an effort has been made to present the general situation of which the dental aspect constituted merely the one item which had been seized upon to represent completely a total problem.

Therapy for both was predicated upon the assumption that there is a strong normal tendency for the personality to adjust if given an opportunity. The simple fact that both patients had centralized their complaints upon one single item of a psychosomatic character, which was alterable if necessary, suggested that prolonged, extensive probing into the experiential life of the patients and elaborate reeducation were not necessarily indicated.

The therapeutic results obtained indicate that an uncomplicated psychotherapeutic approach may be most effective in a circumscribed psychosomatic reaction. Had this method failed with these two patients, there would still have remained the possibility of a more elaborate psychotherapeutic procedure.
The Identification of a Secure Reality

Milton H. Erickson

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Reality, security, and the definition of boundaries and limitations constitute important considerations in the growth of understanding in childhood. To an eight-year-old child the question of what constitutes power and strength and reality and security can be a serious matter. When one is small, weak, and intelligent, living in an undefined world of intellectual and emotional fluctuations, one seeks to learn what is really strong, secure, and safe.

A 27-year-old mother began to encounter serious difficulty with her Eight-year-old son, who was becoming progressively defiant and seemed to find a new way to defy her each day. The mother had divorced her husband two years previously for adequate reasons recognized by all concerned. In addition to her son she had two daughters, aged nine and six. After some months of occasional dating with men in the hope of marriage, she found her son had become rebellious and an unexpected problem. The older daughter had joined him briefly in this rebelliousness. The mother was able to correct the daughter by her customary measures of discipline through anger, shouting, scolding, threatening, and then an angry spanking followed by an intelligent, reasonable, objective discussion with the child. In the past this had always been effective with the children. However, her son Joe refused to respond to her usual measures, even when she added repeated spankings, deprivations, tears, and the enlistment of her family’s assistance. Joe merely stated, quite happily and cheerfully, that he planned to do whatever he pleased and nothing, just nothing, could stop him.

The son’s misbehavior spread to the school and to the neighborhood, and literally nothing was safe from his depredations. School property was destroyed, teachers defied, schoolmates assaulted; neighbor’s windows were broken and their flower beds destroyed. The neighbors and teachers, endeavoring to take a hand in the matter, succeeded in intimidating the child, but nothing more. Finally the boy began destroying things of value in the home, especially after the mother was asleep at night, and then he would infuriate her by boldly denying guilt the next morning.

This final mischief led the mother to bring the boy in for treatment. As the mother told her story, Joe listened with a broad, triumphant smile. When she had finished, he boastfully declared that the author could not do anything to stop him and he was going to go right on doing as he pleased. The author assured him, gravely and earnestly, that it was unnecessary for him to do anything to change the boy’s behavior because he was a good, big, strong boy and very smart, and he would have to change his behavior all by himself. The boy was assured that his mother would do just enough to give him a chance to change his behavior “all by himself.” Joe received this statement in an incredulous
sneering manner. Then he was sent out of the office with the statement that his mother would be told some simple little things that she could do so that he himself could change his behavior. He was also earnestly challenged in a most kindly fashion to try to figure out what those simple little things might be. This served to puzzle him into quiet reflective behavior while he awaited his mother.

Alone with the mother, the author discussed a child’s demand for a world in which he could be certain that there was someone stronger and more powerful than he. To date her son had demonstrated with increasing desperation that the world was so insecure that the only strong person in it was himself, a little eight-year-old boy. Then the mother was given painstakingly clear instructions for her activities over the next two days.

As they left the office, the boy challengingly asked if the author had recommended spankings. He was assured that no measure would be taken except to give him full opportunity to change his own behavior; no one else would change it. This reply perplexed him, and on the way home his mother administered severe corporal punishment to compel him to let her drive the automobile safely. This misconduct had been anticipated; the mother had been advised to deal with it summarily and without argument. The evening was spent in the usual fashion by letting the boy watch television as he wished.

The following morning the grandparents arrived and picked up the two daughters. Joe, who had plans to go swimming, demanded his breakfast. He was most puzzled when he observed his mother carry into the living room some wrapped sandwiches, fruit, one Thermos bottle of fruit juice and one of coffee, and some towels. She put all these items securely on a heavy couch with the telephone and some books. Joe demanded that she prepare his breakfast without delay, threatening physical destruction of the first thing he could lay his hands on if she did not hurry. His mother merely smiled at him, seized him, threw him quickly to the floor on his stomach, and sat her full weight upon him. When he yelled at her to get off, she replied mildly that she had already eaten breakfast and she had nothing to do except to try to think about ways to change his behavior. However, she pointed out that she was certain she did not know any way; therefore it would all be up to him.

The boy struggled furiously against the odds of his mother’s weight, strength, and watchful dexterity. He yelled, screamed, shouted profanity and obscenities, sobbed, and finally promised piteously always to be a good boy. His mother answered that the promise did not mean anything because she had not yet figured out how to change his behavior. This evoked another fit of rage from him, which finally ceased, followed by his urgent plea to go to the bathroom. His mother explained gently that she had not finished her thinking; she offered him a towel to mop up so he would not get too wet. This elicited another wild bit of struggling, which soon exhausted him. His mother took advantage of the quiet to make a telephone call to her mother. While Joe listened, she explained casually that she had not yet reached any conclusion in her thinking and she really believed that any change in behavior would have to come from Joe. Her son greeted this remark with as loud a scream as he could muster. His mother commented into the
telephone that Joe was too busy screaming to think about changing his behavior, and she put the mouthpiece down to Joe’s mouth so that he could scream into it.

Joe lapsed into sullen silence, broken by sudden surges of violent effort, screams, demands, and sobbing interrupted by piteous pleas. To all of this his mother gave the same mild, pat answers. As time passed, the mother poured herself coffee, fruit juice, ate sandwiches, and read a book. Shortly before noon the boy politely told her he really did need to go to the bathroom. She confessed a similar need. She explained that it would be possible if he would agree to return, resume his position on the floor, and let her sit down comfortably upon him. After some tears, he consented. He fulfilled his promise, but almost immediately launched into renewed violent activity to dislodge her. Each near success led to further effort, which exhausted him still more. While he rested, she ate fruit and drank coffee, made a casual telephone call, and read a book.

After over five hours Joe surrendered by stating simply and abjectly that he would do anything and everything she told him to do. His mother replied just as simply and earnestly that her thinking had been in vain; she just did not know what to tell him to do. He burst into tears at this, but shortly, sobbing, he told her he knew what to do. She replied mildly that she was very glad of this but she did not think he had had enough time to think long enough about it. Perhaps another hour or so of thinking might help.

Joe silently awaited the passing of an hour while his mother sat reading quietly. When over an hour had passed, she commented on the time but expressed her wish to finish the chapter. Joe sighed shudderingly and sobbed softly to himself while his mother finished her reading.

With the chapter finally finished, the mother got up and so did Joe. He timidly asked for something to eat. His mother explained in laborious detail that it was too late for lunch, that breakfast was always eaten before lunch, and that it was too late to serve breakfast. She suggested instead that he have a drink of ice water and a comfortable rest in bed for the remainder of the afternoon.

Joe fell asleep quickly but awakened to the odors of well-liked foods. His sisters had returned, and he tried to join them at the table for the evening meal. His mother explained—gravely, simply, and in lucid detail—that it was customary first to eat breakfast and then lunch and then dinner. Unfortunately, he had missed his breakfast, therefore he had to miss his lunch. Now he would have to miss his dinner, but fortunately he could begin a new day the next morning. Joe returned to his bedroom and cried himself to sleep. The mother slept lightly that night, but Joe did not arise until she was well along with breakfast preparations.

Joe entered the kitchen with his sisters for breakfast and sat down happily while his mother served his sisters with pancakes and sausages. At Joe’s place was a large bowl. His mother explained that she had cooked him an extra—special breakfast of oatmeal, a food not too well liked by him. Tears came to his eyes, but he thanked her for the serving, as was the family custom, and ate voraciously. His mother explained that she had cooked
an extra supply so that he could have a second helping. She also cheerfully expressed the hope that enough would be left over to meet his needs for lunch. Joe ate manfully to prevent that possibility, but his mother had cooked a remarkably large supply.

After breakfast Joe set about cleaning up his room without any instruction. This done, he worked hard picking up the stones he had thrown on the lawn. When he asked his mother if he could call upon the neighbors, she had no idea what this portended but gave permission. From behind the window curtains she watched him while he went next door and rang the bell. When the door opened, he apparently spoke to the neighbor briefly and then went on up the street. As she later learned, just as systematically as he had terrorized the neighborhood, he canvassed it to offer his apologies and to promise that he would come back to make amends as fast as he could. He explained that it would take a considerable period of time for him to undo all the mischief he had done.

Joe returned for lunch, ate buttered, cold, thick sliced oatmeal, helped voluntarily to dry the dishes, and spent the afternoon and evening with his schoolbooks while his sisters watched television. The evening meal was ample but consisted of leftovers, which Joe ate quietly without comment. At bedtime Joe went to bed voluntarily while his sisters awaited their mother’s usual insistence.

The next day Joe went to school, where he made his apologies and promises. These were accepted warily. That evening he became involved in a typical childish quarrel with his older sister, who shrieked for her mother. As the mother entered the room, Joe began to tremble visibly. Both children were told to sit down, and the sister was asked to state her case first. When it became his turn to speak, Joe said he agreed with his sister. His mother then explained to Joe that she expected him to be a normal eight-year-old boy and to get into ordinary trouble like all regular eight-year-old boys. Then she pointed out to both of them that their quarrel was lacking in merit and was properly to be abandoned. Both children acquiesced.

**GAINING MOTHER’S COOPERATION**

The education of Joe’s mother to enable her to deal with her son’s problem by following out the instructions was a rather difficult task. She was a college graduate, a highly intelligent woman with a background of social and community interests and responsibilities. In the interview she was asked to describe, in as full a way as possible, the damage Joe had done in the school and the community. With this description the damage became painfully enlarged in her mind. (Plants do grow back, broken windowpanes and torn dresses can be replaced, but this comfort was not allowed to be a part of her review.)

Next she was asked to describe Joe “as he used to be”—a reasonably happy, well-behaved, and actually a decidedly brilliant child. She was repeatedly asked to draw these comparisons between his past and present behavior, more briefly each time, but with a greater highlighting of the essential points. Then she was asked to speculate upon the probable future of Joe both “as he used to be” and as was “quite possible” now in the
light of his present behavior. Helpful suggestions were given to aid the mother in drawing sharply contrasting “probable pictures of the future.”

After this discussion she was asked to consider in full the possibilities of what she could do over the weekend and the kind of role she ought to assume with Joe. Since she did not know, this placed her completely in a passive position, so the author could offer plans. Her repressed and guilty resentments and hostilities toward her son and his misbehavior were utilized. Every effort was made to redirect them into an anticipation of a satisfying, calculated, deliberate watchfulness in the frustrating of her son’s attempts to confirm his sense of insecurity and to prove her ineffectual.

The mother’s apparently justified statement that her weight of 150 pounds was much too great to permit putting it fully on the body of an eight-year-old child was a major factor in winning the mother’s full cooperation. At first this argument was carefully evaded. The mother was helped systematically to marshal all of her objections to the author’s proposed plans behind this apparently indisputable argument that her weight was too great to be endured by a child. As she became more entrenched in this defense, a carefully worded discussion allowed her to wish with increasing desire that she could do the various things the author outlined as he detailed possibilities for the entire weekend.

When the mother seemed to have reached the right degree of emotional readiness, the question of her weight was raised for disposal. She was simply assured that she need not take medical opinion at all but would learn from her son on the morrow that her weight would be inconsequential to him. In fact it would take all of her strength, dexterity, and alertness in addition to her weight to master the situation. She might even lose the contest because of the insufficiency of her weight. (The mother could not analyze the binding significance of this argument so simply presented to her. She was placed in the position of trying to prove that her weight was really too much. To prove this, she would need her son’s cooperation, and the author was certain that the boy’s aggressive patterns would preclude any passive yielding to his mother’s weight. In this way the mother would be taught by the son to disregard her defenses against the author’s suggestions, and she would be reinforced in her acceptance of those suggestions by the very violence of his behavior.) As the mother later explained, “The way that bucking bronco threw me around, I knew I would have to settle down to serious business to keep my seat. It just became a question of who was smarter, and I knew I had a real job to do. Then I began to take pleasure in anticipating and meeting his moves. It was almost like a chess game. I certainly learned to admire and respect his determination, and I got an immense satisfaction out of frustrating him as thoroughly as he had frustrated me.

“I had one awfully bad time though. When we came back from the bathroom, and he started to lie down on the floor, he looked at me so pitifully that I wanted to take him in my arms. But I remembered what you said about not accepting surrender because of pity but only when the issue was settled. That’s when I knew I had won, so I was awfully careful then to be sure not to let any pity come in. That made the rest of it easy, and I could really understand what I was doing and why.”
A LATER REINFORCEMENT

For the next few months, until midsummer, all went well. Then for no apparent reason except an ordinary quarrel with his sister settled unfairly to her advantage, Joe declared quietly but firmly that he did not have “to take that kind of stuff.” He said he could “stomp” anybody, particularly the author, and he dared his mother to take him to see the author that very evening. At a loss what to do, his mother brought him to the office immediately. As they entered, she declared somewhat inaccurately that Joe had threatened to “stomp” the author’s office. Joe was immediately told, disparagingly, that he probably could not stomp the floor hard enough to make it worthwhile. Irately, Joe raised his foot and brought his cowboy boot down hard upon the carpeted floor. He was told, condescendingly, that his effort was really remarkably good for a little eight-year-old boy and that he probably could repeat it a number of times, but not very many. Joe angrily shouted that he could stomp that hard 50, 100, 1,000 times if he wished. Reply was made that he was only eight years old, and no matter how angry he was he couldn’t stomp 1,000 times. In fact he couldn’t even stomp hard half that number of times, which would only be 500. If he tried, he would soon get tired, his stomp would get littler and weaker, and he would have to change off to the other leg and rest. Even worse, he was told he couldn’t even stand still while he rested without wiggling around and wanting to sit down. If he didn’t believe this, he could just go right ahead and stomp. When he got all tired out like a little boy, he could rest by standing still until he discovered that he could not even stand still without wiggling and wanting to sit down. With outraged and furious dignity Joe declared his solemn intention of stomping a hole in the floor even if it took a hundred million stomps.

His mother was dismissed with instructions that she was to return in the “square root of four,” which she translated to mean “in two hours.” In this way Joe was not informed of the time when she would return, although he recognized that one adult was telling another a specific time. As the office door closed upon his mother, Joe balanced on his right foot and crashed his left foot to the floor. The author assumed a look of astonishment, commenting that the stomp was far better than he had expected of Joe, but he doubted if Joe could keep it up. Certainty was expressed that Joe would soon weaken, and then he would discover he couldn’t even stand still. Joe contemptuously stomped a few more times before it became possible to disparage his stomp as becoming weaker. After intensifying his efforts, Joe reached a count of 30 before he realized that he had greatly overestimated his stomping ability. As this realization became evident in Joe’s facial expression, he was patronizingly offered the privilege of just patting the floor 1,000 times with his foot, since he really couldn’t stand still and rest without wiggling around and wanting to sit down. With desperate dignity, he rejected the floor-patting and declared his intention of standing still. Promptly he assumed a stiff upright position, with his hands at his sides, facing the author. He was immediately shown the desk clock, and comment was offered about the slowness of the minute hand and the even greater slowness of the hour hand, despite the seeming rapidity of the ticking of the clock. The author turned to his desk, began to make notes in Joe’s case record, and from that he turned to other desk tasks.
Within 15 minutes Joe was shifting his weight back and forth from one foot to the other, twisting his neck, wiggling his shoulders. When a half-hour had passed, he was reaching out with his hand, resting some of his weight on the arm of the chair beside which he was standing. However, he quickly withdrew his hand whenever the author seemed about to look up to glance reflectively about the room. After about an hour the author excused himself temporarily from the office. Joe took full advantage of this, and of several repetitions, never quite getting back into his previous position beside the chair.

When his mother knocked at the office door, Joe was told, “When your mother comes in, do exactly as I tell you.” She was admitted and seated, looking wonderingly at Joe as he stood rigidly facing the desk. Signaling silence to the mother, the author turned to Joe and peremptorily commanded, “Joe, show your mother how hard you can still stomp on the floor.” Joe was startled, but he responded nobly. “Now, Joe, show her how stiff and straight you can stand still.” A minute later two more orders were issued, “Mother, this interview between Joe and me is a secret between Joe and me. Joe, don’t tell your mother a single thing about what happened in this office. You and I both know, and that’s enough. O.K.”

Both Joe and his mother nodded their heads. She looked a bit mystified; Joe looked thoughtfully pleased. On the trip home Joe was quiet, sitting quite close beside his mother. About halfway home Joe broke the silence by commenting that the author was a “nice doctor.” As the mother later stated, this statement had relieved her puzzled mind in some inexplicable way. She neither asked nor was given any explanation of the office events. She knew only that Joe liked, respected, and trusted the author and was glad to see him occasionally in a social or semisocial fashion. Joe’s behavior continued to be that of a normal, highly intelligent boy who now and then misbehaved in an expected and warrantable fashion.

Two years passed, and Joe’s mother became engaged. Joe liked the prospective stepfather but asked his mother one demanding question—did the author approve of the man? Assured the author did approve, there was then unquestioning acceptance.

**COMMENT**

In the process of living the price of survival is eternal vigilance and the willingness to learn. The sooner one becomes aware of realities and the sooner one adjusts to them, the quicker is the process of adjustment and the happier the experience of living. When one knows the boundaries, restrictions, and limitations that govern, then one is free to utilize satisfactorily whatever is available. But in an undefined world, where intellectual and emotional fluctuations create an enveloping state of uncertainty that varies from one mood and one moment to the next, there can be no certainty or security. Joe sought to learn what was really strong, secure, and safe, and he learned it in the effective way one learns not to kick a stone with the bare foot or to slap a cactus with the bare hands. There are relative values of effort and purposes and rewards, and Joe was given an opportunity to strive, think, assess, compare, appraise, contrast, and to choose. Thereby he could learn and hence could adjust.
Joe is not the only patient on whom this type of therapy has been employed. Over the years there have been a number of comparable instances, some almost identical. In some of these cases the author’s practice of keeping in contact with patients over the years has yielded information repeatedly affirming the value of reality confrontation as a successful measure for defining a secure reality.
An unintentional, completely hypnotic, Corrective Emotional Experience occurred under unusual circumstances at a medical meeting where the author had been asked to present a general lecture on hypnosis without a demonstration. In attendance there was a group of seven physicians, among them psychoanalytically trained psychiatrists, who sat together in the rear to one side of the auditorium. They had previously spoken most adversely about hypnosis and had opposed inviting the author to address the group. Scattered in the audience were a number of other physicians who were also unreceptive of hypnosis, a fact of which the official host for the meeting had informed the author. During the question-and-answer period numerous requests were made that a demonstration of hypnosis be given. Since it was obvious that the vast majority of those present were decidedly in favor of a demonstration, volunteers were called for—but there were none. The author asked if the audience would be agreeable to his choosing at random someone in the audience, and a most favorable response was received. Thereupon a physician was singled out and invited to the speaker’s platform. After a moment’s hesitation he rose and strode up briskly. As he was doing this, the author’s host frowningly shook his head negatively and held up his hand in the “thumbs down” position to indicate that a bad choice had been made. But the author saw no immediate solution to the problem.

(Two explanatory paragraphs will be inserted here so that the reader may better understand the unexpected course of events. After the meeting the author was apprised that his subject was a rather unusual and even somewhat eccentric character. He had never married, and had two interests—his medical practice and his studies. He was a man of high intelligence and integrity, and he was well-respected. He had intensely strong, even extreme likes and dislikes, and he was not hesitant about making them freely and bluntly known. For years he had been bitterly resentful toward psychiatry, and the author’s random choice of him as a subject caused considerable apprehensiveness in the audience.

As for his “studies,” he was always engaged upon some new course of intensive study which was invariably detailed, comprehensive, and systematic, and which he always completed. Usually with the advent of any new or striking development in medicine, he embarked upon an intensive course of study for months at a time, yet devoted himself untiringly to his extensive general practice in a large rural community. Because he was extremely well informed, he was frequently consulted by physicians in other fields—except psychiatry, toward which he manifested a well-verbalized, violent dislike. Also he often freely exhibited unreasonable antagonism toward psychiatrists in general. Even his presence at the lecture had distressed a number of people, who anticipated a disagreeable
outburst from him. The author’s chance selection of him as a subject caused those in charge of the meeting serious alarm, but they could think of nothing to do to avert the expected catastrophe.)

As the man approached the author at the podium, he was asked for his name. His reply was simply the rather brusque question, “Is it really necessary for you to know my name to demonstrate hypnosis?”

He was answered with the statement, “Not at all; just seat yourself comfortably in that armchair while I make a few remarks to the audience.” After a momentary pause he moved the chair so that he would face the author and present his profile to the audience; then he sat down. Addressing the audience, the author reminded them of his comments earlier on ideomotor responses, their involuntary character, and the frequent development of a sense of physical dissociation. Peripheral vision disclosed the subject to be listening with utter intensity. The author continued with an explanation that a voluntary motor response, once initiated, could be converted easily into an involuntary continued response. “For example,” it was stated, “if I take this physician’s wrist and extend it at shoulder level in front of him [suiting action to the words], and then gently, with my right hand, place his hand in a position of dorsiflexion [again suiting action to the words], and ask him to fixate his gaze intently on his thumbnail, and begin the action of moving his hand slowly toward his face [doing so], his elbow will bend gently more and more, and the movement soon becomes involuntary [releasing the hold upon the wrist with a wavering, uncertain, altering, and constantly decreasing pressure of first one finger and then another until, unnoticeably, contact with his wrist ceased, a technique described in a previous article (Erickson, 1964)], and there results an unexpected catalepsy and the rather rapid development of a deep trance state.”

It was at once apparent that exactly what the author had just described was occurring, since this procedure is an indirect, unchallengeable technique seemingly addressed to others, but which puts the subject in the position of listening and trying to understand and thus becoming responsive by virtue of the very effort of trying to understand, thereby to be enabled to challenge the operator. But most astonishingly, as the subject’s hand slowly approached his face, he slowly twisted his body and tilted it forward until he seemed to be in a position to look directly at the group of hostile physicians in the far corner of the room. As his hand came close to his face, there was a slow spreading of the digits, the development of a slightly amused, sardonic expression on his face, and his hand came to rest in the nose-thumbing position. At a total loss to understand this behavior, the author simply watched him for at least three minutes. The man was obviously cataleptic, his blink and swallowing reflexes were absent and no startle response was manifested when the author surreptitiously pushed a heavy pointer off the table to fall noisily on the floor. The audience, however, showed an over-reactive startle response to this disturbance, but the author merely attributed this to the unusualness and rigidity of the subject’s behavior they were witnessing.

At a loss to understand the situation, the author addressed the subject and instructed him to lean comfortably back in his chair, to let his hand slowly lower until it rested
comfortably in his lap, to understand fully that henceforth, whenever he wished, he could go into a profound somnambulistic trance, and to take three deep breaths slowly and then to awaken with an amnesia for having been in a trance.

The subject responded as instructed, but immediately upon awakening, he said most earnestly, “Dr. Erickson, I owe you an apology. I came up here for only one reason, to prove that hypnosis is a fraud, a miserable hoax. That’s why I didn’t tell you my name. It’s W———, but all my friends call me Jim, so just call me Jim. Then, when you asked me to sit down on the chair, I began to do some fast thinking, I went into high speed and I realized that all the things you said here tonight made complete sense. The trouble is, I’ve been too busy listening to a bunch of blowhards [nodding his head toward the far corner of the room] that I didn’t like anyway and actually believing what they said about hypnosis, when all the time they were just showing off their ignorance. I’m a very intolerant man when it comes to somebody shooting off his mouth about something he doesn’t know a thing about, and should keep his mouth shut and his mind open. And when I sat down in this chair, I realized that I was doing the same thing toward them [again nodding his head toward the far corner of the room] that they were doing toward you, and I was joining them. But I didn’t come up here to tell you this, I just want you to know I’m sorry for being rude. And now I’m ready to learn everything you can teach me. What stuns me is how fast what you said tonight has sunk in. And next I’m going to apologize to those fellows [nodding his head indicatively a third time] for being so close-minded and learn from them everything they can teach me. And Mister, I sure mean that—you don’t know what I’m talking about but everybody else here probably does. Now with that off my chest, I’m pleased to be your subject, you can be sure I’ll try to cooperate.”

The author made no effort to understand this explanation but simply asked him if there were any special technique he would like used. He answered, “Mister, I don’t know a thing about techniques, so use some technique where I can sort of look in and see what’s happening.”

“In what field of medicine do you practice?”

“Well, I do a lot of general medicine, but I do a lot of anesthesia for my colleagues, so that would be interesting.”

“Local or general?”

“Oh, you mean me—that is, what kind of anesthesia? Well, it would have to be local if I get to look in on it in me.”

During those questions and answers the author’s study of the patient disclosed him to be in a somnambulistic trance. Turning to the audience, the author stated that the situation they had just witnessed was marked by an actual continuation of the somnambulistic state, despite the subject’s apparent state of waking awareness; that the subject’s interest in hypnosis was obviously so great that his desires would literally become self-
suggestions, and that the author would play only a minor part in the subject’s development of hypnotic phenomena. In fact, the specific request for anesthesia would become manifest in accord with previously observed behavior, and suggestions would not be necessary. As this was said, the author took advantage of his standing position, which shielded his right arm, and as he said the words, “It will be here,” the author drew attention to his right arm by moving it. Neither the audience nor the subject grasped the meaning implied, and the subject said, “I don’t follow you at all.” He was told, “It’s all right, you will.”

The subject answered, “I still don’t get it, but something is happening to me. Look, Mister, I mean Dr. Erickson, that’s just a speech habit of mine, especially when I’m excited, but look Mister, there I go again, but my whole right arm is numb. In fact, I can’t even feel it being there. I can see it hanging there, but I can’t move it, and look, I can’t even feel this [pinching the back of his right arm vigorously]. Now you haven’t hypnotized me, how come I’ve got an anesthesia of the arm? I don’t understand this.”

The author gave the following explanation, apparently addressed to him but which was actually intended to inform the audience. “A few minutes ago the audience watched right arm behavior. You wished to have a local anesthesia. The previous arm behavior [the ideomotor activity] set up a pattern or focus for further hypnotic behavior. There was really no awakening from that trance by you, only the continuance of a profound somnambulistic trance, which often occurs in highly intelligent, vitally interested subjects. As can be noted, your blink reflex has been continuously absent as has been the swallowing reflex. Additionally, despite the fact I am addressing the audience, your behavior is entirely in response to me without a single glance in the direction of the audience, since you [a nod of the head similar to that the subject made previously] are out of rapport with them. Hence, there isn’t any turning toward or attention directed to the audience as I speak, which would be so natural in the waking state. You are looking to me only for a resolution of the obvious confusion expressed by your face.”

The subject spoke, “Mister, I just don’t get you at all. I just don’t know what you are talking about. What I’m interested in is this arm anesthesia. I’ve got an old lady with cancer, and this anesthesia I’ve got in my arm is the thing she needs for her pain. Oh, Ruth, Ruth.” Previous comparable experience allowed the author to recognize immediately what had happened; the subject was promptly asked for the benefit of the audience, “By the way, where are we?” The reply startled the audience, “Oh, didn’t I tell you? This is my office, and the girl will bring in the record on the old lady with the cancer.”

A few questions clarified for the audience that in the subject’s intense interest in hypnosis and in his earnest desire to seek information, he had spontaneously reoriented himself to his office, his favorite place to study.

By intruding upon the subject’s wishes, the author was enabled to have him demonstrate all of the various phenomena of deep somnambulism to the satisfaction of the severest critic in the audience. Nobody questioned the validity of the hypnotic responses.
At the conclusion of the demonstration the subject was dismissed with the statement that he could now awaken from the trance, that he could remember any and all of his trance experiences if he so wished, that he could develop a trance state whenever he wished, and that he could now return to his seat in the audience. He aroused, started to leave the stage, paused, turned excitedly, and declared, “Listen! You’ve had me hypnotized. I’m remembering a lot of things. I didn’t know you did that! That anesthesia was certainly real. And I am interested! I do have an old lady with cancer. Maybe I can do something for her besides narcotizing her.”

As a final demonstration the author asked, with special intonation, “And you can develop a complete amnesia for everything, can you not?” His response was an immediate development of a trance, whereupon the author in a casual tone of voice said, “Fine, thank you very much, that’s all except that Louis [the author’s host] might want to ask you if you can go into a trance.”

The subject aroused immediately, whereupon Louis asked him, “Jim, do you really think you could go into a trance?”

The answer was, “Well, this afternoon I was completely certain that hypnosis was a lot of hocus pocus, but after the lecture tonight and the thinking I’ve done, I’m completely certain it’s psychosomatic interrelationships that are definitely applicable in various medical conditions, and I can promise you that I’m going to make a sufficiently intensive study so that I can convince those fellows back there”—nodding his head toward the hostile group. “But first I want Dr. Erickson to induce a trance in me and let me experience some hypnosis, and then, Mister, I’m going to get every book on hypnosis that Dr. Erickson recommends, some good books on psychology that Joe [indicating a member of the audience] can recommend. And [smiling broadly] I’ll have those fellows back there recommend some books on psychiatry and psychosomatics and I’ll get out my anatomy and neurology texts, and Mister, I’m going to have me a time, and when I finish, I’ll know something about hypnosis, and then I’m going to see how hypnosis fits into medicine the way it should be practiced.”

Upon leaving the stage, Jim strode to the back of the room and shook hands cordially with each of the special group. In the general discussion that followed Jim discovered that he could recall all of the events of the trance and forget them practically at will. This intrigued him as greatly as it did the audience.

In the time that has elapsed since then, well over a year, Jim has followed his plan of study, and now uses hypnosis extensively in his general practice. Of remarkable note was the fact that Jim’s long-continued resentment toward psychiatrists and psychiatry, so much in evidence for years, vanished that evening in the hypnotic state. Warm professional friendships and a new view of a medical specialty resulted from that apparently unintentionally developed Corrective Emotional Experience in the hypnotic state.
DISCUSSION

The foregoing account is an excellent example of a Corrective Emotional Experience hypnotically induced. The situation in its setting and nature made it easy to describe and explain. It demonstrates additionally the unimportance of the therapist’s complete awareness of everything without being necessarily handicapped in directing or aiding the patient’s progress. It clearly illustrates the need and the value of actual behavior in enabling a patient to make therapeutic progress. Also of importance was the author’s unconcerned acceptance of the patient’s behavior and his utilization of the total setting and the patient’s behavior as measures of indirectly suggesting an interweaving and an integration of the forces governing the patient. Addressing remarks to the audience and to the patient—actually separately, though simultaneously, by having the choice of words convey one meaning to the patient and another to the audience—is always a most effective means of promoting therapy. In his many lectures before the professional public the author has many times deliberately undertaken therapy for patients not seen previously, but who “volunteered” as “demonstration subjects.” In the guise of suggestions leading to the demonstration of hypnotic phenomena, therapeutic suggestions can be indirectly given without the audience becoming aware of the pertinences to the subject. Subsequent inquiries have disclosed that many corrective emotional experiences on the lecture platform have been of sustained value. Often, too, the author has found out that the “volunteering” as a “demonstration subject” is a trial by the patient, to test for himself his readiness to accept therapy with subsequent good results.

For example, a woman who was a lifetime enuretic “volunteered” as a demonstration subject. Just previous to the demonstration she had been asked in the waking state if there were anything she wished the author to do. She stated that a physician friend of hers in the audience was particularly interested in enuresis in small children, and as the author turned to the audience, a physician nodded his head affirmatively. Nevertheless, the author, being a psychiatrist, wondered if there might be a more personal application to the requester. With subtle but strong emphasis, he asked the woman, “Do you mind if I discuss this matter helpfully with you here on the platform?” She answered agreeably, but a slow flush covered her face, not deeply enough to be apparent to the audience.

Juvenile enuresis was discussed at length with various careful emphases while the woman went into a trance, and she was then used as a demonstration subject immediately after the discussion of enuresis.

Two years later, while lecturing there again, the same woman was noted to be present. She was sought out and taken aside and asked if she wished to volunteer again. She replied simply, “No, not really. I don’t need to now.” The implication of this last statement suddenly became apparent to her. She flushed deeply and hesitantly said, “You knew, didn’t you?”

“Yes, but tell me, please, what happened.”

“As you discussed it, I knew that you were talking to me as well as the audience, and I sat in frozen horror because I knew one little slip of your tongue would expose me to the
audience. It was horrible. I guess I went into a trance to escape. Then when you finished discussing it, you explained a posthypnotic suggestion in which you told a patient that it was over with and done with, and belonged to the past, and to go on to other and pleasing things. I knew you were saying that to me; and my horror and terror disappeared, and I felt so happy and relieved and comfortable. Then you began demonstrating things, but I just felt like I was in heaven. And that was the end of it—that horrible terror, that sudden feeling of peace and comfort, and the end of my problem. I don’t understand. I don’t want to understand. I’m just happy. Many, many thanks to you.”

Many other instances of a Corrective Emotional Experience could be cited, since the author utilizes it in psychotherapy extensively. Why and how it serves the individual’s needs is usually difficult to understand. Sometimes it is used without employing hypnosis, but this is more difficult. Hypnosis allows freedom and ease in structuring the therapeutic situation and renders the patient much more accessible. Also, hypnosis allows ready retreat if the patient is not yet ready, without there being any loss of therapeutic gains already made. One can easily and safely reinterpret a structured Corrective Emotional Experience for which the patient is not yet ready, and thus leave the way open for a future approach. The Corrective Emotional Experiences vary in relation to the individual and in relation to his problem. The essential task is to structure the therapeutic situation in such fashion that emotions are greatly intensified, all behavior inhibited, and the need for behavior intensified. Then, and not until then, an opportunity for directed behavior with a special significance is given.

In the case of the physician reported above, the author was aware of a difficult situation from the “thumbs-down” signal, and was then made more acutely aware of it by the challenge in the refusal by the volunteer to give his name.

If the readers will review the handling of this situation, they will note an immediate inhibition of the physician by instrumentalizing him as a display object for the audience, the initiation of passive directed behavior, the careful shifting of the intense emotional state that the man already had into an intense emotional interest in his own subjective experience, which he himself augmented by his intense emotional interest in his cancer patient. This was followed by a redirection of his interests toward his colleague Louis, which, perhaps unnecessarily, intensified his behavior in relation to his other colleagues. Thus, a very marked reorientation of this physician in his life situation and his total life adjustment was effected by simple little items of behavior which he progressively enlarged into a revision of his emotional and intellectual attitudes.

As for the enuretic woman, she became hopelessly trapped by the author’s clinical attentiveness, and rapidly led in a terrifying, bewildering, threatening sea of emotions, inhibited in all of her behavior and helpless until suddenly she was propelled into doing the things the author wanted her to do, and doing these things well and competently. This created a feeling and an attitude which she carried over into the field of her enuresis problem, where, without explicitly so declaring, she wanted the author’s aid to tell her to do well and competently the things that she knew the author would tell her to
do. Thus, a long-continuing pattern of behavior was set into action, tremendously reinforced by the woman’s own emotional history.

In brief, the Hypnotic Corrective Emotional Experience, however simple it may appear, is a highly complex restructuring of subjective understandings of one’s subjective experiences that can be initiated very simply and then gently guided toward a therapeutic goal. Essential is good clinical attentiveness to the patient’s behavior, a confident awareness that one can delay, even halt, and nullify hypnotically whatever is taking place, and postpone, modify, or reinforce the structured situation leading to a therapeutic goal. More than once this author has found himself in the need of arresting the patient’s behavior hypnotically in some distracting, harmless manner while he carefully revised his own understandings, thus to meet better the patient’s needs.

What happens if a hoped-for Corrective Emotional Experience gets out of hand and becomes uncontrolled? Merely a disagreeable experience for the patient and properly increased awareness by the therapist of the problem at hand, with a need to repair rapport lest the patient seek help elsewhere. Even at the worst, the patient may be benefited by the debacle which serves to render the patient more aware of his needs. More than once this author has deliberately structured a Corrective Emotional Experience wrongly and watched the patient react unfavorably; and then, with carefully mended rapport, he began again, aided by the patient’s unexpected unconscious wisdom in restructuring the corrective Emotional Experience. As for actual harm this can be best summarized by comments from patients, of which the following is an excellent example: Things really went all wrong there for a while, and that shook me awfully. I didn’t think I could ever get straightened out, but then things would begin to slide together so smoothly, and I would begin to think that being so badly shook just kind of speeded things up.”

In conclusion, the Hypnotic Corrective Emotional Experience is a relatively easy and effective psychotherapeutic measure in the hands of an attentive clinician. It is, as is illustrated in the instances cited, best “played by ear” with no elaborate plans formulated, but with a multitude of possibilities floating freely in one’s mind ready for adaptation to each new development presented by the patient. It is easily arrested and nullified if not properly structured, and at the worst can only lead the patient to seek a more competent therapist. Used with care and discrimination, the Hypnotic Corrective Emotional Experience is of great value in shortening psychotherapy and in bringing about a therapeutic reordering of the patient’s adjustments to his life situation.
The February Man: Facilitating New Identity in Hypnotherapy

Milton H. Erickson and Ernest L. Rossi

This case material is reproduced from Erickson & Rossi, Hypnotherapy: An Exploratory Casebook (Irvington, Chapter 10, 1979).

Up to this point we have emphasized that hypnotherapy involves the utilization of the patient’s own life experiences and that the indirect forms of suggestion are the means of evoking those experiences for therapeutic change. What happens, however, when the patient has been severely deprived in some basic life experiences? Can the therapist supply them vicariously in some way? Sensitive therapists have long recognized their role as surrogate parents who do, in fact, help their patients experience life patterns and relationships that have been missed.

In this chapter we will present some of the senior author’s approaches to supplying a patient with a personal relationship in a manner that anchors her within a more secure inner reality around which she can create a new identity for herself. This is the case of a young woman who so lacked the experience of being mothered that she gravely doubted her own ability to be one. Through a series of age regressions the senior author visited her in the guise of the February Man: A kindly granduncle type who became a secure friend and confidant. A series of such experiences enabled her to develop a new sense of confidence and identity about herself that led her eventually to a rewarding experience of motherhood with her own children.

The senior author has actually played the role of the February Man with a number of patients throughout his career. So complex are some of the details of his work in these situations, however, that he never quite completed any of his manuscripts about them. The following case is thus a synthesis of several of the senior author’s original manuscripts together with commentaries on them by the junior author.

The reader is invited to explore with us some of the approaches and issues involved in the work of the February Man. There is much about this work that is beyond our own understanding. The use of indirect suggestions to integrate hypnotic and real-life memories to create a self-consistent internal reality is an art that does not entirely lend itself to rational analysis. We do try, however, fully realizing we have fallen short and are in need of the reader’s creativity to fill some of the gaps and to carry the work further.

Initial Interview: A Lonely Childhood

At midterm of her first pregnancy the wife of a young doctor on our hospital staff approached the senior author for psychiatric help. Her problem was that although happily married and pleased with her pregnancy, she was fearful that her own unhappy childhood
experiences would reflect themselves in her handling of her child. She stated that she had “studied too much psychology” since it made her aware of the possible inadvertent unfortunate handling of a child, with resulting psychological traumatization.

She explained that she had been a most unwanted child. Her mother never had any time for her. Her care rested in the hands of her mother’s unhappy spinster older sister who, in return for a home, acted as nursemaid, housekeeper, and general factotum. Her preschool days had been spent almost exclusively in her nursery, and she was left to devise her own games and entertainment. Occasionally, when her mother gave a social tea, she would be trotted out briefly for exhibition and told what a sweet, pretty little girl she was and then dismissed. Otherwise, her mother, between social engagements, looked in upon her in the nursery briefly and casually. She had been sent to a special nursery school and later to various private schools for her grade school and high school education. During the summers she was sent to special camps to “further” her education. During these years her “mother took time out from her round of pressing social engagements and trips abroad” to see her daughter as often as was “humanly possible.” Essentially she and her mother had remained strangers.

As for the father, he, too, was a busy man, greatly absorbed in his business enterprises and traveling much of the time. He did have a genuine affection for his daughter, however, and had frequently found time to take her, even as a small child, out to dinner, to the circus, to amusement parks, and to other memorably delightful places. He also had bought her toys and presents befitting her needs, in contrast to the “horribly expensive” dolls with which her mother showered her, but with which her aunt would not let her play because they were “beautiful” and “valuable.” She had received only “the best of everything” from her mother, but her father had always given her “many little things that were really nice.” At the age of eighteen she had rebelled against “finishing” school and, to her mother’s intense distress and resentment, had insisted on attending a state university. Her mother’s chief argument was the debt the daughter owed her for “practically ruining” her figure in order to give birth to her. The father, greatly dominated by his wife but much in love with her, had secretly abetted his daughter in her decision and had encouraged and aided in every possible way, but without trying to overindulge her.

Her university adjustments had been good scholastically, but she felt that she had made insufficient use of her social opportunities. Early in her senior year she had met an intern, five years older than she, with whom she fell in love. She had married him a year later. This had distressed her mother, since the intern lacked “social position,” but the father had privately expressed his approval.

Because of this history she now wondered what kind of mother she would be. Her psychological reading had convinced her that her rejection by her mother and her emotional starvation as a child would in some way adversely affect the handling of her own baby. She wanted to know if, through hypnosis, her unconscious could be explored and either her anxieties relieved or she could be made aware of her deficiencies and thus
make corrections. She asked the senior author to consider her problem at length and to give her another appointment when he felt he might be able to meet her needs.

She was told that before this could be done, it would be necessary for her to relate at length all her anxieties, fears, and forebodings. In so doing she was to give as comprehensive a picture of their nature, variety, and development as possible. It was explained that the primary purpose of this report was to make certain that the senior author appreciated as fully as possible her feelings and thoughts before any attempts were made to ascertain causes and remedies. From this additional material, of course, he privately hoped to learn more details of her life history that he could use to facilitate the hypnotherapeutic work.

**Second Interview: A Spontaneous Catharsis**

At the next interview the patient was exceedingly fearful, anxious, and tearful. She expressed disconnected fears of hurting, neglecting, and resenting her child. She feared feeling tied down by it, of being overly anxious, of giving over compensatory attention to it, of making it a hideous burden in her life instead of a pleasure, of losing her husband’s love, of never loving the child, and so on.

She elaborated upon these ideas poorly but in relationship to every possible stage of the child’s eventual development.

She wept throughout the interview, and while intellectually she regarded her fears as groundless, she declared that their “strong obsessional character” was causing insomnia, anorexia, and severe depressive reactions that terrified her.

If she tried to read or to listen to the radio, the printed page or the program would be obscured by vivid, compelling memories of her own childhood unhappiness. She recognized that all her fears were abnormally exaggerated, but she felt helpless to do anything about them.

Except for innumerable anxieties little actual history was obtained. She asked tearfully if the writer thought he could help her, since she felt she was breaking down more rapidly than ever. She was assured that before her next appointment a therapeutic plan would be worked out for her.

**Third Interview: The Interpolated Trance, Age Regression and Amnesia**

At the next interview she was assured that an elaborate program had been worked out and that the results would undoubtedly be most satisfying to her. What the plan was could not be disclosed to her yet, but through hypnosis her unconscious would acquire adequate understanding. All that she needed to know consciously was that hypnosis would be employed and that the task could be begun immediately if she wished. She acquiesced eagerly. In this session approximately five hours were spent training her adequately as a
hypnotic subject. Particular emphasis was placed upon age regression. Her intelligence and excellence as a subject made possible the elaborate training considered necessary for the planned procedure.

During the training slowly and cautiously she was regressed in time repeatedly to some safe past situation into which, in some fashion, the writer could enter directly or indirectly, without distorting the regression situation. Thus the first regression was to the first interview with her. In having her relive that interview, it became easily possible to introduce a new element not actually belonging to the situation but that could easily fit into it. In accord with her revivification of that interview the writer merely remarked, “Do you mind if I interrupt and introduce a thought that just came to my mind? It just occurred to me that you could easily be a good hypnotic subject, and I wonder if you would mind closing your eyes and sleeping hypnotically for a few moments, and then arousing and continuing from where I interrupted?” Thus an interpolated trance was introduced into that reliving of the first interview, in which no hypnosis had occurred.

R: The first trance has the effect of dissociating the patient away from the surrounding reality into her internal environment. When you then interpolate a second trance into the first, it effects an even deeper regression into herself. The basic purpose of the interpolated trance is to get the patient further removed from outer consensual reality. It’s particularly useful for age regression.

E: Yes, I don’t have to help her withdraw from the outer environment with the interpolated trance. When she gets back to reality, it will be much more difficult for her to recover that interpolated trance for which she has an amnesia even in the trance state.

R: So an interpolated trance is another way of effecting a deeper hypnotic amnesia.

E: In future trances she’s going to have an amnesia for the interpolated trance, but she would have to go through it to get a complete memory of the first trance in which it took place. I gave her many positive supportive suggestions during the interpolated trance. This served to reinforce all the positive values of that initial interview.

R: It’s like a feedback loop, where what comes later reinforces the positive values of what occurred earlier.

E: Yes, and it’s reinforcing what happens now by virtue of the “past” that I’ve transplanted into the initial interview. I work in all directions. In everyday life when strangers meet they may speak casually in a general way until they discover something common in their past: They might have vacationed in the same place or come from the same state or town or gone to the same school. Sometimes they discover to their delight that they have a few acquaintances in common and can
now share more intimate details of their lives. They have now created a strong rapport in the present based entirely on experiences from the past.

R: They have created a shared “phenomenal world in common” (Rossi, 1972a). They have built associative bridges that now bind them together in friendship. This is a common everyday process of social relating that you are now utilizing to enhance your rapport with this patient. The interpolated trance is a way of rapidly creating a positive “history” that enhances current relations.

**Rapport Protection: Indirect Suggestion and Contingent Possibilities**

She was then regressed to an intern’s party at which there was a number of the senior author’s former medical students. In the process of regression the suggestion was implanted that she might meet him at that party or that someone would mention his name, and undoubtedly this would happen when someone approached her and attracted her attention by gently squeezing her wrist. Then, when this unexpected thing happened, she could make a full response to the wrist pressure and react in accord with whatever situational need developed. Primarily, this was to introduce a physical cue to permit ready induction of a trance state at any time, even during the reliving of past events that had occurred long before meeting the senior author. Various such regressions were induced, aided by special information that had been privately supplied by the husband. These were utilized to condition her for trance induction in any set of psychological circumstances.

E: I was building rapport protection with this procedure. I once regressed a subject at Clark University to ten years of age. While regressed, he explained that he was on an errand to buy a loaf of bread for his mother. We could all see the abject terror on his face because he did not know anyone in that room (where as an adult he was being hypnotized). I spent a wretched four and a half hours trying to get back into rapport with him because he was afraid of me and afraid of everyone else. That taught me that thereafter I’d have a secondary way of establishing rapport with the subject such as touching a wrist. It’s an attention-attracting but otherwise meaningless cue. The subject cannot easily incorporate it into the age-regressed pattern of behavior.

R: You did not directly tell her that pressure on her wrist was a cue to enter trance or to pay close attention to what you were suggesting.

E: If I had said it that directly, she could reject it. Therefore I put it in an indirect framework of *contingent possibilities*: She might meet me. Someone would approach her; she *could* make a full response to the wrist pressure and react in accord with *whatever situational need developed*. These (the italicized words) are all undefined. There is no demand or threat in all this, and therefore no need for resistance or rejection.
R: We usually don’t reject undefined possibilities in everyday life. Rather, possibilities and contingencies usually evoke our sense of wonder, speculation, and expectation. Possibilities actually initiate pressures of *unconscious search* within us that may trip off useful unconscious processes. “Whatever situational need” also covers all possibilities, including whatever suggestions you give her. You give her the most general form of an indirect suggestion here.

E: A most general form that can be filled in by the patient’s specific understanding.

**Interpolating New Life Experiences: The February Man**

She was trained to develop in good fashion extensive regressions that were made to serve merely as a general background and situation for new, interpolated behavioral responses. She was regressed to past situations, and that frame of reference was employed merely as a background into which new hypnotic behavior could be interpolated. When sufficient training had been completed to ensure good responses, she was regressed to childhood at the age of four. The month of February was selected because it was her birthday. She was oriented to the living room of her childhood in the act of merely walking through it. She had often walked through her living room. Since the state of regression was limited to that act, it would constitute only a frame of reference. The walking through could be arrested and new behavior introduced into that setting without altering or falsifying the situation. Thus the new behavior intruded into that situation could be related temporally to the events of that age-regression period.

As she roused somnambulistically in this regressed state, she was greeted by the senior author: “Hello, little girl. Are you your Daddy’s girl? I’m a friend of your Daddy’s, and I’m waiting for him to come in to talk to me. He told me yesterday that he brought you a present one day and that you liked it very much. I like your Daddy, too. He told me it would soon be your birthday, and I’ll bet he brings you an awful nice present.” This was followed by silence, and the senior author apparently absentmindedly snapped open and closed his hunting case watch, with no further effort to engage her in conversation or to attract her attention. She first eyed him, then became interested in the watch, whereupon he held it to his ear and stated that it went “tick, tick” very nicely.

E: “Hello, little girl” assigns her a hypnotic role.

R: In that first second when she opens her eyes in somnambulistic trance you immediately reinforce the age regression so there could be no doubt about it. Is she going to see you as Dr. Erickson or as someone she does not know in her past? Your opening remark orients her into the past.

E: And there have been people in her past who have said just such a thing.

R: You then attract her attention appropriately by playing with your watch. This is just about right for a four-year-old; you do not introduce yourself in a direct or
demanding way. You behave very much as a visitor to her house might when she was a child.

Wrist Cue as a Nonverbal Signal for Metasuggestions Orienting the Somnambulistic State

After a few moments the suggestion was offered that she might like to snap the case open or to listen to the watch. She nodded her head shyly and extended her hand. Taking hold of her wrist as if to help her, the senior author handed her the watch. She looked at it and played with it. The suggestion was offered that if she listened to it for a little while, it would make her very sleepy. This was followed by the comment that soon the senior author would have to go home, but that some time he would come back, and, if she wished, he would bring his watch so she could open and close it and listen to it.

She nodded her head, and her hand holding the watch was guided to her ear. Her wrist was slowly squeezed, and trance suggestions were given accompanied by suggestions that maybe next summer the senior author would come again, and maybe she would recognize him.

E: I had to get out of her house. I ended that interpolated life experience with the wrist cue in an appropriate way (guiding her hand with the watch to her ear) and suggesting she would get sleepy as she listened to it.

R: Having her go to sleep is fairly appropriate behavior for a four-year-old listening to a watch, and her sleep allowed you to leave. It also enabled you to give her the posthypnotic suggestion about seeing her again next summer maybe, and maybe she would recognize you. These possibilities are appropriate for her age because a four- to five-year-old child might not recognize a friend after a year. But why did you give her the rapport cue by squeezing her wrist as you added these suggestions?

E: Although she was in a somnambulistic trance, further hypnosis would be needed to effect an alteration of that state to induce other phenomena.

R: I see. Even during a somnambulistic state special rapport is needed to effect important suggestions. The wrist cue is an orienting signal for the metasuggestions you will use to guide the somnambulistic state; it tells her important suggestions are coming. I have had the difficulty of working with some subjects who were so obstinate during the somnambulistic state that I could hardly get a word in edgewise. Like self-centered children, such subjects would soon take over the situation and simply live out an inner experience without my being able to relate to them. This may be valuable for cathartic purposes, but it does not permit the therapist to interpolate new experience as you are doing here.
E: You need another hypnotic frame of reference to orient her to important suggestions without verbally defining it as such and without altering my role as a stranger, Daddy’s friend.

R: Classical age regression has typically been a simple reliving of a past life experience. A catharsis or process of desensitization is relied upon as the therapeutic means of resolving pent-up emotions of life traumas.

E: That does not add anything. Here I’m adding to the past.

R: That’s the object of the entire procedure. You regress her to establish a frame of reference into which you can interpolate therapeutic life experiences. You are adding new experiences to her memory bank; you’re adding new elements of human relating that she missed in reality.

E: You can add belief to something that does not exist if you repeat it often enough. That’s why I had to give her many experiences with me as the February Man. I’m adding reality to a nonexistent thing.

R: It becomes “real” in terms of internal reality. With this approach you can alter a patient’s belief system; you cannot really change her past, but you can change her beliefs about her past.

E: You can change beliefs and values. It’s not really that we can believe lies; rather, we discover more things. Patients believe their limited reality until they discover more reality.

R: I wonder if we can equate “discover more reality” with creating new consciousness? There is still a basic question here, however. Are you (1) really adding something new to the personality, or are you (2) simply helping her discover and experience a natural, inherent pattern of human relating (the archetypal child-parent relationship) that she very much needed and wanted? Utilization theory would emphasize the second alternative; you are structuring circumstances that allow her to evoke and utilize inherent (species-specific) behavior patterns that must be expressed for normal development. But you are certainly adding a new content within the framework of this inherent pattern.

**Continuing Experiences with the February Man: Ratifying the Historical Reality of Age-Regressed Experience**

She was then permitted to experience about fifteen minutes of profound hypnotic sleep. This sleep was a passage of time during which my departure and eventual return (as had already been suggested) could take place. Her wrist was then again gently squeezed, and suggestions were offered that she better be in the yard because the flowers were blooming for the first time since her birthday last winter, and perhaps her Daddy’s friend might come again. At all events she could really open her eyes very, very wide to see the
flowers. She opened her eyes and was apparently enjoying her visual hallucinations when the writer, from behind, addressed her, “Hello, little girl. Do you remember me?” She turned, eyed him carefully, smiled, and said, “You’re Daddy’s friend.” The reply was made, “And I remember your name. It is R.” In this way the senior author became established as an actual figure in her past life without impinging upon realities or distorting them, but merely by adding to them by a simple process of temporal association. Thereupon a casual conversation was initiated at a childish level about the red and pink and yellow flowers (she said they were tulips), whereupon she reminded the writer about his watch, and essentially the same course of events ensued as had previously. Many more comparable instances were developed to ensure the possibility of the writer’s intrusion into her past without invalidating the regression state. She was given extensive experience with the February Man, a figure that became more and more established in her life history.

E: I had learned from the initial interviews that her childhood home did have extensive flower gardens with red, pink, and yellow flowers. I would further ratify the historical aspects of the experience by pretending to have an unclear memory of my previous visits with her. How clear does anyone remember an experience of a year ago? Two years ago? Four years ago? I also introduced changing views. As she gets older, she gets a different perspective on things. I’d say, “That first doll you had was really very nice.” “Remember your enthusiasm for that first circus?” I might make such remarks to the ten- or twelve-year-old girl about the six-year-old girl.

R: You built associative bridges between the trance experiences at different age levels that established the historical reality of your visits with her.

**Indirect Posthypnotic Suggestion**

Finally she was placed in a profound trance and given extensive posthypnotic suggestions to ensure a comprehensive amnesia for all trance events and to ensure continued cooperation. I’d gently squeeze her wrist and say “You have now completed that task. I want you to go into a profound trance at this time. I want you to enjoy resting. I want you to feel fresh after you’ve awakened, comfortably enjoying the feeling of being wide awake, prepared for a new day’s activities.”

E: That latter suggestion, “prepared for a new day’s activities,” implies that she will be ready for more work; we are just beginning.

R: That’s how you also imply a posthypnotic amnesia without directly telling her she would not remember. You could then put her back into trance for another experience with the February Man.
Time for Hypnotic Work

In subsequent sessions, usually of several hours’ duration, essentially the same procedure was followed.

E: I had to have several hours in order to let her have an experience with the February Man at one age level, rest, and then another experience at another age level. Time is expandable and compressible, but a certain amount of real clock time is still needed for careful work. Initially you really don’t know what the patient’s capacities are. Time is needed to explore them.

Integrating Hypnotic and Real-Life Memories: Creating a Self-Consistent Internal Reality

A number of hypnotherapeutic sessions now took place following this same pattern. She was regressed to many different periods of her life, usually in a chronologically progressive fashion, taking care not to let the created situation impinge contradictorily upon the actual realities of the past. For example, on one occasion, regressed to a nine-year-old level, she manifested intense astonishment upon opening her eyes and seeing the senior author. Cautious inquiry disclosed that she was visiting a distant relative for the first time and had just arrived the previous night. A few questions elicited enough information to orient the senior author so that he could claim a business friendship with her relative. This laid a foundation very necessary for the subsequent ubiquity of him in her life experience. Aiding in the acceptance of his ubiquity was the fact that both of her parents traveled extensively and often unexpectedly, and that they had innumerable acquaintances and friends. Hence it was easily assumed that the same was true of the senior author as “Daddy’s friend.” Also of importance was the February Man’s knowledge of various cities she had visited and the fact that he, as well as she, had studied psychology, all of which provided a wide background permitting her to accept him unquestioningly. As the procedure continued, the technicalities of securing responsive behavior became minimal, and a dozen regressed states could be developed in an hour’s time. These were all utilized to secure a report by her of things and attitudes current to the regression period, as well as an account of expected or anticipated events. Anticipated events served admirably in enabling the senior author to direct regression states to “safe” periods. However, care had to be exercised, since anticipations were not always fulfilled. Frequently, however, the “visit” was devoted to an account of what had happened since the last “visit” that is, the preceding regressed state. She learned to look upon the senior author as a recurrent visitor and as a trusted confidant to whom she could tell all her secrets, woes, and joys and with whom she could share her hopes, fears, doubts, wishes, and plans.

From time to time it became necessary to induce comprehensive amnesias, obliterating various of the senior author’s “visits,” and to regress her to an earlier age and to go over an already partially covered period of her life more adequately. Thus, some sudden change in her life, not anticipated at an earlier age regression, might have become established before the period of the next age regression, thereby creating a situation at variance with established understandings. On such occasions the last age regression
would be abolished by amnesia suggestions, and a new regression to an earlier time would be induced to permit the securing of pertinent data.

R: You made a very careful and extensive effort to integrate hypnotic and real memories so they were molded into a self-consistent inner reality. This would ensure the permanence of the new attitudes you were facilitating in her. If there were contradictions and a lack of consistency between the hypnotic and real memories, self-corrective processes within the unconscious would have tended to gradually eliminate the hypnotic suggestions as foreign intrusions. This may be why so much hypnotic work in the past has had only temporary or partial effect. Direct suggestions made even while a patient is in a deep somnambulistic state are not programmed within the mind forever in a rigid way. The human mind is a dynamic process that is continually correcting, modifying, and reformulating itself. Inconsistencies are either worked out in a satisfactory manner or are expressed as “problems” (complexes, neuroses, psychosomatic symptoms, etc.). There is thus nothing magical or mysterious about the effectiveness of your approach: It is based on very careful, thorough work integrating real memories with hypnotic experience.

**Facilitating Therapeutic Attitudes: A Therapy of Life Perspectives: Dreams and Hypnosis**

The consistent and continual rejection she experienced from her mother presented many opportunities to reorganize her emotions and understanding. By this procedure the senior author’s role became one of friendship, sympathy, interest, and objectivity, thereby giving him the opportunity to raise questions concerning how she might later evaluate a given experience. Thus, in expressing her grief over breaking a cheap little china doll her father had given her and which she treasured, she could declare that, when she grew up and became a mother and had a little girl who broke her doll, she would know that it wasn’t something “awful bad” but that she would know just how her little girl would feel. Similarly, a fall on the dance floor in her teens was regarded by her as an utterly and completely devastating experience. Yet she manifested a readiness to understand the senior author’s comment that she should rightly appreciate it as such in the present but that at the same time she could also understand how, in the future, it could really be regarded as a minor and completely unimportant event, perhaps even amusing. Her first adolescent infatuation, her jilting by the boy, and her tremendous need to understand herself in relation to that event were dealt with. Her resolution to leave the finishing school, to enter the university, her choice of studies, her scholastic struggles, and her limited social life were all covered. The meeting with the man who became her husband, her doubts and uncertainties about him, the eventual engagement, and the mother’s attitude toward him, toward the marriage, and toward the subsequent pregnancy were all detailed to the senior author in “current” accounts of what was happening to her. Numerous other instances of rejection, neglect, and disappointment by her mother and father were relived and discussed with the February Man. Real happy memories were also relived and integrated with the hypnotic memories to ensure a comprehensive integration of them.
Whenever she had a traumatic life situation, she could now discuss them with her father’s friend, the February Man. In effect you became a therapist at such times. This is a curious state of affairs, you as her current therapist became a therapist in her past, helping her deal with her difficult life situations as they occurred. I’ve noticed something similar in dreams. Some patients seem to relive their past in dreams but correct the traumatic aspects of their past with their current adult perspectives (Rossi, 1972a; 1973c). This again points out the self-corrective aspect of the psyche; it is in a continual process of reformulating or resynthesizing itself to achieve a more integrated pattern of functioning. You utilize and facilitate this resynthesizing aspect of psychic functioning with your role as the February Man. You are doing hypnotically what frequently happens naturally during dreams.

E: Yes. [The senior author now recalls such a dream of his own, when the adult Dr. Erickson observed himself as a child (Erickson, 1965a).] Dreams give us the opportunity to relive past events and appraise them critically from an adult perspective.

R: Dreams are autotherapeutic processes that help the mind correct and integrate itself. I also believe we are synthesizing new phenomenological realities in our dreams that become the basis of new patterns of identity and behavior (Rossi, 1971; 1972a, b; 1973a, b, c.).

A Reversal of Realities: Deepening the Therapeutic Frame of Reference

Toward the end of this extensive reorganization of her attitudes about her past, a new memory was recalled: Her secret resolve years ago to have hypnotic anesthesia should she ever marry and become pregnant. As she now again considered this possibility, she received a letter of foreboding from her mother requesting that the term “grandmother” never be used—in essence, rejecting the unborn baby. This letter intensified the patient’s anxieties and fears anew.

To deal with these renewed anxieties a variation in our hypnotic procedure was developed. In this variation a blanket amnesia was first induced for all her previous hypnotic work, and she was asked to again relate all her fears and anxieties. In this state, as expected, her account was comparable to her original expression of her problems before hypnotherapy.

A new trance state was then induced in which the blanket amnesia was removed. She was then regressed to a week before the arrival of her mother’s letter. In this state of hypnosis she was asked to recall fully all the many visits, talks, and discussions over the years she had had with the senior author as Daddy’s friend. As she recalled his many visits and their conversations on so many subjects, the suggestion was offered that she ought to consider the present minor worries against that total background. As she began this
correlation of her unhappy ideas in the past as she conceived it at the moment, she began to develop amazing insights, understandings, and emotional comfort. Having reestablished the new attitudes developed in the hypnotic work, the senior author next led her into an age-regression state covering the period just after the receipt of the mother’s letter. After expressing some sensible views about her mother’s problem, she was asked to give the reactions she could develop if she did not include in her thinking “all she knew about her past.” She was told that she ought to speculate aloud on how she could really enlarge her reactions into exaggerated fears and anxieties by just “not being comprehensive in her thinking.” She was urged to offer “speculative statements” expressing such anxieties. She then proceeded to verbalize them as she thought would be possible if she “did not think intelligently.” This speculative account was identical with that which she had originally given just before therapy began and the previous account with the blanket amnesia for all the hypnotherapeutic work. But it was given as a “speculative” account which was decidedly different from the new reality of her emotional life that now included the new frames of reference she had developed with the February Man.

Subsequent regression states were similarly utilized. Her “speculations” about how she could exaggerate her fears always gave accounts similar to the one she gave originally before hypnotherapy. These speculations were always in sharp contrast to her “real attitudes” developed with the help of Daddy’s friend, the February Man. She now drew extensively upon her “actual” past history, with all its interpolated experiences with Daddy’s friend. During this period a tremendous amount of her past history came out in clear relevance to her entire current problem. As this type of activity continued, she developed insights that were remarkably corrective.

R: This is an ingenious twist: what was originally a painful reality now becomes the “speculative account,” while the new attitudes introduced by hypnosis become the abiding reality. That is, she is now accepting her expanded frame of understanding developed with the February Man as her “real” views, while her previous behavior is now seen merely as a speculative account of how badly things could be if she “did not think intelligently.” This procedure may be helping her integrate the February Man frame of reference at an even deeper level. This is particularly the case because she is already in a deep hypnotic state as she experiences this reversal of realities.

**Termination: A Final Conscious Integration of All Trance Work**

Finally, as she progressed in this regard, the topic of hypnotic anesthesia for the delivery of her child was mentioned increasingly by her while she was in trance. She was reassuringly told that as the months of pregnancy passed, it was absolutely certain that all of her anxieties would be comprehensively and comfortably understood and thus become a resolved experience of the past. In their place would be a realization that in some way she would meet someone who would teach her to understand herself happily. Since she was in an age-regressed state, this was naturally a reference by implication to the senior author as someone she would meet in the future. In so doing she would be trained to
become an excellent hypnotic subject and thereby her college resolve for a hypnotic delivery would be fulfilled.

The termination of therapy was accomplished rather simply. She was regressed to the time of preparation for her first visit to the senior author’s office. She was assured by him—still in the role of Daddy’s friend—that her trip would be fully successful in many more ways than she really expected. The scene was then shifted to the office, and she was much astonished to see the February Man. The senior author was also astonished! She was puzzled at his presence, explained that she had come to see Dr. Erickson. She was assured that she would see Dr. Erickson and that he would meet her wishes fully, but that, for a few minutes, she should sleep most profoundly. During this trance approximately one half-hour was spent instructing her so that after she awakened she would recall from the beginning, in chronological order, every trance experience she had had, together with all insights and understandings that she had developed up to the date shown by the day’s newspaper on the desk. At the close of the interview she was told to spend a few delightful days reviewing her memories, making certain that she understood, remembered, and accepted all her past in an adjusted fashion. As for the hypnotic anesthesia, she would be certain of it, but the minor details would be arranged in the next interview.

R: This was a final summation for a final conscious integration of all her therapy. She now finally learns how you played the role of the February Man, how you reversed her realities, and so on. Yet this does not undo the effectiveness of the new attitudes and frames of reference you helped her develop. Why doesn’t it? After all your incredibly complex efforts to develop a new frame of reference, integrate it, and deepen it, why do you end the therapy with this complete denouement?

E: Because I may have made some errors. She may have made some errors. Let’s make sure we get the whole set of errors corrected.

R: You are not afraid of undoing your therapeutic work because you actually have helped her develop new frames of reference and understandings that have therapeutically altered her emotional life. This case contrasts sharply with those cases in which you like to maintain an amnesia for all hypnotherapeutic work. What is the difference?

E: Some personalities need amnesia, some do not. It’s a matter of clinical experience to distinguish them.

R: Those patients whom you judge to have destructive conscious attitudes toward the therapy might do better with an amnesia.

E: This patient was actually left with some amnesia for the negative emotions she experienced in relation to her mother. My final posthypnotic suggestion to her was to “spend a few delightful days reviewing her memories, making certain that
she understood, remembered, and accepted all her past in an *adjusted* fashion.”
This precluded any regression into the catastrophically negative affects and anxieties she was experiencing before therapy.

**Training the Obstetrical Analgesia: A Two-Year Follow-up**

At the next session some days later she stated that she had been interested primarily in thinking about her hypnotic delivery. After much discussion with her husband, during which he was primarily the listener, she had decided on an analgesia if it were possible. She explained that she wished to experience childbirth in the same fashion as she had, as a child, sensed the swallowing of a whole cherry or a lump of ice, feeling it pass comfortably and interestingly down the esophagus. In a similar manner she would like to feel labor contractions, to sense the passage of the baby down the birth canal, and to experience a sense of distension of the birth canal. All this she wished to experience without any sense of pain. When questioned about the possibility of an episiotomy, she explained that she wanted the sensation of the cutting without pain and that she wanted to feel in addition the suturing that would be done. When asked if she wished at any time to experience any feeling of pain merely as a measure of sampling it, she explained: “Pain shouldn’t have any part in having a baby. It’s a wonderful thing, but everybody is taught to believe in pain. I want to have my baby the way I should. I don’t want my attention distracted even a single minute by thoughts of pain.” Accordingly, as a measure of meeting her wishes, she was taught to develop complete hypnotic anesthesia. (Usually the procedure is to proceed from numbness to analgesia to anesthesia.) Since in this instance an analgesia was the primary goal, anesthesia was induced extensively and then systematically transformed into an analgesia. (That a complete transformation of anesthesia to analgesia could be effected is doubtful, but the patient’s wishes could be met in this manner, and whatever anesthesia remained would only supplement the effectiveness of the analgesia.)

When she had been trained sufficiently to meet various clinical tests for analgesia, extensive training was given to her to effect the development of a profound somnambulistic posthypnotic trance with “that degree and type of analgesia you have just learned,” so that she could enter into labor without any further contact with the senior author. Additional instructions were that she would awaken at the completion of labor with a full and immediate memory of the entire experience. Then, when she returned to her room, she would fall into a restful, comfortable sleep of about two hours’ duration, and thereafter she would have a most pleasant hospital stay, planning happily for the future.

About seven weeks after the delivery she and her husband and baby daughter visited the senior author. They reported that, as she entered the hospital, she had developed a somnambulistic trance. During the labor and delivery her husband was present. She had talked freely with her husband and the obstetrician and had described to them her labor contractions with interest. She had recognized the performance of the episiotomy, the emergence of the head from the birth canal, the complete delivery of the baby, and the suturing of her episiotomy—all without pain. The expulsion of the placenta caused her to
ask if there was a twin because she felt “another one moving down.” She was able to laugh at her error when informed it was the placenta. She counted the stitches in the repair of her episiotomy and inquired if the doctor had “cheated” by giving her a local anesthetic because, while she could feel the needle, it was in a numb, painless way that she associated with the numb feeling of her cheek after a local dental anesthetic. She was relieved when informed that there had been no local anesthetic.

She was shown the baby, looked over it carefully, and asked permission to awaken. She had been instructed to be in full rapport with her husband and the obstetrician and to do things as needed to meet the situation. Hence, inexperienced in the situation, she carefully met the need of abiding by the situation by making sure it was in order to awaken. She again looked the baby over. Then, upon telling her husband that she had full memory of the entire experience and that everything had occurred exactly as she desired, she suddenly declared that she was sleepy. Before she left the delivery room, she was sound asleep, and slept for one and a half hours. Her stay in the hospital was most happy.

Two years later she announced to the senior author she was having another baby, and asked that she be given a “refresher course, just to make certain.” One session of about three hours in the deep trance sufficed to meet her needs. Much of this time was used to secure an adequate account of her adjustments. They were found to be excellent in all regards.
The papers of this section that represent some of the most complex experimental and clinical work Erickson has ever done. In spite of this incredible complexity, however, the basic questions that underlie these investigations are straightforward: Is it possible to use hypnosis to artificially structure a conflict, neurosis, or psychopathology? Is it possible to reconstruct or create an entire personality with hypnosis for therapeutic purposes?

The roots of this experimental research derive from the word-association test that was first developed by Wilhelm Wundt and Carl G. Jung in Europe and a century ago and the neuropsychologist, Luria, in Russia. Words that were associated with emotional complexes were found to result in verbal blocks, longer reaction times, and other psychomotor disturbances that could be measured. The experimental study with Huston and Shakow in 1934 was the first publication wherein Erickson described the use of hypnotically induced complexes. A careful reading of volume five of this series (The classical Psychodynamics of Hypnotic Phenomena, particularly the papers on Mental Mechanisms and Dual Personality, suggests how the creation of an entire complex by hypnosis was the next logical development for Erickson. His technique was still relatively undeveloped for this first experimental study, however, and thus its results tended to be unreliable.

By the next year, 1935, these deficiencies of technique were remedied in his paper "A study of an experimental neurosis hypnotically induced in a case of ejaculatio praecox." It is not until almost ten years later in 1944, however, that Erickson actually published a detailed analysis and explication of the method he used in the 1935 paper. How does he account for this? Erickson explained to this editor that when he first published the verbatim transcript containing the actual words he used to induce the complex, he assumed that his professional readers would naturally understand the significance of his careful choice of words and suggestions.

It wasn't until several years later that his discussions with Gregory Bateson, Margaret Mead, and Lewis Hill convinced him that he was thinking and doing a lot more than was apparent from a raw transcription of his words. Thus, he came to write the final paper in this section in which he, for the first time, gives a detailed, phrase-by-phrase analysis of his work. Erickson included many examples of vocal dynamics, the multiple meaning of words, and the patterns of associations used to formulate an experimental neurosis for therapeutic purposes. This hypnotically induced neurosis so closely paralleled the patient's actual neurosis that the hypnotic implant could serve as a kind of emotional lightning rod to discharge and cure the actual neurosis. We see in these papers the origins and essence of two cornerstones of all Erickson's later hypnotherapeutic work: (1) the utilization approach, wherein he uses the patient's own associations and potentials to formulate (2) indirect suggestions for the evocation of the patient's abilities to effect his own therapy.

These endeavors find their ultimate expression in what Erickson calls the February Man approach. This approach was first described in Jay Haley's book about Erickson's work, Uncommon Therapy (1973), and is presented in greater detail in this editor's co-authored volume with Erickson, Hypnotherapy: An Exploratory Casebook (1979). Although Erickson was more modest about his accomplishments, this editor believes that through this approach Erickson finally lays the foundation for an effective hypnotherapy of the future oriented toward nothing less than the entire reconstruction and creative redevelopment of a personality. How such a creative redevelopment of a personality could be possible can now be understood in terms of our new neuroscience concepts of a psychotherapy that facilitates gene expression and brain plasticity.
A Clinical Note on a Word-Association Test

Milton H. Erickson

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The usefulness of the word-association test in detecting the presence of concealed or repressed memories is well recognized. Usually, however, the results obtained are indicative only of possible avenues for exploration, and it is customary to resort to other techniques to obtain more information. In the following account an instance is reported wherein the word-association test served not only to indicate the presence of a repressed or concealed memory, but also, upon repeated administrations of the test, to elicit, in one-word summaries, the entire sequence of events in the unhappy memory. The situation leading to this finding was as follows:

Experimental work was being done on the constancy of responses to the words of an association test in which lapse of time and hypnosis were employed as variants. The procedure was essentially to give the subject a carefully selected list of words in the normal waking state and then the next day to repeat the test with the subject in a deep hypnotic trance. Following this, at intervals of one to three days, the test was repeated in either the waking or the hypnotic state until it had been given seven times. One subject employed was a 25-year-old, single, white female. At the time of the first administration of the test, it was noted that the subject showed a very long reaction time to the stimulus word *stomach* and had shifted her position uneasily. It was thought immediately that this behavior indicated possibly a repressed complex, but before the test could be continued, the subject spontaneously explained that at the previous meal she had overeaten and still felt her stomach to be uncomfortably distended. No additional significance was attached to this matter, although it was noted that on subsequent administrations of the test she still showed a long reaction time and tended to shift her position uneasily. This continuance of her original behavior was considered to be possibly nothing more than a conditioning occasioned by the original setting, especially since the subject gave only casual explanations for her replies when questioned later and always listened to the word *stomach* with an amused smile. Unfortunately, no record was made of her rationalizations at the time, since no apparently unusual explanations were given.

Several months after the completion of the test, but before the data had been analyzed, this subject made a confidant of the author, explaining that several years previously she had had a love affair which had resulted in a pregnancy. As she related this story, she declared that her first intimation of this pregnancy had been “the enlargement of my abdomen” since her menstrual cycle was most irregular. This “worried me just terribly,” and upon seeking medical aid she had been advised that she “was going to have a baby.” This “made me awfully afraid,” and she had decided to meet the situation “by having an
operation done. I was awfully sick afterward—I thought I was going to die. When I finally got well, I just forgot about it all, but during the last couple of weeks it's come back to me and I felt like talking about it to you.” She could give no explanation of why she had revived that memory, nor was there any thought at the time that there could be any possible relationship between this story and her responses on the word-association test. Further, the subject had never had an opportunity to read her responses on the tests.

Subsequently, in analyzing the data obtained from the experimental procedure, the sequence of responses to the word *stomach* and the states in which they were obtained were found to be as follows:

<table>
<thead>
<tr>
<th>Response Word</th>
<th>Mental State</th>
<th>Reaction Time in Seconds</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Big</td>
<td>Hypnotic</td>
<td>6</td>
<td>Mon.</td>
</tr>
<tr>
<td>(2) Worried</td>
<td>Waking</td>
<td>5</td>
<td>Tues.</td>
</tr>
<tr>
<td>(3) Baby</td>
<td>Hypnotic</td>
<td>4</td>
<td>Fri.</td>
</tr>
<tr>
<td>(4) Afraid</td>
<td>Waking</td>
<td>6</td>
<td>Sat.</td>
</tr>
<tr>
<td>(5) Operation</td>
<td>Waking</td>
<td>6</td>
<td>Tues.</td>
</tr>
<tr>
<td>(6) Sick</td>
<td>Hypnotic</td>
<td>4</td>
<td>Wed.</td>
</tr>
<tr>
<td>(7) Forgotten</td>
<td>Waking</td>
<td>3</td>
<td>Sat.</td>
</tr>
</tbody>
</table>

The paralleling of the response words and the actual story is at once obvious. Consideration of the response words alone requires no imagination to construct the entire story. Almost identical terms were used in both instances and in the same sequence, despite the lapse of time intervening between the experimental and the personal situations and the absence of any conscious realization that there existed any relationship between the two situations. This verbal rigidity is suggestive of the emotional intensity of the problem and the need of adhering to a definite method of approach to it.

More remarkable, however, is the peculiar persistence manifested in the disclosure of the complex material during the experimental situation. The induction of a deep hypnotic trance was apparently without any effect upon her unconscious emotional problem. Neither did the intervention of nonexperimental days seem to modify the emotional needs aroused by the fortunate coincidence which occurred during the first test. One may conjecture that the initial setting of a gastric indiscretion resulting in abdominal distress and distension constituted a most favorable background for the revival of the originally repressed material. The nature of that setting permitted easy rationalization, thereby obviating any need for defense or disguise mechanisms. Thus, a train of associations was stimulated into action and was conditioned to a certain limited method of expression. In consequence, it manifested itself progressively at each properly offered opportunity. Evidently, to judge from the course of development of the personal situation, the strength of the emotions involved exercised a compelling force upon the subject, causing her to seek relief from her problem by confiding it to someone. She had done this in the experimental situation, but in such a fashion that only partial emotional satisfaction had been obtained. This relief had sufficed for a time, but finally, because of its inadequacy, the problem became acute, causing her to recall it consciously and to seek a more complete catharsis by confiding it again in a direct fashion to the same person.
Study of Hypnotically Induced Complexes By Means of the Luria Technique

Paul E. Huston, David Shakow, and Milton H. Erickson


**INTRODUCTION**

Recently Luria (Lebedinski & Luria, 1929; Luria, 1929, 1930, 1932) has experimented with a technique which may be applied to the investigation of affective conflicts. This method involves the association of higher central nervous system processes with a voluntary movement so that conflicts in the former are disclosed in the latter. Experimentally the central processes are activated by the verbal stimuli of an association test, the subject being instructed to make a slight pressure with his preferred hand on a tambour simultaneously with every verbal response. If the verbal stimuli do not arouse affective conflicts, the voluntary pressures are regular in character, but if a conflict is aroused, the pressure curves become irregular. Luria explains this effect as follows: Having trained a subject to associate a motor response of the preferred hand with every verbal response, thereby establishing a close functional relationship between them, any word occurring to the subject which he does not give as a response will appear in the voluntary movement as a partial reaction. It is assumed here that the inhibition of the verbal response is associated with affect, i.e., the subject does not respond with the first word since some complex would be revealed. Also the pressure curve may lose its smooth regular character or, to follow the Luria terminology more closely, the normal, voluntary movement is disorganized because stimuli which elicit responses possessing affect may also arouse larger amounts of excitation than stimuli eliciting nonaffective responses. This excitation tends to discharge itself immediately via the voluntary motor pathway. Luria has referred to this tendency as the “law of the catalytic action of the stimulus.” This law appears to be a corollary of another, the “law of the decreased action of the functional barrier.” The functional barrier is a cortical property. It regulates by inhibition the motor activities of the organism, giving them an integrated character. Affective excitation weakens the functional barrier, and hence the motor activities become disorganized. A third law is that of the “mobilization of inadequate masses of excitation.” This seems to involve “neurodynamical perseveration.” The excitation which accompanies the affect is not always discharged completely via the verbal response, hence some movements will persist in the preferred hand after the voluntary response. Under conditions of large amounts of excitation a further spread to other motor systems may occur—for example, disturbing respiration and/or causing involuntary movements of the non-preferred hand.
It is not our purpose to review the numerous experiments reported by Luria upon which these so-called laws are based. We were interested primarily in the possibilities of the Luria technique for obtaining information about the affective conflicts of a subject and for its possible application to psychotic patients. For this purpose we repeated, as part of an exploratory procedure, one of his important experiments, that of the attempted induction of a conflict in a subject by means of hypnosis. Such a procedure affords the opportunity of examining a subject before, during, and after the establishment of a conflict.

To produce a conflict in a subject Luria fabricated a story of a reproachable act committed by the subject—an act which would be contrary to the subject’s usual personality trends. A number of critical words were taken from this story and placed in a list of control words which were not specific to the story. The total list was presented in the setting of a free discrete association procedure. The subject was required to press with his preferred hand on a tambour with each verbal response. He was then hypnotized, and the story recounted to him. After this he was awakened and the combined word-association and motor-response method was repeated. Under hypnosis the conflict was removed. This was followed by a waking control session. If the theory and technique are valid, the critical words should show discoordinated voluntary pressure curves as compared with those of the control words. This assumes, of course, that the suggested story was accepted by the subject, that a conflict was produced in him, and that it had been removed successfully. In addition to the voluntary pressure curves Luria recorded verbal reaction times and in some cases involuntary movements from the nonpreferred hand and respiration. All were recorded on an ordinary kymograph.

**APPARATUS, TECHNIQUE, AND POPULATION**

This was the experiment which we repeated with some modifications. Luria’s list usually contained 20 to 30 words with six to nine “critical” words. We used 100 words, including 10 taken from the fictitious story, to avoid, if possible, perseveration effects and to give more control material. Furthermore, the “critical” words were separated by seven to ten control words, whereas Luria often placed two or three “critical” words together. In addition, hypnotic control experiments were introduced, and in some cases the control and the “complex” sessions were repeated to study the effects of hypnosis and of repetition per se. By way of definition, the term complex is used as referring to the story of a reproachable act committed by the subject intended to produce an affective disturbance or conflict in him.

Four male and eight female subjects between the ages of 20 to 30 years were used. This group consisted of four medical interns, two graduate students in psychology, two nurses, two occupational therapists, and two college graduates doing special work about the hospital. All were well-trained hypnotic subjects and fairly well known to us. None of them had any knowledge of the Luria theory or technique. We shall present in detail the complex, the experimental procedure, and the results on one subject. The results obtained on the other subjects will then be summarized.
DETAILED REPORT ON ONE SUBJECT

The complex for the sample subject, a male aged 24, was narrated as an account of his personal experience, and an attempt was made to establish it as a falsification of memory. The story in summary form was as follows: One night, while visiting some friends, he met a girl to whom he was much attracted. During the conversation, attention was called to her new brown silk dress, and she explained that, although not able to afford it, she had bought the dress hoping to make a good appearance when applying for employment. He gave her a cigarette and lighted one also. While smoking, he noticed the smell of burning cloth occasioned by contact of his cigarette with the girl’s dress. Unobtrusively he withdrew his hand, noting with relief that the girl had not yet noticed the accident and that she held her own cigarette above the burned hole. The girl soon became aware of the damage. She attributed it, however, to a spark from her own cigarette. He tried to take the blame by assuming the responsibility of having given her the cigarette, but the girl refused his apparent generosity. The next day, by which time he had summoned up enough courage to tell her the truth in order to save his self-respect, he found that she had left the city.

From this account ten words: silk, dress, brown, cigarette, burned, hole, blame, damage, smell, self-respect, were selected as “critical” words and placed as Nos. 7, 16, 28, 40, 49, 60, 68, 77, 88, and 98 in the list of words (see Table 1).

In the experimental room the subject reclined on a chaise lounge and rested his fingertips on deep, large tambours, one on each side, the forearms being supported by the wide arms of the chaise lounge. He was instructed to respond to the verbal stimuli of the association test with the first word which came to him and simultaneously with his response to make a downward pressure on the tambour with his preferred hand. Voluntary responses of the preferred hand and such involuntary movements of the nonpreferred hand as might occur, as well as thoracic respiration and verbal reaction time, were recorded on a special long-paper kymograph. The experimenter, seated out of the subject’s view, gave the verbal stimuli, wrote down the verbal responses, and marked the verbal reaction time with a telegraph key. A practice series of 20 words, none of which appeared in the experimental list, was first administered in order to establish the association of verbal response with simultaneous voluntary movement of the preferred hand. The list of 100 words was then given in a waking control session. After this the subject was hypnotized and the procedure repeated. This was the hypnotic control session. At the next experimental period—usually the following day—the subject was hypnotized first, the complex story told to him, and the experiment performed during hypnosis. This constituted a hypnotic complex session. The subject was then awakened from the trance, and a waking complex session was held. After this the subject was rehypnotized and an attempt made to remove the conflict by giving him insight into the situation and permitting him to understand the falsity of the story. At a third period additional hypnotic and waking control sessions were held.

In this particular case two hypnotic controls instead of one were obtained after the complex was removed. Also the complex was not removed in this subject for 24 hours. That night he slept poorly, awakened with a headache which persisted until the removal
of the complex in the afternoon, had no appetite, was resentful and antagonistic toward the hypnotist, and somewhat uncooperative toward additional hypnosis. He was unable to assign any reason for these manifestations. Throughout the day he gave away his cigarettes and apparently could not enjoy smoking. He rationalized his behavior by the statement that he “guessed” he was giving up the habit. We offer this as evidence that the attempt to induce the conflict produced a profound reaction in the subject.

The results have been analyzed within each session and from session to session. Various aspects of change in the verbal, voluntary, involuntary, and respiratory responses, in reaction time and certain other aspects of behavior such as bodily movement, laughing, sighing, etc., were considered for different word classes. The word classes were the following:

1. **Complex** words the 10 words taken from the story told to the subject.

2. **Complex-Associated—First Type**. These were words which the subject himself apparently connected in some way with the story, as indicated by the verbal responses. For example, in the subject under discussion, the stimulus word *Smooth* (No. 18) elicited the response “rough” in the control sessions and in the waking complex session, but in the hypnotic complex session the response was “silk.” To qualify for classification as a Complex-Associated—First Type word the response had to appear to all three of the authors as definitely related to the complex situation, to be one of the words actually used in the complex story, and not to have appeared in any control session prior to the induction of the complex. This criterion for selecting Complex-Associated—First Type words we consider as being conservative and as likely to result in the omission of some items since the same response in control and complex sessions may have a different meaning for the subject. This point will be discussed later.

3. **Natural Complex** words. These were chosen on the basis of our knowledge of the person: and from what he reported when the list was reviewed with him after the conclusion of the experiment. In this particular person they were words which presumably would usually arouse some affect outside of the experimental situation. The stimulus word *fall* (No. 90) was such a one. The subject two years previously had been in an airplane accident in which he had broken an ankle.

4. Reference to Table 1 shows that the same word (No. 90) elicited a response in the first control session which might be connected with such a natural complex, but after the complex induction the responses changed to “light” and “spark,” which fact led us to believe that this stimulus word also became related to the complex. Because there were a number of such words which changed in class from one session to another, an additional class was formed, called *Natural Complex + Complex-Associated* words.

5. A **Complex-Associated—Second Type** classification was made on the basis of disturbed nonverbal responses which might be related to the complex story in an
indirect way. We made the assumption here that the technique used did reveal the presence of affect and attempted to see if we could establish some association with the complex story. Sometimes the subject could explain why he responded with the particular word. In either case the stimulus was put into the second type of Complex-Associated words. Such information was obtained from the subject after the experiment was finished and the procedure had been explained to him. This was done by examining with him each of the verbal responses. Obviously there are many more possible sources of error in this classification than in the others, and the results therefore must be scrutinized with great care.

6. All the remaining words were called Neutral. Our knowledge of each subject’s life was not adequate, and the Natural Complex class probably suffers mostly on the side of omission. It is also likely that among the Neutral words are some which should have been classed Natural Complex and Complex-Associated. 

Each of these word classes was first analyzed for the number of “disturbances” in the verbal and nonverbal material from session to session. By a “disturbance” in the verbal response is meant any significant word from the complex story which first appears in a complex session, e.g., to the C word brown (No. 28) the subject’s responses for the first control sessions are “eyes” and “color,” whereas in the complex sessions the responses are “burn” and “silk”; after the removal of the complex the responses are “white,” “color,” and “white.” Here the responses “burn” and “silk” are rated as verbal disturbances. Because of the criteria set, it is likely that some verbal disturbances may have been omitted, e.g., the response “clothes” to dress (No. 16) in Session IV. Since “clothes” appeared in the second control, we did not count the same response in this session as a verbal disturbance. It may have been specific to the complex here and have had an entirely different significance for the subject. In the voluntary, involuntary, and respiratory responses any fairly definite deviation from the normal was counted as a disturbance, after agreement by two of the authors working independently and then combining judgments. If there was disagreement as to the presence of disturbances, the nonverbal response was considered as not disturbed. In the voluntary responses irregularities in the baseline after the stimulus word was given, or in the pressure response, or after the stylus had returned to the baseline but before the next stimulus word was given, were recorded as voluntary disturbances. Figure 1 gives examples of these. Involuntary changes in the nonpreferred hand consisted of either an increase in tremor amplitude or shifts in the baseline. Respiratory changes were those which involved sudden inspirations or expirations or increased depth or rate of breathing. The respiration curve was complicated by the chest movements which accompanied the verbal response, hence these had to be considered when rating respiratory disturbances. A verbal reaction time was considered as disturbed only if it was extremely long.
Figure I. This figure is from the waking complex Session IV of the sample subject (No.1). (1) Verbal reaction time. (2) Respiration. (3) Left-hand, involuntary. (4) Right-hand, voluntary. (5) Time in seconds. The voluntary pressures on words Nos. 14 and 16 are disturbed. The respiration line does not show characteristic breathing since the pneumograph was not drawn as tightly about the chest as was the usual practice. The loose adjustment was made in this subject because such large inspirations generally accompanied his respiratory disturbances that the stylus of the recording tambour moved off the kymograph.
The verbal responses in all sessions and the disturbances which were associated with them are presented in Table 1. A careful perusal of this table will show the marked change which the verbal responses underwent in Sessions III and IV, especially those classed as C and CA1. No additional reference will be made to these responses except in special instances. Each session is summarized at the bottom of the table for types of disturbance appearing on the word classes. It is at once apparent that the totals for the complex sessions show a greater number of disturbances than the totals of the control sessions, the hypnotic complex having 38 and the waking complex 60, as opposed to 14 and 21 of the respective control sessions. This increase is largely due to those word classes designated as C and CA1. In Session III—the hypnotic complex session—27 of the 38 disturbances are accounted for by these groups, and in Session IV—the waking complex session—31 of the 60 fall in the C and CA1, classes. The induction of the complex has apparently had two effects: to “set” the subject so that he gave verbal replies which were related to the complex and to disorganize his voluntary, involuntary, and respiratory behavior. In addition, these effects manifest themselves differently in the hypnotic and waking states. Of the 27 disturbances accounted for by C and CA1, words in Session III, 21 are verbal, while in Session IV but 12 of the 31 disturbances are verbal. Reference to Table 2 shows this clearly. In hypnotic Session III 84 percent of the C and CA1, words were disturbed verbally, and their nonverbal disturbance was 5.3 percent. In waking complex Session IV the verbal disturbance has fallen to 48 percent on the class C and CA1, taken together, while the nonverbal has risen to 21.4 percent.

The following explanation of this result occurs to us. Since the complex was given under hypnosis, it is reasonable to assume that the resulting mental set would cause the subject to reply to the C words with a response which is related to the complex story. That this set was of considerable importance is seen by the other words (CA1) which were drawn into the complex situation, there being 15 such. In the waking state, however, the subject, as nearly as we could determine, had an amnesia for the complex and was therefore probably in lesser contact with it. At the same time he was in greater rapport with the experimental environment, hence the verbal responses related to the complex were not elicited as easily. To explain the small number of nonverbal responses in the hypnotic complex session, there being four on C and CA1 words (excluding reaction time), we might assume that whatever excitation the conflict created was discharged verbally in giving the related response. In the following waking complex Session IV, however, the verbal responses related to the complex were not elicited as readily and the excitation created by the conflict spread into the motor response, giving rise to greater disturbances. Both C and CA1 words illustrate this point. In the hypnotic complex Session III there were nine responses on the C words related to the complex and none on the nonverbal. But in the waking complex Session IV there were but two which were disturbed verbally alone, three both verbally and nonverbally, and three nonverbally. On CA1 words in the hypnotic complex Session III the results are: verbal alone, 9; verbal and nonverbal, 3; nonverbal alone, 0; in the waking complex Session IV: verbal alone, 4; verbal and nonverbal, 3; nonverbal, 3. The further implication of these results is that, while the combined association-motor method of Luria does seem to reveal conflicts
induced by means of hypnosis, a conflict need not necessarily result in disorganization at the nonverbal level. It would be difficult otherwise to explain the paucity of nonverbal disturbances in the hypnotic complex session. It seems that some such assumption as we have indicated concerning the possibility of a complete discharge of excitation verbally is necessary. 17

**TABLE 2**
Percentage Verbal and Nonverbal Disturbances for Word Classes (C & CA, Combined) and for All Others (CA, + NC, NC, CA,, N)

<table>
<thead>
<tr>
<th>Session</th>
<th>Waking Control</th>
<th>Verbal</th>
<th>Nonverbal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>D</td>
<td>%</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>C &amp; CA</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Others</td>
<td>0</td>
</tr>
<tr>
<td>II</td>
<td></td>
<td>C &amp; CA</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Others</td>
<td>0</td>
</tr>
<tr>
<td>III</td>
<td></td>
<td>C &amp; CA</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Others</td>
<td>3</td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td>C &amp; CA</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Others</td>
<td>2</td>
</tr>
<tr>
<td>V</td>
<td></td>
<td>C &amp; CA</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Others</td>
<td>0</td>
</tr>
</tbody>
</table>
But how shall we account for the other disturbances which have appeared in these two sessions? Indeed, what is the meaning of the disturbances which occur in the control sessions? In Session III there were three verbal disturbances on the word Class $CA_1$ which have not been discussed thus far. It is clear that the verbal disturbance is due to the $CA_1$ and not to the $NC$, since our criterion of classifying them $CA_1$, was based on relationship to the complex story. No nonverbal disturbances appear in this class. Two voluntary disturbances appear on the class designated as $CA_2$ on Nos. 9 and 96. These are probably related to the complex as already indicated by the way in which they were selected. The remaining 6 disturbances are on 5-words. These are numbers 36, 37, 59, 65, and 93. No. 37 (“Stomach-food”), with a voluntary disturbance, and No. 59 (“Health-sanitarium”), also with a voluntary disturbance, may both be considered as indicative of some natural complex material, since the subject reported he was taking a tonic for stomach trouble at the time of the experiment. This re-receives some confirmation from No. 67 (“Hungry-sick”). On the other hand, it is possible that this group of words implies that the subject felt miserable—a “sick to the stomach” feeling—because of his behavior in the complex story. Such an interpretation finds support in the somewhat greater unpleasant affective tone of the session as compared with the first two control sessions. Nos. 37 and 59 may also involve an element of perseveration from 36 and 58, respectively. The disturbances on No. 65 (“Concentrate-meditate”)—voluntary and reaction time—may have arisen because of the subject’s preoccupation with the complex story. On No. 93 (“Fine-coarse”), disturbed in the voluntary aspect, the response which appeared in a previous control session may have taken on a figurative meaning for the subject, referring to his behavior in the complex situation as “coarse.” We are unable to account for the voluntary disturbance on No. 36 (“Short-long”) satisfactorily.
We have attempted to account for all the disturbances in the other sessions according to the principles set forth above. However, since we do not feel these explanations are pertinent to our present purpose, we shall give but a few additional examples.

The waking complex Session IV has 15 disturbances on 14 N words: Nos. 10, 24, 34, 46, 53, 64, 67, 73, 75, 92, 93, 99, and 100. No. 53 (“Sour-taste”) — this is the only time in which “taste” appears as a response to this stimulus words. This fact in combination with the appearance of an involuntary disturbance suggests that the subject was referring to the unpleasantness of the complex in a figurative sense. There may also be an element of perseveration from No. 52 involved, which also showed considerable disturbance. No. 73 (“Swift-fast”) — the response “fast,” which is a different type of response from that of the control sessions, being a synonym as opposed to an antonym, appears with a voluntary disturbance. We may interpret this as probably referring to the necessity of speed in notifying the girl of the truth, a point touched on in the complex story.

Having considered the complex sessions we shall take up the control sessions, beginning with Session I. In this first waking control session there are 21 disturbances on 17 words. It is especially interesting to note that there are six disturbed NC words out of a possible seven — a fact which would seem to indicate that NC material may be turned up, at least the first time the test is given. These NC disturbances are on Nos. 19, 32, 52, 55, 90, and 91.

The possible explanation that may be given to the other disturbances is that they are the results of natural complexes, permanent or transitory, of which we were not aware (enhanced or unenhanced by a “shock” effect), chance disturbances due to “shock,” somewhat unusual, stimulus words for the subject, or perseveration. No. 68 (“Blame-accuse”) with a respiratory disturbance, and No. 71 (“Persecute-electric chair”) with voluntary and reaction time disturbances are probably disturbed because the stimulus words are somewhat unusual and often carry an unpleasant tone.

In Session II, hypnotic control, we should expect the “shock” effect of Session I to be reduced, but since hypnosis may reach a deeper personality level, the possibility of more natural complex material being aroused should be considered. The total disturbance in Session II has fallen to 14 and appears on words 2, 10, 27, 41, 49, 54, 58, 67, 86, 93, and 100. Word No. 41, with disturbances of respiration and reaction time, is NC, and No. 67 (“Hungry-stomach”) with a voluntary disturbance, may also have been connected with a natural complex, as has been already indicated. As for No. 49 (“Burned-chemistry”) — respiration and reaction time disturbed — we have a post experimental report of severe acid burns received by the subject at one time, which may account for the present disturbance. No. 54 (“Soldier-fight”), having a voluntary disturbance, may be connected with the natural complex involving fall and high, since the subject’s airplane accident, already mentioned, took place while he was in the Army Air Corps.

In Session V, the first waking control after the complex session, we find 14 disturbances which fall on Nos. 19, 27, 29, 37, 60, 64, 66, 68, 71, 80, and 90. Any analysis must now consider the possibility of verbal and nonverbal affective residuals and nonaffective
verbal residuals from the complex sessions. No. 19 (“Kiss-hug”), disturbed in the voluntary and respiratory aspects, is \textit{NC}, and it is probable that the \textit{NC} part of No. 90 is responsible for the voluntary disturbance on it since the verbal response is “hurt.” The verbal disturbance on No. 66 (“Lamp-burn”) is probably due to a verbal affective or nonaffective residual.

The disturbances fall to 10 in the hypnotic control Session VI—on Nos. 9, 10, 13, 14, 17, 61, 68, and 90. Nos. 13, 17, and 90 are \textit{NC} words.

Session VII shows 9 disturbances on Nos. 29, 38, 60, 61, 74, 85, 88, and 96. The nonverbal disturbance of a voluntary nature combined, with the verbal responses on No. 29 (“Beautiful-pretty”) suggests an affective residual. The verbal disturbance on No. 88 (“Smell-burn”) suggests either an affective or nonaffective residual.

The attempt to account for disturbances not related to the induced or natural complexes has, in the very nature of the case, to be quite speculative. We included examples of these interpretations because it seemed to us to point out the problem which future experimentation must face in order to make the technique a really satisfactory one.

Reference to Table 1 shows the mean reaction times and S.D.’s for all sessions and the means for the word classes. Examination of the means and S.D.s of all the sessions, despite questions which might be raised about the legitimacy of this measure of variation in this case, shows several interesting points. While the means of the first two controls are practically identical, the S.D. of Session I is somewhat larger than that of Session II, which may be an expression of what we have referred to as the “shock” effect. The word classes which contribute largely to this larger S. D. in Session I are \textit{CA}_1 + \textit{NC}, \textit{NC}, \textit{CA}_2, and \textit{C}, in order of their departure from the total mean from great to small. Since in the first control sessions the \textit{CA}_1 + \textit{NC} and \textit{NC} groups are really all \textit{NC}, it seems clear that there is a tendency for \textit{NC} words in this session to be delayed. The longer-than-mean time on the \textit{CA}_2 class may be caused by some natural complex material. Word No. 71 (“Persecute-electric chair”) and its response suggests this inference. Since the \textit{C} words, in general, were a bit unusual, this might lengthen their time. The class means have come together considerably in Session II—the \textit{NC}, however, still being the longest. The mean of Session III is slightly greater, but the S.D. has continued to fall, the most surprising fact being the short reaction time of the \textit{C} words, nine of which were disturbed verbally. This seems to support the verbal discharge hypothesis presented earlier and is in line with Luria’s “law of the catalytic action of the stimulus.” In the waking complex Session IV the mean has continued to rise, being greatest of any session, and the scatter has increased. The increases are on \textit{CA}_2, \textit{C}, and \textit{CA}_1, words, which is to be expected if there has been any tendency to inhibit verbal responses. After the removal of the complex the means and S.D.’s decline to new low levels, probably due to a practice effect (Wells, 1927). In none of the sessions may the differences between means be regarded as significant statistically. Rather it is their general agreement with what might be expected which is striking.
Another point which might be mentioned is that there was a tendency for responses which were more highly specific to the complex to appear on the 10 Complex words and for those which were less specific to appear on Complex-Associated words. This tendency was not paralleled in the magnitude of the voluntary disturbances.

**SUMMARY OF RESULTS ON ALL SUBJECTS**

Twelve subjects went through the same general procedure. There is evidence that nine accepted the story told to them as an account of something they had done. We base this on their general behavior during and between experiments, an example of which we have given in discussing the sample case.

Table 3 summarizes the results on all cases. Since there is a considerable amount of overlap, the plus (+) signs should be regarded only as indicative of predominant trends. In the waking state nonverbal behavior was disturbed in Subjects 1, 3, 4, 5, and 6c; in the hypnotic state in Subjects 2, 3, 4, 5, 6a, and 6b. The results on Subjects 7, 8, and 9 are largely negative so far as disorganization of the nonverbal aspects are concerned. Of the nine subjects who accepted the complex (Table 3), six gave definite evidence that some aspect of the Luria technique revealed the presence of a conflict. One of this group (No. 2) presented disturbances which were almost all of a voluntary character in hypnosis, with almost none in the waking complex sessions, so that it would have been difficult on the basis of the latter alone to know whether the subject had a conflict. However, after reinforcement of the suggestion, a few verbal and nonverbal disturbances appeared in the next waking complex session. This implies that this type of conflict may be entirely at the hypnotic level but if sufficiently strong may result in disturbances in the succeeding waking session. Two subjects (Nos. 3 and 4) showed voluntary disturbances in both states. One subject (No. 5) had greater involuntary responses than voluntary in hypnosis and waking, and the subject (No. 1) whom we discussed in detail showed his greatest nonverbal disturbance as voluntary in the waking state. Another subject went through the experiment three times: in the first two (Nos. 6a and 6b) the disturbances appeared in hypnosis as voluntary, the third time (No. 6c) voluntary disturbances were found in both states. It is difficult to generalize about these six cases because such marked individual differences are found among them. However, one of the consistent findings is that the preponderance of verbal disturbances occurs in hypnosis and the relative importance of the nonverbal increases in the waking state. Another is that the C words, as would be expected, tend to evoke verbal responses which are more specifically related to the complex than any others.
### TABLE 3

**Results on All Subjects**

<table>
<thead>
<tr>
<th>Subject No.</th>
<th>Sex</th>
<th>Complex Accepted</th>
<th>How revealed as disturbances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Verbal only</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>Yes</td>
<td>+</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>Yes</td>
<td>+</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
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</tr>
<tr>
<td>4</td>
<td>F</td>
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</tr>
<tr>
<td>5</td>
<td>F</td>
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</tr>
<tr>
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<td>F</td>
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<td>+</td>
</tr>
<tr>
<td>6b</td>
<td>F</td>
<td>Yes</td>
<td>+</td>
</tr>
<tr>
<td>6c</td>
<td>F</td>
<td>Yes</td>
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</tr>
<tr>
<td>7</td>
<td>M</td>
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<tr>
<td>8</td>
<td>F</td>
<td>Yes</td>
<td>+</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>Yes</td>
<td>+</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

H = Hypnotic Complex Session  
W = Waking Complex Session

Of the other three subjects who accepted the complex, in two the evidence that there was any connection between the complex and the nonverbal disturbances was of a dubious character. Each case presented some peculiarities of its own which are worth mentioning. One subject (No. 7) who had eight sessions—two complex sessions, one hypnotic and one waking, being added—had the largest group of words associated with the complex of any of our subjects. In the first hypnotic complex session there were 24 $CA_1$ words and 16 $CA_1 + NC$ words. Yet only three $CA_1$, and two $CA_1 + NC$ words were disturbed in the voluntary responses. One of each class had a voluntary disturbance without a verbal disturbance. Likewise there were eight verbally disturbed $C$ words, but only one had a voluntary disturbance. In the succeeding waking complex session there was one verbal disturbance on Class $C$ and one on $CA_1 + NC$. The $C$ class had two voluntary disturbances, and the $CA_1$ class had five. In neither session was there an increase of nonverbal disturbance on the other word classes. In such a case it is important to examine the disturbances in the other classes and attempt to discover if these can be related to the complex, paying especial attention to those which were undisturbed in the control sessions. It was found that a few of these could be connected, but the result was not very convincing. The results on the other two complex sessions were essentially the same except that the total disturbance declined somewhat. Another fact about this case was the large increase in nonverbal disturbances in the first hypnotic control session, as against the waking control, the numbers being 18 and 5, respectively. This suggests that there may be a “shock” effect which appears in hypnosis in some cases. This interpretation is supported by the fact that there were but two disturbances in the last hypnotic control and an increase in unusual responses in the first hypnotic control session over the previous waking control—the values being 10 and 2.
Another subject (No. 8) gave somewhat different results. Although there was a considerable amount of nonverbal disturbance in each session, there was little apparent relation to the complex. Verbal disturbances were few. In the hypnotic complex session there were found but five—two on C and three on CA₁ words. This was true, likewise, of the posthypnotic complex session. The verbal responses were, however, sufficiently specific to the complex story to show its effect. The interesting point about this case is that from an examination of the total disturbances for each session there appears to be a “shock” effect in both the waking and hypnotic states, greater in the former, and which has a differential rate of decline upon repetition, being faster in hypnosis than in the waking condition.

In another subject (No. 9) there were a considerable number of verbal disturbances in both the hypnotic and waking complex sessions but few nonverbal disturbances which could be related to the complex situation in either the hypnotic or waking states. This individual had 12 sessions, six complex and 6 noncomplex, divided equally between the hypnotic and waking states. Four control sessions preceded the induction of the complex, and two were conducted after its removal. The control tests showed an interesting phenomenon—with repetition of the experiment there was a decline of disturbances. This was true of both the waking and hypnotic conditions and is better evidence for the existence of a “shock” effect than the decline in the case of those subjects in which but two controls were performed before the complex was suggested. There is also the possibility that this decline in disturbance is evidence of an “abreactive” effect. Failure to take this factor into consideration, whatever its cause, may lead to questionable conclusions. Luria, we believe, has not taken sufficient account of it in his studies of students before and after school examinations, criminals before and after confession of a crime, etc., (1930, esp., pp. 43-128), and for that reason the differences may not be as marked as he indicates. Along with repetition went a slight reduction in reaction-time means and a shrinkage of scatter about these means. (This same general effect was noted in three other cases in which control repetitions were obtained.) Because of our failure to obtain many nonverbal disturbances we allowed this subject to keep the complex overnight and repeated the hypnotic and waking sessions the following day. The result was a slight decline in total nonverbal and verbal disturbances. The next day we tried to reinforce the complex by repeating the suggestion to the subject. This resulted in a slight increase in both types of disturbances, bringing them back to about their original level. (In another subject reinforcement was tried with much more positive results—i.e., a great increase in disturbances, the effect being especially marked in hypnosis on nonverbal disturbances.)

It seems certain, then, that with repetition one has a reduction in disturbances during the complex sessions. An abreactive factor, a forgetting factor, or a decrease in “shock” effect, must all be considered as possible causes for this decline.

The levels-of-discharge hypothesis which we have suggested in this paper is consistent with results obtained on all the subjects who accepted the complex. Stated broadly, the hypothesis implies that if affective excitation created by a conflict is not discharged
completely at one level, it ought to appear at another. In terms of the present experiment, if the affect was not totally released in giving a verbal response related to the complex, there ought to be a nonverbal (voluntary, involuntary, or respiratory) disturbance. This may occur with or without a lengthened reaction time. The reaction time would be increased on those items in which there was some inhibition (conscious or unconscious) of the verbal response. The time would not be lengthened if a response related in some way to the conflict was either adequate or inadequate to discharge the affective excitation.

It should be noted that Subjects No. 2, 3, 4, 5, 6a, and 6b give motor evidences of a conflict in hypnotic states, a point which we discussed in connection with Subject No. 1 when we analyzed in detail the results obtained from him. The motor disturbances were much more marked in these cases than in Subject No. 1. Subjects No. 1, 3, 4, 5, and 6c gave similar evidence in the waking states. In the hypnotic states Subjects No. 1, 7, 8, and 9 did not give motor disturbances, and in the waking condition Subjects No. 2, 6a, 66, and 7 did not show many nonverbal disturbances. It may be argued, as indicated previously, that the failure to give motor disturbances in the hypnotic or waking states in these subjects shows the absence of conflict.

The levels-of-discharge hypothesis we have advanced, on the basis of our experiments, is an extension of the Luria theory as we have stated it. Motor disturbances occur, according to Luria, when there is an inhibition of the verbal response or when there are large amounts of conflict-excitation present. Our hypothesis assumes that motor disturbances will appear when there is inhibition of the verbal responses. However, motor disturbances may or may not be found when the conflict arouses large amounts of excitation. If the verbal response is adequate to discharge this excitation, there will be no motor disturbances, but if the verbal response is inadequate, then motor disturbances will appear. We have attempted to account for the failure to obtain motor effects when the subject had a conflict in this way.

Of the remaining three subjects, two definitely refused to accept the complex (Nos. 10 and 11). Both were given the same complex, which was of a serious nature. As medical interns they were supposed (in the story suggested to them) to have been anxious to acquire proficiency in the technique of the cisterna puncture, practicing on patients who had just died. Through a mistake in the location of the bed in a poorly illuminated ward, they performed the puncture on a comatose patient instead of a dead one, and due to faulty technique the vertebral artery was pierced by the needle. An internal hemorrhage resulted and death ensued. Each had gone from the ward without making a report of the accident. After we had finished the experiments, we questioned the subjects and discovered that they had not believed that they were involved in the complex situation. One said that the behavior of the person in the story was so different from his own that he could not imagine himself as committing the action, although he tried hard to believe it. The other subject reported that after the suggestion of the story he had had a mental picture of himself performing a cisterna puncture, but that this was entirely dissociated from the complex. The whole situation had seemed very real to him, but he had known that he had not gone on the ward in the evening to perform the operation. Both of these
cases, however, showed an increase in disturbances in the complex sessions. These disturbances fell almost entirely on words classed as $N$ and in one case to a slight extent on $NC$. In one case the increases appeared largely as respiratory disturbances; in the other they were scattered among all the nonverbal aspects. Luria has spoken of an increase in respiratory disturbance as indicative of “trauma,” by which he means those cases in which the person has reacted to a “shocking” experience. He contrasts these with those in which the individual has taken a part in some act which, if contrary to the personality trends of the person, leads to a conflict. The implication of the results in these two subjects is that to produce a conflict the complex act must be one possible for the subject to imagine his doing.

The third case (no. 12) in which negative results were obtained, from the standpoint of accepting the complex, involved the failure to mail a roommate’s letter of application for a graduate school fellowship until after the final date for application had passed, while the subject mailed one of her own and obtained the same fellowship. This subject explained after the experiment that the account as stated had not been entirely logical and that she felt it was artificial. She had elaborated it with numerous details to make it more credible. In the posthypnotic complex state she was aware of a desire to let her mind dwell upon events that might have happened in the trance state; by so doing she thought she might rid herself of something unpleasant. Yet she felt vaguely that she ought not do this since it might disturb the hypnotic situation. Complex removal was accomplished in her in the waking state by suggesting that she recall the story, and this she was able to do. It is our impression in this case that the acceptance of the story was more intellectual than emotional. There was a slight increase in disturbances in complex sessions, appearing in the hypnotic state on $N$ and $NC$ words almost entirely. In the waking complex session there was a small increase over the hypnotic complex session caused by disturbances appearing on $C$ and $CA_1$ words. This makes it appear that some conflict has been set up. The most striking thing about this subject, however, was the large number of unusual verbal responses. By unusual responses we mean those which are individual to the subject as compared to those expected from a group of persons living in a similar environment. In the case of the words which we took from the Kent-Rosanoff list we designated as unusual those responses which had a very low or zero frequency, unless the subject’s occupation and habitat made the response seem appropriate. (In the subject whose case we presented in detail [Table 1] the response “sigh” to the stimulus whistle No. 38 was considered as unusual. This was true also of the response “me” to the stimulus persecute No. 71.) The values ran as follows: Session I, waking control—7; Session II, hypnotic control—11; Session III, hypnotic complex—18; Session IV, hypnotic control—9. The majority of these fell on the word classes $NC$ and $IV$. An examination of the individual responses which appeared in Sessions III and IV which had not occurred in Sessions I and II showed that some could be accounted for as $NC$, some as related to the complex, and some as influenced by both. This analysis was made in the same way as in the attempt to account for all the disturbances in the sample case. Although the numbers dealt with are small, they suggest that the increase in unusual responses may be augmented directly by the complex, or indirectly through the sensitization of $NC$.
CONCLUSIONS

The outstanding difficulty of the technique is the more or less speculative method which must be resorted to for the explanation of nonverbal disturbances not clearly related to the complex. For more exact experimental investigations one certainly should know more about the personalities of the subjects than we did. It is likely also that the list of neutral words would vary from subject to subject. An attempt should be made to secure subject constancy rather than constant conditions for all subjects. This would make it possible to attack a number of problems on a more objective basis, some of which are here presented.

1. Must a subject be aware of a conflict to obtain voluntary disturbances? Our data offer arguments for, but mainly against, this possibility. We believe that Luria’s point both ways also. However, he seems to hold for the necessity of awareness to obtain voluntary disturbances. The problems dealing with repression and suppression of conflicts and Luria’s concept of “functional barrier” are involved here.

2. To what limits can the technique be carried to reveal the “natural complexes” of a subject? Our data suggest that what we believed were natural complexes are disclosed especially during the first experimental sessions. In any attempt to study natural complexes the complications introduced by what we have termed the “shock” effect must be considered. Both problems are probably related to personality types. Luria has suggested in another connection that there are what he calls “reactive-stable” and “reactive-labile” personalities. It is probable that natural complexes will disclose themselves more easily and shock effect be greater in the latter type.

3. Can one get information about the interrelationship of conflicts? Our material suggests that in some subjects the artificially induced complex may cause at least temporary disappearance of the natural conflicts, and in other subjects enhancement of the natural complexes. Also in this connection we found that the NC words carried fewer nonverbal disturbances after the removal of the complex than before its induction. Does the removal of one complex have a general “abreactive” effect upon the subject, or is the apparent “abreaction” due to mere repetition?

4. Can one study by this method the kinds of objects and situations to which complexes attach themselves? Witness our CA₁, CA₂, and CA₁ + uc word classes. This problem is closely related to that of symbolization.

5. Are there different levels of affective discharge? If so, under what conditions does one level rather than another carry the discharge? What relationship obtains among the various discharge levels? Is there a hierarchy? Can one level become a surrogate for another? Our results indicate that the more discharge at a verbal level, the less at a nonverbal level, and vice versa. It must be remembered,
however, that these differences were quite marked between the hypnotic and waking states and may be partially due to hypnosis.

6. Can a distinction be made from the pressure curves alone between affective conflicts and those which are at a more intellectual level—e.g., the attempted solution of difficult intellectual problems? Or is affect at the basis of both types? Luria has made some beginnings in this direction (1932, p. 205-239).

7. Can a complex be induced by direct- or by indirect-waking suggestion? An example of the latter might be that in which a person is made the subject of some unpleasant rumor by a group of persons.

8. What correlation would there be between sympathetic variables such as heart rate, blood pressure, galvanic skin reflex, etc. and those studied here? In this connection it would be well to know more about gross movements of the subject which may or may not be associated with affect.

9. What are the possibilities of this method in the study of conflicts as revealed during the course of the psychoanalytic interview? It would seem that data of theoretical value could be gained from such an investigation.

10. What is the effect of fatigue and toxic states in making conflict material more available? Luria has suggested that the regulating ability of the “functional barrier” is lowered during fatigue (1932, p. 384).

11. Under what conditions do perseverative effects appear? Do they tend to appear at one level more than another? There is some indication from our data that perseveration tends to appear at a level lower than that of the level of the preceding disturbance; for instance, if the disturbance is verbal, then the perseverative disturbance tends to be voluntary, involuntary, or respiratory.

12. What is the effect of hypnosis on the individuality of verbal responses? (This is a question not connected directly with the Luria technique but was suggested by our experiments.) There seemed definite indications that hypnosis increased the individuality of the responses, as was seen from a comparison of the means of the frequency ratings by Kent-Rosanoff standards on $N$ words. However, we are not certain that this is caused by hypnosis, since in those subjects in whom we had a repeated waking control there was also a considerable fall in frequency. Yet there were three subjects in whom the frequency-decline from waking to hypnotic states was so marked that we feel we may be dealing with personality types in this respect. In setting up an experiment of this kind it would be necessary to take the “shock” effect on individuality of response into account.

13. What is the effect of a complex on the individuality of verbal responses? This might be studied from the point of view of Kent-Rosanoff frequencies or some autogenous standards such as a frequency table built up on a number of
repetitions of the stimulus word series for each subject. There is some indication in our material that a complex individualizes the responses on N words in the waking state and makes the responses less individual in the hypnotic states.

**SUMMARY**

In an attempt to test the validity of the Luria method of detecting affective conflicts, one of his experiments was repeated. A complex was induced hypnotically. Verbal, voluntary, involuntary, and respiratory responses were studied. Four male and eight female subjects were used. The results obtained and the interpretations suggested are the following:

1. There was evidence that nine subjects accepted the story told them as something they had done and that it produced a profound reaction in them.

2. In six of these nine subjects some nonverbal (motor) aspect of the Luria technique revealed the presence of the conflict in either the hypnotic or waking states. These subjects in the hypnotic states tended, in general, to give verbal responses definitely related to the conflict with relatively few nonverbal disturbances. In the waking state the relative importance of the nonverbal disturbances increased over the verbal. The hypothesis is suggested that there may be “levels of discharge” so that if excitation created by the conflict is not discharged verbally, there is a spread to voluntary and involuntary motor levels. An implication of this hypothesis is that the motor aspects of the Luria technique sometimes may not reveal the presence of the conflict.

3. In the three other cases, those of subjects who accepted the story suggested to them, the evidence that the Luria technique revealed the existence of a conflict was lacking or was of a dubious character. These three cases are discussed with special reference to the effect of the artificial conflict upon their verbal responses.

4. The results from the three subjects who refused to accept the complex suggest that the reproachable act must be of such a nature that the subject can plausibly conceive of his participation.

5. Data collected from repeated sessions on the same subject indicate that there is a “shock” effect which appears chiefly in the first session as a large number of motor disturbances and declines upon repetition. This “shock” effect must be evaluated properly before valid conclusions in this type of experiment can be drawn.

6. Repeated experimental sessions on the same individual while he had the conflict showed a gradual decline in motor disturbances from day to day, pointing to an “abreactive” factor or a forgetting factor.

7. Certain other theoretical implications of the experiment are discussed, and a list of problems which may be approached by the Luria technique are included.
The division of labor in this study was as follows: the problem was set and the data analyzed by the first two authors (psychologists); the hypnotic work and organization of the complexes was done by the third author (a psychiatrist); and the experimental work was performed by the first author.

In general we shall adhere to Luria’s terminology in this paper.

Luria argues that previous work on affection and emotion has yielded disappointing results because there was no intimate relationship between the affect and such physiological expressions as blood pressure, heart rate, respiration, etc. According to Luria the expressiveness of any motor system will depend upon its degree of inclusion in the psychological structure where the conflict is located, hence the preferred hand is selected to make the voluntary pressures because of the close relationship between the speech centers and the neural control of the preferred hand.


The work was done during the years 1930 to 1932.

The 90 other words consisted of 66 from the Kent-Rosanoff Association Test (1), which give high frequencies of “most common” responses and which might be considered as neutral in character, i.e., generally without emotional tone; five we believed significant for schizophrenic patients—words 10, 31, 46, 65, and 85; five significant for psychotics in general—words 6, 13, 34, 58, and 71; and five words which are often of affective value for normal individuals—words 19, 37, 55, 74, and 91. (Words 37 and 91 appear also in the Kent-Rosanoff list.) The remaining eleven words are “double-barreled,” that is, they may easily be taken in more than one sense. These were Nos. 2, 4, 22, 43, 62, 63, 80, 90, 93, 95, and 100. (Words 25, 75, and 82 among the Kent-Rosanoff group may also be considered as “double-barreled.”) Since our ultimate purpose was the application of the procedure to psychotic patients, we introduced the affective and “double-barreled” words, planning to use the responses from the normal subjects as control material.

Our tambour system, while not quite like that of Luria, is not different in its essential requirements.

All the hypnotic work was done by the psychiatrist. Hypnotic rapport with the subject for experimental procedures was transferred to the experimenter, the same instructions being used on all subjects. The psychiatrist kept all subjects under observation for at least a month to note any possible residual effects of the experiment. (None were observed.) Close supervision was particularly maintained in those cases in which the subject was allowed to keep the complex overnight. All trances were of a profound somnambulistic type, characterized by dissociation and, with one exception which will be discussed later, apparently by total amnesia for trance events. Administration of the complex was achieved by two sets of instructions identical for all subjects. These were planned to prepare them to “recall” the complex as an actual memory and to strengthen their acceptance of this “memory” and their emotional reaction to it. Removal of the complex was accomplished by the hypnotist’s reviewing the preliminary instructions, the story, and the final instructions, indicating the falsity of the whole account and allowing the subject to verify in his own mind the unreality of the entire complex story. This was—had to be—done in both the trance and waking states.

Each session took about 15 minutes. The stimulus words were given as rapidly as the experimenter could write down the verbal responses, except when a disturbance appeared. In the latter case the disturbance was allowed to subside before the next stimulus was given.
This was done some time after the conclusion of the experiments. In the present case there were six “Complex-Associated” words of the second type. The stimulus word dark (No. 9) elicited the response “room” in the hypnotic complex session. This was so classified because the subject informed us that he had placed the complex situation in a poorly lighted room to make the action more plausible. The response “beautiful” to Fairy (No. 63) was thought by us to have come about through “girl” — i.e., Fairy ⇒ girl ⇒ beatiful. (The attractiveness of the girl had been emphasized in the complex story.) Guilty (No. 58) yielded two unusual reactions in the complex sessions, “self-conscious,” and “no.” These, responses might be related to the emphasis on the loss of self-respect in the complex. Persecute (No. 71) as stimulus, with the unusual response “me,” may fall into the same context. The subject reported that the response “necklace” to neck (No. 80) resulted from his visualizing the girl in the story as wearing a necklace. The responses “stores” and “display” to the stimulus street (No. 96) may have been connected with window displays of new dresses, since the fact that the girl was wearing a new dress was stressed in the story.

Hereafter we shall refer to the word classes by the following symbols:

- **C** — Complex
- **CA₁** — Complex-Associated — First Type
- **CA₂** — Complex-Associated — Second Type
- **NC** — Natural Complex
- **CA₁ + NC** — Complex-Associated — First Type + Natural Complex
- **N** — Neutral

An attempt was made to determine which reaction times might be considered disturbed. This was first done by distributing the reaction times of every session of each subject and computing the S.D. However, because of the illegitimacy of such computations on a heterogeneous population and because of the skewed distributions which we obtained in many cases — 1.5 times the S.D., which we set as our criterion, fell outside the limits of the distribution — this attempt was given up. We finally took those reaction times which seemed to stand apart from the rest of the distribution. Usually this gave four or five disturbed reaction times in a session.

We recognize that in using the word disturbance for both verbal and nonverbal effects we are not being consistent. In the former case we are using the word in the sense of a change in response in the direction of the complex, in the latter in the sense of a disorganized response. However, since the term is convenient, we are continuing its use in both senses.

A refined statistical treatment of the data was attempted, but we came to the conclusion that this was premature because of the qualitative stage of the technique and the exploratory nature of the experiment.

These percentage figures are arrived at by dividing the actual number of disturbances by the possible number of disturbances. Since there are 25 **C** and **CA₁** words, the possible verbal disturbance is 25. However, since each word may be disturbed nonverbally in the voluntary, involuntary, and respiratory aspects, there are 75 possible nonverbal disturbances. The total possible nonverbal disturbance on all other words together is 225. Reaction time is excluded since the standard we used was relative to the whole distribution of reaction times, so that only a few long times for each session could be marked as disturbed.

The actual number probably depends upon many factors such as the strength of the complex, the nature of the complex itself, its relation to the stimulus words, and personality traits.

It is possible to urge that the subject had little or no conflict in the hypnotic state because the complex was given to him in this condition. Thus, by virtue of having heard the story, without assuming personal responsibility for the act, he was set to give verbal responses related to the complex with no affect necessarily associated with them. It should be noted, however, that an attempt was made, in the hypnotic instructions which were used when the complex story was told to the subject, to associate affect with the story. It was repeatedly emphasized to the subject that he had committed an act which made him feel miserable. The subjects in general were restless after the induction of the complex and gave one the impression that something distressed them. It is interesting also to examine the verbal reaction times of the **C** and **CA₁** words in Session III. The mean of the **C** words is 2.6 seconds, being shorter than the mean of the
100 words, which was 3.0 seconds. None of these words carried any nonverbal disturbances. A reaction time mean on the C words which is close to the total mean of the whole stimulus word list is consistent with both the levels-of-discharge hypothesis and the “nonaffective set” view. That is, there is no reason in either case why any delay should take place. The reaction process simply runs its normal course, discharging more affective excitation in the former case than in the latter. The CA1 words have a mean of 3.2 seconds. Of the 15 words in this class, 12 have verbal disturbances. It is interesting to note that three of these 12 have nonverbal disturbances, words No. 45, 48, and 85, and each one has a long reaction time, the values being 4.4, 5.1, and 5.0 seconds, respectively. This result would seem to imply that there was inhibition of the verbal response which was reflected in the nonverbal aspects as disturbances. The motor responses give some evidence of conflict in the hypnotic state. Unfortunately there are only a few instances in this subject, so that the question cannot be answered decisively. In some other cases the issue is clearer, however, and we shall return to this topic later.

18 We have kept the class separate, however, since there are some nonverbal disturbances in other sessions which may be due to NC.

There are numerous disturbances which are not accounted for on the basis of a relationship to the induced complex or to natural complexes. One might attempt to explain these disturbances by the following methods. Often it is impossible to make a satisfactory decision. Some of these methods apply to all sessions and some only to particular sessions. Those which apply to all sessions are the following: (1) Perseveration effects (disturbances appearing on words following affective stimulus words), which may be both verbal and nonverbal or either one separately. If the perseveration is verbal and the subject gives a response which is related to the complex, then it would be classed CA1 but if it is unrelated, we would be unable to tell whether or not it is a case of perseveration. There is the possibility, however, that perseveration may make the verbal response unusual. The clearest example of perseveration in a nonverbal disturbance would be that which follows a verbal or nonverbal disturbance and which appears on an N word. (2) Cases of unusual stimulus words to which the subject has difficulty in giving a response, or cases where the subject inhibits the first response which occurs to him but which is not connected with a conflict. Here one would expect longer reaction times. (3) Transitory “natural-complexes”—those which have arisen just prior to a particular experimental session and which were not present at the next session. (4) Chance disturbances due to movements of the subject because of physical discomfort of some kind. One may raise the question here of the relationship of such movements to affective stimulus words. Our data on this point are not sufficient since a semiopaque curtain separated the subject and the experimenter through which only gross movements of the former could be detected. The subject was unable to see the experimenter because the latter’s corner of the room was darkened. (5) Natural complex situations unknown to us.

The explanations which apply to particular sessions are the following: (1) Responses which are related to the complex, but which we did not detect. These could be C, CA1 or CA2, C and CA1, in those cases in which the response was the same as that of the first control sessions but in which the subject ascribed new meaning to the stimulus word, relating it to the complex; CA2, in which we were unable to establish the associative links. This should apply especially to complex sessions and to some extent to control sessions after the removal of the complex (see 5 below). (2) Natural Complex situations, the thresholds of which have been lowered by the artificial complex so that words not marked NC become disturbed nonverbally. This should apply primarily to complex sessions. (3) Disturbances which are reactions to hypnosis itself and not the complex as such. These might be due to two different factors. The words which were used by the hypnotist in putting the subject into the trance, e.g., “Sleep,” might become disturbed if the subject had developed any antagonism toward the hypnotist because the unpleasant complexes were suggested in hypnosis. The other factor is the possibility of ambivalence toward hypnotism. One would expect such disturbances to appear largely in the waking complex sessions and perhaps in later waking control sessions, since in the waking state rapport is probably not as good as in the hypnotic state. (4) Disturbances due to “shock”—those arising from the subject’s apprehension in a new situation in which he does not know entirely what is expected of him. This is mainly relevant for the first session. One speculates in this connection whether or not apprehensiveness in a new situation sensitizes the” natural complexes” of the individual. (5) In the control sessions after the complex removal one has the possibility that there are residuals of the complex. Also, if there has been an enhancement of the subject’s natural conflicts, disturbances on NC words might be found here. In attempting to account for disturbances falling on N
words we shall point out which of the above explanations seem the most likely to us insofar as we have any
basis for our conclusions.

20 An analysis of the verbal responses of the complex sessions indicates that there has been such a shift
toward unpleasantness from the first control session; cf., e.g., in Session III, Nos. 38, 48, 61, and 98.

21 Another interesting point with regard to Session IV is that the subject showed one of the general
behavioral characteristics which we were observing. On No. 89 (“Tobacco-cigarette”), a CA\textsubscript{1} word, the
subject sighed deeply.

22 In this subject the instructions were altered the third time the experiment was performed. Instead of
permitting her to have a posthypnotic amnesia for the complex story, which was the usual technique, we
told her while hypnotized that she would be aware of the complex posthypnotically but would not dare to
think about it, although it would cause her to worry greatly. The increase in voluntary disturbances would
seem to imply, if the instructions were followed, that the subject must be aware of the complex to manifest
such disturbances. Luria has also commented on this point (1932, pp. 149-161), maintaining that if the
complex is removed from consciousness, if is also insulated from the motor area since the two have been
combined functionally by the technique. On the other hand, in the other five successful cases posthypnotic
amnesias were present, and all of them (one after reinforcement) showed a rise of nonverbal disturbances in
the waking complex sessions. When these sessions were completed, the subjects often manifested surprise
about some of their verbal responses which related to the complex. Luria has also noted this (1932, p. 136).
Whether the surprise of the subjects was genuine or was in the nature of rationalizations based upon some
knowledge of the complex we are unable to state definitely. Our impressions is that the surprise was real.
Luria, however, argues that each critical stimulus word makes the complex conscious, at least partially, and
hence disrupts the motor responses. His evidence in this connection is based on continuous free association
experiments in which the subject eventually got around to giving responses related to the complex. These
were accompanied by motor disturbances. Our material indicates that both conscious and unconscious
conflicts may be revealed by the technique. This question is probably connected with the strength of the
conflict and the intimacy of the relation between it and the motor response.

23 The general result on all cases was that four subjects showed some increase in the number of individual
responses in the first hypnotic control session as compared with the first waking control session. Three of
these four showed increases in the first hypnotic complex session and three showed increases in a waking
complex session over the hypnotic complex session.

24 Besides the aspects already discussed, additional analyses were made of the following: stereotypy,
echolalia, individuality of response by autogenic norms, and disturbances of the ascending and
descending limbs of the voluntary responses. However, we are not reporting on these aspects in this paper.

25 The ambiguity of the term “awareness of a conflict” must be pointed out. We find it difficult to determine
what Luria means in his discussion of this point (1932, pp. 149-161). There seem to be three possibilities:
awareness of the presence of affect, awareness of the situation connected with affect, awareness of why the
situation arouses affect. In our series the subject (6\textsubscript{a}, 6\textsubscript{b}, 6\textsubscript{c}) in whom “awareness” was necessary seems to
favor the last possibility.

26 Olson and Jones (1931) have found that religious, political, and social attitudes may be studied by the
Luria method.

27 The mean of the first waking as compared with the first hypnotic was 34.33 higher and had a Fisher’s ‘r’
of 4.030, a value yielding a probability of less than 0.01. This means that the difference was significant.
Study of an Experimental Neurosis Hypnotically Induced in a Case of Ejaculatio Praecox

Milton H. Erickson

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The experimental investigation of the clinical problems of personality disorders presents an interesting but difficult task. Most studies on such problems have been done by psychoanalysts acting chiefly in the role of therapists. For this reason purely experimental work has been neglected because of the necessity of abiding by prescribed rules and definite concepts. However, students in this clinical field, foremost among whom are the psychoanalysts themselves, are becoming increasingly aware of the need for a systematic technique which will lend itself to laboratory proof as contrasted with the present empirical proof of subjective and clinical experience. As an approach to the experimental study of personality disturbances, a case of ejaculatio praecox was selected and subjected to a laboratory procedure intended to yield some information regarding the psychological mechanism termed abreaction.

The technique of experimentation was suggested by the well-established clinical fact, both in medicine and in psychoanalytic therapy, that recovery from one illness (or conflict) frequently results in the establishment of a new physiological equilibrium (or “redistribution of libido”), thereby permitting the favorable resolution of a second concurrent and perhaps totally unrelated illness (or conflict). Of similar influence was the well-known fact that an intercurrent disease may exercise a favorable effect upon the original illness—for example, malaria in paresis. Consideration of these ideas suggested their adaptation to the case in hand at a psychic rather than the usual somatic level. It was determined to give the patient a second illness, which was to be a neurosis so formulated that it might symbolize or parallel the original difficulty, and might be expected to arouse similar or possibly identical affects. The assumption was made that such similarity or identity of affects would establish some dynamic relationship between the two neuroses, possibly through identification, or perhaps through an “absorption” of the one conflict upon the other; and that when the patient, by virtue of the experimental situation, was forced to relive, abreact, and resolve the conflict of the induced neurosis, there might occur a transference or generalization of the abreactive process to the original difficulty. Or perhaps the abreaction and resolution of the induced conflict might establish a new attitude or organization of the personality. At all events the immediate experimental purpose was to establish a dynamic interrelationship of the two neuroses and to induce a readjustment of the personality.

The subject of this experiment was a single white male, 25 years old, who possessed a degree of doctor of philosophy in psychology. In addition he possessed a fair knowledge of clinical psychology and was well acquainted with the author’s hypnotic techniques and
methods, since he had been acting as a hypnotic subject for the author and had been used extensively in experimental work for a period of a year before he disclosed his complaint. Finally, because his difficulty had become progressively worse, he decided to seek psychiatric assistance, and to this end he complained to the author of ejaculatio praecox and requested aid in overcoming this symptom. His story was essentially as follows: Three years previously he had decided to engage in sexual intercourse and had made many attempts, but always with a strong sense of guilt which he rationalized as a feeling that he was desecrating womanhood. From the first he had suffered from ejaculatio praecox, but on a few occasions he had succeeded in securing a second erection permitting penetration, but this was always followed by a precipitate orgasm and flaccidity. As these failures had been repeated, he had become increasingly concerned and worried, and his problem had become progressively more acute. Originally the overt act of beginning intercourse had resulted in an ejaculation, but at the time he sought aid, kissing or embracing and sometimes merely casual contact with an attractive girl would cause an erection and precipitate an orgasm with a complete loss of potency. Even when he did succeed in securing a second erection, he had not been able to utilize it either because of another precocious ejaculation or because of a precipitate orgasm upon penetration. He had resorted unsuccessfully to such measures as “prophylactic” masturbation to reduce his sexual tension and to the selection of girls without erotic appeal for him. His emotional reaction to these experiences was one of acute shame, bitterness, self-disgust, and inferiority.

At the conclusion of his story the young man was informed that the author would do no more than to take his case under advisement, and no therapy would be attempted until after a period of consideration; also, he was urged to seek assistance from another psychiatrist. Then, changing the subject matter of discussion, the patient’s cooperation was requested for a special hypnotic experiment which he knew had already been under consideration for some time and which was to be developed in the course of the next few months. Although not fully content about the postponement of therapy, he continued his cooperation in regard to present and projected hypnotic work. Later, during the elaboration of the plans for the special hypnotic work, the idea of this experiment was conceived and promptly elaborated for investigation. No intimation of this fact was given to the patient. Instead, he was allowed to continue in his belief that therapy was indefinitely postponed and that the author was wholly absorbed in the previously projected hypnotic work, concerning which the patient had not been given any information. The rationale for this deception was the assumption that any therapeutic results of the hypnotic procedures utilized could be attributed then to the therapy itself rather than to the patient’s hopes and expectations. A second gain, an important consideration in hypnotic therapy, was the possibility of hypnotizing the patient deeply for the experiment without making his success as a subject contingent in any way upon his neurosis.

During the course of the experimental work in which the patient had cooperated, he had been trained to accept “artificial complexes.” These complexes were fabricated stories of an emotional nature told to the subject while in a profound hypnotic trance as accounts of actual past personal experiences which should constitute definite memories for him.
Utilizing this background of the patient’s, a special complex was fabricated for him which, when properly implanted in his mind, would tend theoretically to produce a second neurosis of the type discussed above. This fabricated story, which follows shortly in its exact wording at the time of administration, together with all hypnotic instructions as recorded in full by the attending secretary, is purely a fancy of the author’s based upon an actual wish of the patient’s to secure a certain academic fellowship.

However, to orient the reader more easily, it may be advisable to indicate as a preliminary measure the symbolism contained in the complex story. The heterosexual situation and its implications are apparent at once. Less clear are the symbolic equating of cigarette with penis and ashtray with vagina, but consideration of the heterosexual drives involved and the emotional forces at play in that particular setting—the man’s attraction to the girl, his desire to give her something and thereby to gain satisfaction for himself, the girl’s display of herself by means of her artwork, and the parallelism of the catastrophe of this contact with those of past heterosexual contacts—gives rise to a fair plausibility of such identifications.

As soon as the patient had been placed in a profound somnambulistic hypnotic trance of the type characterized by an apparently complete dissociation from all environmental stimuli and by an apparently total amnesia posthypnotically for all trance events and suggestions, he was given the following instructions:

Now as you continue to sleep I’m going to recall to your mind an event which occurred not long ago. As I recount this event to you, you will recall fully and completely everything that happened. You have had good reason to forget this occurrence, but as I recall it, you will remember each and every detail fully. Now bear this in mind, that while I repeat what I know of this event, you will recall fully and completely everything just as it happened, and more than that, you will reexperience the various conflicting emotions which you had at the time and you will feel exactly as you did while this occurrence was taking place.

Now the particular event of which I am going to tell you is this: Some time ago you met a man prominent in academic circles who manifested an interest in you and who was in a position to aid you in securing a certain research fellowship in which you were much interested. He made an appointment with you to see him at his home, and on that day you called at the designated hour. When you knocked at the door, you were met not by this gentleman but by his wife, who greeted you cordially and was very friendly, making you feel that her husband had given a good account of you to her. She explained apologetically that her husband had been called away for a few moments but that he would return shortly and had asked that you be made comfortable in the library. You accompanied her to this room, where she introduced you to a charming girl who was obviously rather shy and reserved and who, she explained, was their only daughter. The mother then requested your permission to go about her work, explaining that the daughter would be happy to entertain you while you waited. You assured the mother that you would be very comfortable, and even now you can recall the glow of pleasure
you experienced at the thought of having the daughter as a hostess. As the mother left the room, you set about conversing with the girl, and despite her shyness and bashfulness you soon found that she was as attractive conversationally as she was pleasing to the eye. You soon learned that she was much interested in painting, had attended art school, and was really profoundly interested in art. She timidly showed you some vases she had painted. Finally she showed you a delicate little glass dish which she had painted in a very artistic manner, explaining that she had decorated it as an ashtray for her father, to be used more as an ornament than as an actual ashtray. You admired it very greatly. This mention of using the dish as an ashtray made you desirous of smoking. Because of her youth you hesitated to give her a cigarette. Also, you did not know how her father might feel about such things, and yet you wanted to observe the courtesies of smoking. As you debated this problem, you became increasingly impatient. The girl did not offer you a cigarette and thus solve your problem, and you kept wishing that you might offer her a cigarette. Finally in desperation you asked her permission to smoke, which she granted very readily, and you took a cigarette but did not offer her one. As you smoked, you looked about for an ashtray, and the girl, noticing your glance, urged you to use the ashtray she had designed for her father. Hesitantly you did so and began talking on various topics. As you talked, you became aware of a rapidly mounting impatience for her father’s return. Shortly you became so impatient that you could not enjoy smoking any longer, and so great was your impatience and distress that instead of carefully putting out your cigarette and then dropping it in the ashtray, you simply dropped the lighted cigarette into the ashtray and continued to converse with the girl. The girl apparently took no notice of the act, but after a few minutes you suddenly heard a loud crack, and you immediately realized that the cigarette you had dropped into the ashtray had continued burning and had heated the glass unevenly with the result that it had cracked in pieces. You felt very badly about this, but the girl very kindly and generously insisted that it was a matter of small moment, that she had not yet given the ashtray to her father, that he would not know anything about it, and that he would not be disappointed. Nevertheless, you felt exceedingly guilty about your carelessness in breaking the ashtray, and you wondered how her father would feel about it if he ever learned of it. Your concern was plainly evident, and when he mother came into the room you tried to explain, but she graciously reassured you and told you that it really did not matter. However, you felt most uncomfortable about it, and it seemed to you that the girl felt badly too. Shortly after this a telephone call was received from the father, stating that he was called away for the rest of the day and asking your permission to see you on a later day. You left the house very gladly, feeling most wretched about the whole situation and realizing at the time that there was really nothing you could do about it.

Now, after you are awakened, this whole situation will be on your mind. You will not consciously know what it is, but nevertheless it will be on your mind, it will worry you and govern your actions and your speech, although you will not be aware that it is doing so.
I have just told you of a recent experience of yours, and as I recounted it to you, you recalled it in detail, realizing the whole time that I gave you a fairly accurate account of the situation, that I gave the essential story. After you awaken, the whole situation will be on your mind, but you will not be conscious of what it is, you will not even be aware of what it might be, but it will worry you and it will govern your speech and your actions. Do you understand? And you do feel badly about this thing.

The patient was promptly awakened from the trance state, and within a few moments he seemed completely awake. He appeared to have a total amnesia, not only for the trance events and suggestions, but also for the fact of having been hypnotized, the usual finding after deep hypnosis. He showed particular bewilderment in orienting himself, since darkness had fallen during the time that he had been asleep. He was engaged immediately in a casual conversation by two colleagues of the author who were present, while the secretary made full notes of all conversation together with a description of the patient’s behavior and manner. It is not possible to present this material in its entirety because of its length and because of the necessity of preserving the patient’s identity. The significant parts, however, have been abstracted for presentation here.

Three general types of phenomena occurred during the posthypnotic period. The first of these was the domination of every train of thought in the patient by his implanted, now subconscious, complex. Although he conversed fluently on a variety of topics, each one was soon noted to be related to the complex, but in a manner apparent only to an observer who knew the whole situation. Care was taken not to suggest topics related to the complex, and the patient himself made no reference to the content of the complex story itself, nor did any of his utterances suggest any conscious awareness of it. Neither was he given any suggestions which would serve to influence the trend of his behavior. Indeed, the colleague of the author who bore the burden of conducting the procedure was kept uninformed of the author’s purposes as a means of ensuring undirected responses from the patient. When the patient was asked about a certain friend of his, he told of that friend’s small children breaking bric-a-brac. As the conversation continued, he told of the travels abroad of another friend who had visited art galleries and museums containing ancient painted vases; he spoke of the author’s library and the advisability of insurance for personal property; and he laughingly told of an instance of careless smoking by a friend which had nearly resulted in a serious fire. Any topic of conversation introduced by the others present was soon developed by the patient in such fashion that a bearing upon the content of the complex became apparent to the observers. Furthermore, each conversational topic rapidly appeared to become unpleasant to the patient, and he would change the subject repeatedly, only to return compulsively to some remark which could be related easily to the complex.

Secondly, there occurred disturbances in the form of his stream of speech. Irrelevancies, stammering, blocking, loss of train of thought, repetitions, persistence of certain ideas, undue urgency, and sudden strong emphases were all noted frequently. Thus, upon awakening, he began smoking and talking until he suddenly observed a painted earthen ashtray at his elbow, whereupon he twisted uncomfortably in his seat, stammered, lost his
train of thought, but gradually recovered his poise as the author’s colleague assumed the burden of the conversation. Later, while talking about traveling abroad, he interjected remarks about the irreparable loss to art occasioned by the breaking of ancient vases and then continued the main topic of conversation without apparent realization of his digression. Again, in mentioning the author’s library, he became unduly solicitous and urgent about insurance. In none of these instances did the patient seem to sense anything unusual in his behavior, despite their frequent occurrence. Observation at the time and consideration of the record later indicated that these behavior disturbances of the patient arose not in response to external stimuli but rather from his own intrapsychic state.

The third type of phenomena noted during this period was phobialike, obsessive behavior in regard to ashtrays, as judged by his previous known behavior. When casually handed a substantial, though ornamental ashtray, he received it in a gingerly, fearful manner and appeared to be afraid to use it. Instead, after many hesitant, abortive, and apparently compulsive attempts to flick ashes into it, he put them into the cuff of his trousers in an embarrassed manner. Now and then he would succeed in dusting them into the tray, whereupon he would crush them repeatedly and uneasily with his fingertips, as if to reassure himself about sparks. He held his cigarette butt until it burned his fingers, glanced at the floor and lifted his foot as if to dispose of it in that fashion, attempted to extinguish it in the cuff of his trousers but seemed too embarrassed to do so, made repeated abortive attempts to extinguish it in the ashtray in front of him by tapping the cigarette gently against the tray, and finally searched the room casually until he found a metal dish, wherein he extinguished the butt methodically, over-carefully, examining and reexamining it as if to be sure that it was not still burning. Whenever anyone dropped a used match into a tray, he seemed compelled to retrieve it immediately and to cool it between his finger and thumb before replacing it carefully on top of the ashes. While conversing he examined and reexamined his ashtray in a detached manner, moved it unnecessarily away from the edge of the table and finally put a soft mat under it. Despite all this difficulty in smoking he accepted unconcernedly a cigarette whenever proffered or helped himself to his own supply, only to repeat his phobialike behavior as he smoked.

Having noted this much of the patient’s behavior—of which the above is only a brief summary—it was felt that he had “accepted” the complex and had possibly developed in consequence an artificially induced neurosis. He was then questioned directly and urged to give an account of what had occurred since he entered the office. Despite insistent questioning he was able to state only that he had spent the time smoking and conversing with the author’s colleagues. No information was obtained suggesting that he had any conscious realization of the fact that he had been hypnotized or subjected to an unusual procedure. Accordingly, he was rehypnotized, and in this trance he was instructed to recall completely upon a wakening the entire experimental situation and to discuss freely his reactions, speech, behavior and conduct. It was assumed that by means of this procedure a “removal” of the complex could be effected, since the patient could thus relive it at a conscious level and thereby might gain an insight into his reactions. As he awakened, a casual conversation was initiated which he soon interrupted to ask if he had told the author of a recent unhappy experience of his. He proceeded to relate the story of the complex as the recollection of an actual event, doing so with appropriate emotional
responses, even identifying the father as a man who actually could have played such a role. As he concluded he started, looked bewildered, showed intense amazement, then smiled with relief and understanding, and declared, “Why, that was just a suggestion you gave me—in a hypnotic trance, too!”

After this realization he began to discuss fully the various details of his conversation and conduct, progressing in chronological sequence, each item serving to awaken its successor as a fresh memory. Meanwhile, the secretary made full notes of his discussion and manner and of the questions and remarks addressed to him. He explained that, as the complex was narrated to him, he had displaced, elaborated and falsified true memories, weaving them into the fabricated account, thereby giving the complex story the reality of an actual event. This transformation of the fabrication into a reality for him had been achieved readily upon his identification of the father with a gentleman whom he knew slightly and whom he had wished might play such a role. It was aided further by a strong resentment which he had developed immediately toward the author for having pried into his affairs and having learned about the unhappy incident. Upon awakening, he had felt at ease and comfortable but impelled to talk. As he talked, however, he had become aware of a constantly growing sense of discomfort, augmented by each topic of conversation and by his own remarks and those of others despite the casual, appropriate nature of such comments. He had been astonished to discover his fear of an ashtray, and he had tried to conceal this terror and to overcome it by sheer force of will. At the same time the tray had fascinated and distracted him repeatedly. Although he had tried, he had not been able to reach any understanding of his reactions. He had become even more distressed when he found that the same feeling of terror had attached itself to other ashtrays and even to used matches. “I was just terribly afraid,” he declared, “afraid of anything with heat in it.”

When asked to describe his emotional reactions in their sequences, the patient stated that, when the complex had been given to him in the trance state, he had reacted to it “just as any normal person would to such a situation. It was a miserable thing to have happen.” Upon awakening from the trance, he had not experienced any particular emotions, but as he had begun to talk, he had developed the same sort of emotional state as he recalled having experienced in the hypnotic trance during the administration of the complex. However, as he continued to talk and had experienced blockings of speech and periods of stammering, and had become aware of his intense fear of ashtrays, his emotional discomfort had increased markedly, and he had become “wretched,” “miserable,” “depressed,” “unhappy,” “anxious,” and “fearful.” He described these changes naively by saying that the familiar and pleasant surroundings in which he had found himself had made his emotional distress seem “silly,” “foolish,” “inadequate,” and “reasonless,” and that this feeling had impelled him to “reach into past experiences” and to seize upon “embarrassed affects” taken from “past embarrassing experiences” and to “add” these new and stronger emotions to those already existing. This had given him a sense of having improved the situation immeasurably in some indefinable way, but it had made him “feel terrible, awful then.” (It had been noted during the latter part of the time in which the patient had the complex that he had become labored and strained in behavior,
speaking with effort, sighing deeply, and perspiring profusely—an observation which had led immediately to rehypnotizing him and “removing” the complex.)

The patient was questioned about the “past embarrassing affect” which he had “added” to the original affects. However, without any apparent effort to evade the question, he launched into an academic discussion concerning the possibility of transference of learning as applied to emotional responses, which did not appear to yield any pertinent information. Neither did he seem to grasp the significance of the question.

Accordingly, he was asked how he felt about the whole situation as he recalled it. He replied, “Well, I’m glad to know that it was just a lot of suggestion and that it didn’t really happen.” He added that his hesitant, fearful manner of trying to use the ashtray must have appeared ridiculous, saying, “Let me show you how I did it.” He proceeded to imitate his previous conduct in great detail, suddenly interrupting himself to say, “Now, I’ll show you how I do it now.” Lighting another cigarette, he tossed the match into the tray as he talked, and finally extinguished his cigarette by crushing the tip against the bottom of the tray and shoving it back and forth through the ashes, remarking with a smile, “Now, I can feel satisfied about it.”

Following this the patient was thanked for his services and dismissed with the understanding that the experiment had been concluded.

Three days later the patient returned to the author’s office in a jubilant frame of mind, declaring excitedly, “I can do it.” When asked to explain what he meant, he stated that on the previous evening he had been in the company of a girl who had responded warmly to his advances. As usual, upon kissing her he had experienced an ejaculation, but instead of reacting with his customary sense of shame and depression, his erotic desire had increased, there had been no loss of his erection, and he had been able to consummate the sexual act, prolonging his pleasure greatly and repeating the act during the night. He was permitted to tell about this experience in detail, after which he began to question the author as to the origin and validity of his “cure.” Noncommittal replies were made and he was reminded that in the past he had succeeded after a preliminary ejaculation. He protested that no comparison could be drawn between past successes and that of the previous evening, which had given him his first sense of genuine sexual satisfaction. Also, his whole psychic attitude and reaction had been entirely new, since he had not experienced any of his customary feelings of fear, shame, and inferiority, but on the contrary he had felt confident, secure, and free. Nevertheless, the author’s disbelieving manner caused him to leave the office in a discouraged, doubtful frame of mind.

Several days later he returned, again jubilant, declaring “You’re wrong, doctor, I am cured.” His story very briefly was that, after leaving the office, he had been much depressed by the author’s doubts, and for two days he had continued in a wretched frame of mind. Finally, in order to know the truth, he had secured a girl and had spent the night with her in his apartment. He had begun his love-making cautiously, and as his partner responded, he had become increasingly ardent. Since no untoward event had occurred, he had lost all doubts and had proceeded to the overt sexual act. During the act a neurotic
fear had developed that he might be unable to have an ejaculation, but this fear had been promptly dispelled by an orgasm. After a rest he had repeated his performance satisfactorily. The next night he had obtained another girl and had confirmed his “cure.” (Subsequent investigation into the truth of the patient’s story confirmed his report.)

At the close of this account the patient was asked what explanation of the change in him he could offer. He declared that he had no explanation, that apparently he had spontaneously resolved his conflicts, and that he was satisfied to let things remain as they were. The author suggested that he sit quietly and think hard, letting his mind wander at will, and as he did so, to recall all the various emotions he had so often experienced in conjunction with his precocious ejaculations. After a few moments he flushed, moved uneasily, then soon, in a low, monotonous tone of voice said, “I see it now—I put my cigarette in the ashtray and it broke—spoiled everything—I felt terrible—just the same way—I see it now—I was afraid to use the ashtray—I’d try to—I’d pat the ashes to be sure there were no sparks—I’d use my trousers.” An expression of amusement and understanding appeared on his face. “But I showed you I could do it. Remember? First, I showed you how I acted when I was afraid, and then I showed you when I wasn’t afraid. Remember how I put it out by rubbing it around?” He paused, his reminiscent manner disappeared, and in a puzzled tone of voice he said, “Say, that was that complex you suggested to me—say, that explains a hell of a lot to me—I see through a lot of things now—now I know what I meant when I said I could be satisfied.” As an amused afterthought he added, “No wonder my feelings were so awful.”

An attempt was made to secure an elaboration of these utterances and to elicit an explanation of his apparent identification of the emotions of his neurosis with those aroused by the fabricated story, but he became so ill at ease and appeared to develop such repressive mechanisms against further conscious insight that it was considered unwise to press questions. The only information obtained was the inadequate statement that “the emotions were just the same” for his ejaculatio praecox and the situation of the suggested conflict.

Several months later the patient was asked to read and check the accuracy of this account of his problem. When he reached the paragraph containing his “explanation,” he put the page aside, saying, “Do you know, doctor, I can’t remember what my explanation was. Let me think.” Within a few moments he repeated in total the scene described above, uttering almost exactly the same words. As he concluded, he picked up the page, read it eagerly, exclaiming repeatedly, “That’s it, that’s it.” Again he seemed unwilling or unable to elaborate further, protesting that he had explained the whole matter previously on the basis of the similarity of emotions.

More than a year has elapsed since this experimental procedure. During the first few months the patient indulged freely in sex relations whenever the opportunity offered, with no recurrence of his symptom. Then, after a period of abstinence, he again developed precocious ejaculation, but without the previous emotional concomitants and without loss of his erection, and in each instance he was able to consummate the sexual act satisfactorily. During the last few months he has discovered that a mere recollection of
the experimental procedure will suffice to inhibit a precocious ejaculation, and he is able to function normally. He does not feel handicapped in any way and is well satisfied with his sexual life, and he has not developed any other neurotic symptoms.

**DISCUSSION**

Careful examination of the above report discloses a wealth of complex psychodynamic manifestations which appear to have been elicited as stimulus-response reactions. From these a number of inferences may be drawn which invite discussion.

Concerning the ultimate soundness of the therapeutic result, there may be legitimate doubt, since the origin of the neurosis and its purposes and function for the personality are not known. However, the fact that the patient can function normally now and can obtain personal satisfactions hitherto impossible, indicates definite and significant changes in his personality reactions of clinical validity. Further, the results suggest that the psychoanalytic theory of pregenital fixation in ejaculatio praecox, developed by Abraham (1927), may not be applicable to every case, since in this instance it is difficult to comprehend how the experimental measures utilized could have bridged such a gap in libido development.

Another question concerns the possibility that the previous hypnotic experimentation, by developing suggestibility, capacity for dissociation, and responsiveness to direct or implied suggestions, might have influenced his neurosis by giving him special insights or new methods of expression. During that time, however, no improvement from his neurosis occurred. For the same reason the hypothesis may be excluded that the author’s role as combined hypnotist and promised therapist was unconsciously formulated by the patient as one of an authority-surrogate and permissive agent upon whom he could place the responsibility for successful coitus. Further, it may be contended that the mere induction of a strongly emotional state in the hypnotic trance might have constituted a sufficiently vital experience to occasion a reorganization of the psychic economy with a consequent alteration of the neurotic structure. This is negated by the fact that in the previous work he had been subjected to procedures similar to the one used in this investigation which were equally strongly tinged emotionally, though in a different regard. None of these experiences appeared to have had any role other than that of teaching him how to accept suggestions and how to mobilize his affective responses.

An important consideration is the patient’s demonstration of the phenomenon of interpolating into a communication one’s own feelings, ideas, and experiences. Given a factually baseless communication, he incorporated it into his mental life, reacted appropriately to it emotionally, and apparently transformed it into a vital part of his psychic life. But in doing so, he interpolated into it other and past experiences, ideas and affects of other origin, formulating the admixture into a new emotional constellation of greater inclusiveness and significance, to which he reacted in a new fashion, as judged by his subsequent behavior and explanations. The means by which he achieved this elaboration appears to have been his unconscious response to the equating of the various emotions which were centered around a single object and which were aroused.
simultaneously by the intentionally devised relationships, connotations and symbolizations contained in the story of the complex. His vague desire to possess the girl and at the same time to please her, and his desire to smoke and at the same time to give her something which would eventuate in his own satisfaction were integral parts of his general emotional state in relation to the girl. Similarly, his admiration for the ashtray constituted part of his admiration for her, and the expression of a part of his emotional reactions served as a vicarious expression of the other part. This composite nature of his affective reactions formed an emotional background against which one object could be substituted for another to evoke one or another aspect of a common emotion. Accordingly, the cigarette could acquire thereby the cathexis of the penis and the ashtray that of the vagina with a symbolic representation of the one by the other. That such symbolic values did obtain is indicated by the concluding part of the experiment in which the patient appeared to develop some form of conscious insight. His fragmentary remarks signify an intermingling of ideas and affects, an equation of the emotions from one source with those of another, and an identification emotionally of the suggested conflict with that of his neurosis. It is indicated further by the record of his speech and behavior during the time that he had the complex, and by his posthypnotic discussion, all of which suggests strongly that deep affects not appropriate to the story of the complex were stimulated. Particularly interesting are his naive descriptions of deep emotions, and the physiological concomitants of strong feeling states which he manifested in the first trance state of this experiment—namely, profuse perspiration, deep sighing, and strained behavior.

In this same regard arises the question of whether or not deep affects are amorphous in character and are dependent upon stimulation for definition and for direction into channels of expression. The patient’s extreme emotional response to the content of the artificial complex suggests, figuratively speaking, the attachment of an amorphous mass of affect to the relatively simple ideas it contained with a consequent disruption of the personality reactions.

A final question for discussion is the rationale of the patient’s explanation of his recovery in terms of the suggested complex. A plausible inference seems to be that, having verbalized the emotions of his neurosis in terms of the trance events during the experimental situation, he had been conditioned to that method of response. Hence, when asked to recall those same emotions and to explain his recovery, he did so in accordance with the established pattern. But as he did so, a new psychic factor—specifically, the mental perspective derived from his successful experiences—gave his utterances a new significance for him, enabling him to declare, “Why, that was the complex—that explains a lot of things to me—now, I know what I meant when I said I could be satisfied!”

**SUGGESTED PROBLEMS FOR FURTHER INVESTIGATION**

The author is well aware that, however valid the results are in this one instance, no general conclusions concerning the neurosis of ejaculatio praecox or its therapy can be drawn from a single case subjected to a new experimental approach. Nor has this account been offered as a possible solution to such a problem. Rather, the purpose of this report is
to direct attention to the practicability of the use of hypnotism as a possibly fertile technique for the laboratory study of the dynamics of human behavior. Any therapeutic aspects of such study are of secondary value until a better understanding of the processes involved is achieved.

Although used profitably in experimental academic work, there has been a tendency to overlook the feasibility of hypnosis as an investigatory agent in the study of psychodynamic problems. This investigation indicates that hypnotic measures can be used in a significantly productive fashion to elicit dynamic responses and to manipulate psychological processes. Although no absolute conclusions can be drawn from the findings above, certain inferences and hypotheses, previously discussed are warranted concerning the mental mechanisms involved, the dynamic relationships developed, and the methods for determining or influencing behavior and affective responses. These, in turn, suggest a number of definite experimental problems which invite analytical study and of which a few most relevant to this investigation will be presented.

The first of these problems is the practicability of evolving a technique for the development of experimental neuroses in a human subject for laboratory study. The present investigation is not entirely satisfactory experimentally because of some degree of sophistication in the subject. Despite this fact and the crudity of the technique employed, the results obtained suggest significant clinical and experimental possibilities. The study needs to be repeated, however, on a naive subject with a simpler personality problem such as a specific mild phobia, and in connection with a thorough investigation into the genesis of the symptom for the purpose of elucidating the experimental results. By means of this procedure a more comprehensive appreciation of the interrelationships of conflicts and the influence of one complex upon another might conceivably be reached.

A second problem is the possibility of studying the concept of abreaction. An improved technique similar to that used above, but controlled by continuous observation of the subject and by the centering of his behavior around activities less heavily endowed with affective values and social implications, might offer a good approach to an experimental investigation of the nature, mechanisms, and methods of induction of abreactive processes. A counterpart of experimentally induced abreaction may be found in the “living-out” of fantasies in the psychoanalytic procedure, the clinical results of which also suggest the feasibility of studying abreaction in a laboratory setting.

Another investigatory aspect would be that of devising a technique whereby the subject could be induced to select from a communication the material requisite to form a complex. The present experiment indicates that such a selection was made in this study, since the fabricated story symbolized also an Oedipus complex and a sister-incest situation to which the patient apparently did not react. Such a technique might serve materially to disclose natural complexes and to reveal personality trends and types. Huston et al, referred to above, found suggestive evidence that the hypnotic induction of complexes served to reveal natural complexes. Malamud and Linder (1931) have also
made an approach to this problem from another angle by showing pictures to patients and then obtaining reports of their subsequent dreams.

The patient’s emotional behavior during the experiment gives rise to the conjecture that affective responses may be “conditioned” somewhat like the conditioning of neuromuscular responses. This might conceivably be accomplished by arousing deep affects upon which, as a direct sequence, a second emotional situation could be created. An illustration of this is to be found above in the establishment of an affectively significant heterosexual situation out of which arose a special emotional state. From such experimentation, by noting sequences, direction, methods of expression, and purposes served, information regarding the genesis, attachment, and interrelationships of emotional reactions might possibly be obtained.

An approach to some of the problems of symbolization is also suggested by this report. The role of similarity of affects in producing symbolic values may be inferred from the patient’s account of his recovery. Experimentation designed to attach similar affective tones to dissimilar objects or concepts might conceivably yield information regarding the development of symbolic equivalents. To illustrate, the present experiment might be repeated by arousing the affects of the Oedipus complex, followed by a second emotional situation centered around a fabricated role of authority exercised by the subject. Verbalization of the one situation in terms of the other would possibly indicate the establishment of symbolic values. Or, if the patient’s symbolization resulted from the connotations and the relationships of the ideas communicated to him, experimental procedures based on temporal contiguity and association of ideas might give pertinent results.

Another problem is concerned with the question of the development of insight, the factors controlling its growth, its influence upon mental structures, and its function in the psychic economy. The patient studied apparently acquired insights, some complete, others partial, presumably as a result both of the sequences and the nature of his behavior. The same technique, but with continuous observation of the subject and an adequate objective record of his behavior before, during, and after the experiment, might serve to give an appreciation of any progressive manifestations of insight. Or, the omission of certain parts of the procedure, the changing of sequences in the experimental behavior, or the introduction of new measures might determine the relative importance of the various experimental steps. For example, what would have been the ultimate result in this case had the patient failed to demonstrate, “how I do it now,” or had he been informed of the experimental procedure by the author instead of recalling it himself?

**SUMMARY**

A patient seeking a therapy for a neurosis of ejaculatio praecox was subjected to an experimental procedure wherein an attempt was made to induce in him a second neurosis by means of a hypnotically implanted complex. This complex had been formulated to symbolize or to parallel his actual neurosis. In consequence of this procedure there appeared to result an identification of the induced conflict with his original neurosis and a
fusing of their affective reactions. After the patient had been forced to relive, abreact, and gain insight into the suggested conflict, it was discovered that he had made a clinical recovery from his original neurosis and that he was still able to function normally a year later. A discussion is given in which possible psychological processes and mechanisms underlying the experimental results are elaborated, the ultimate soundness of the therapeutic results is questioned, and emphasis is placed upon the practicability of hypnosis as an experimental procedure in the analysis of personality disturbances. There follows a list of certain specific problems suggested by this study.

1A detailed report of such an experimental procedure may be found in Huston, P. E., Shakow, D., and Erickson, M. H. A study of hypnotically induced complexes by means of the Luria technique. Journal of General Psychology, 1934, 11, 15-97.
The Method Employed to Formulate a Complex Story
For the Induction of an Experimental Neurosis in a
Hypnotic Subject

Milton H. Erickson


In 1935 a report was published on the induction by hypnosis of an experimental neurosis in a patient suffering from ejaculatio praecox (Erickson, 1935). The procedure employed was that of fabricating a story which would parallel and symbolize the patient's actual neurosis in terms of an ordinary, credible, but unpleasant instance of social behavior. This story was then told to him while he was deeply hypnotized in such fashion that he would believe it to be a true account of an actual past experience of his which he had repressed completely. The patient's profound psychological and neurophysiological reactions and responses to this procedure and the experimental neurosis he developed were reported in the original article. However, for reasons pertinent at the time, no explanation was given of the process by which this artificial complex was fabricated or of the logic that was employed in attempting to make that story uniquely significant to the patient. Instead, the original worksheets, outlines, and rough drafts as well as the final copy were filed away for possible future use. Recently, discussions with Margaret Mead, Gregory Bateson, Lewis B. Hill, and others on hypnotic techniques of suggestion and methods of interpersonal communications have suggested the possible value of presenting in detail the explanation of how that complex was fabricated. Also, such an analysis seems warranted by the continued experience of the superiority of this general type of technical procedure in inducing extensive changes in the behavior of hypnotized subjects, as contrasted to the less satisfactory results secured from spontaneous, unplanned, haphazard suggestions, or when the same degree of detailed care is not exercised in building up hypnotic suggestions and hypnotic situations. In considering how to devise or formulate a suitable complex applicable to the subject, the task seemed to be essentially a problem of, “It is not only what you say, but how you say it.” Under the proposed experimental conditions “what” was to be said had to be a seemingly innocuous and credible but fictitious story of a past forgotten social error by the subject. The content of such a story was relatively simple to determine and required little imagination, since the patient had been a hypnotic subject of mine for over a year and I knew him intimately, I was well acquainted with his family, and I also had professional knowledge of his neurosis. Hence the content of the story was easily made to center around an imaginary visit at the home of an unidentified prominent man. There he was supposedly greeted by the man’s wife and introduced to an attractive only daughter, in whose presence he smoked a cigarette and accidentally broke a prized ashtray.
The “how” of telling this story seemed primarily to be a task of so relating the fictitious account that it would become superimposed upon his actual experiential past in a manner that would cause him to react appropriately to it emotionally, to incorporate it into his real memories, and thus to transform it into a vital part of his psychic life.

This could be done, it was reasoned, by taking the objective items contained in the essential content of the story and so weaving a narrative about them that they would stimulate a wealth and a variety of emotions, memories, and associations that would in turn give the story a second and much greater significance and validity than could its apparent content.

To do this would require a careful choice and use of words which would carry multiple meanings, or which would have various associations, connotations, and nuances of meaning which would serve to build up in a gradual unrecognized, cumulative fashion a second more extensive but unrealized meaningfulness for the story.

Also, the words, by their arrangement into phrases, clauses, and sentences, and even their introductory, transitional, and repetitive uses could be made to serve special purposes for building up emphasis or cutting it short, for establishing contrasts, similarities, parallelisms, identifications, and equations of one idea to another, all of which would build up a series of associations and emotional responses stimulated, but not aroused directly, by the actual content of the complex. Additionally, sharp transitions from one idea to another, sequential relationships of various ideas and objects, shifts of responsibility and action from one character to another, the use of words that threatened, challenged, distracted, or served only to delay the development of the narrative were all employed to formulate a story possessing a significance beyond its formal content.

Additionally, it must be noted that the patient had been a hypnotic subject of mine for a long time and that therefore he had had a wealth of experience in responding to both direct and indirect suggestions. Thus, his experiential background was of a character to enable him to react adequately to the indirect, concealed, and disguised suggestions and significances of the fictitious story.

Supplementary to this is the fact that the hypnotist, in administering the complex to the patient, was fully aware of what he hoped each item of the story might mean to the patient. Hence, the hypnotist’s voice in administering that complex to the patient would carry a load of meaningful intonations, inflections, emphases, and pauses, all of which, as common daily experience constantly proves, so often convey more than spoken words.

Essentially, the task, as worked out, was comparable to that of composing music intended to produce a certain effect upon the listener. Words and ideas, rather than notes of music, were employed in selected sequences, patterns, rhythms, and other relationships, and by this composition it was hoped to evoke profound responses in the subject. These responses were to be of a type not only hoped for in terms of what the story could mean but which would be in accord with the established patterns of behavior deriving from the patient’s experiential past.
How well this was done, aside from the experimental results secured, is a matter for speculation. No proof can be offered that the explanation of the complex offered is correct, or that someone else, using the same words, could not construct an entirely different explanation. Proof, if there is to be any, can only be inferential at the best. However, continued experience with the greater effectiveness of hypnotic suggestions carefully calculated as to structure, as contrasted to the lesser effectiveness of spontaneous suggestions primarily concerned with an obvious content, indicates that this initial effort at an analysis of an interpersonal communication of a particular type is warranted.

One additional preliminary to the presentation of the explanation of the complex relates to the actual process of composing the story. During a period of several weeks the story was rewritten in various wordings many times before it seemed to be satisfactory. Two colleagues read and discussed the proposed complex story and contributed a number of helpful suggestions for the final wording of it. Other colleagues contributed unwittingly by discussing, upon request, the meaningfulness of sentences worded in slightly different ways. Also, items of fact relating to the patient, such as his attitudes toward his parents, conversational clichés, patterns of behavior, and actual experiences, were all kept in mind and worked directly or indirectly into the story at every opportunity so that it might have a special and unique appeal for the patient.

As a method of presenting the explanation, the story as devised will be given in the first column of Table 1 and the explanation, logic, intended significances, hoped-for reactions and responses will be given in the second column in the form of comments. These are listed as they were formulated for the final draft of the complex. No attempt will be made to show preliminary or partial formulations as they were worked out from one draft to the next. Finally, the reader must bear in mind that these explanatory remarks constitute only pre-experimental formulations of what the complex might possibly mean to the subject and that hence they are not necessarily to be taken at face value. They constitute simply a Pre-experimental effort to determine the possible meanings of an intended specific interpersonal communication in a special situation. In a few instances it was possible to confirm the validity of a number of these comments post-experimentally, but for the most part such confirmation was not actually feasible aside from also being precluded by the experimental situation.

Table 1

<table>
<thead>
<tr>
<th>The Complex</th>
<th>Explanatory Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>“Now” relates to the present, the immediate, circumscribed, highly limited present; it will not bear upon the past nor upon the future; it is safe, secure.</td>
</tr>
<tr>
<td>as you</td>
<td>“You” is a soft word; the subject is introduced gently.</td>
</tr>
<tr>
<td>The Complex</td>
<td>Explanatory Remarks</td>
</tr>
<tr>
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</tr>
<tr>
<td>continue</td>
<td>“Continue” is a most important word, since it carries on into the future, it contradicts “now,” which relates to the present, and it introduces an indefinite extension into the future. Hence, the subject unwittingly makes a change from the “now” situation into a continuing future situation.</td>
</tr>
<tr>
<td>to sleep</td>
<td>Thus he has the time situation changed and at the same moment is given a command to “continue to sleep,” a command based upon the past, including the present and extending into the remote future.</td>
</tr>
<tr>
<td>I’m</td>
<td>First-person pronoun, which means that anything done is to be done by the hypnotist and that the subject can be safely passive.</td>
</tr>
<tr>
<td>going</td>
<td>“Going” carries on the future connotation of “continue,” but enlarges it by bringing both the hypnotist and the subject into the continuation into the future.</td>
</tr>
<tr>
<td>to recall</td>
<td>“Recall” signifies the past, and we are both going into the future, taking with us the past.</td>
</tr>
<tr>
<td>to your</td>
<td>Second-person pronoun, emphasizing that we are both going into the future and taking the past with us.</td>
</tr>
<tr>
<td>mind</td>
<td>“Mind” is a selected, important, most important part of him, a part of him related to the past.</td>
</tr>
<tr>
<td>an</td>
<td>“An” means just one, a certain one, and yet is at the same time so indefinite.</td>
</tr>
<tr>
<td>event</td>
<td>“Event” is a specific word; just one event, “an event,” and yet, despite its seeming specificity, it is so general that one cannot seize upon it or resist or reject it or do anything but accept “an event.”</td>
</tr>
<tr>
<td>which occurred</td>
<td>“Occurred” is a narrative word; lots of things occur, especially minor things.</td>
</tr>
<tr>
<td>not</td>
<td>If the subject wishes to reject, deny, or contradict, the word “not” gives him full opportunity. He can seize upon it and attach to it all of his resistances to an acceptance of the story; it is literally a decoy word to attract his resistances. The sequences are “occurred not”—</td>
</tr>
<tr>
<td>The Complex</td>
<td>Explanatory Remarks</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><em>in</em> other words, “did not occur” — but, even <em>should</em> his resistances seize upon “not,” that decoy is legitimately snatched away by the next two words, and thus his resistances are mustered, mobilized, but left unattached and frustrated.</td>
<td></td>
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<tr>
<td><em>long ago.</em></td>
<td>Actually “not long ago,” —”not” now destroys itself as a negative word; it is positive in that sequence. Furthermore, it is highly specific, but in a vague, general way; when is “not long ago”? Yesterday? Last week? Also “not long ago” is real, since we do have a “not long ago” in our lives; thus a weight of truth is given which will radiate.</td>
</tr>
<tr>
<td><em>As I</em></td>
<td>First person again, assuming responsibility.</td>
</tr>
<tr>
<td><em>recount</em></td>
<td>Previously, I was going “to recall,” but in this phrase I immediately withdraw from that responsibility. Now I am only going to “recount,” and “recount” and “recall” are totally different words. Thus the responsibility for “recall,” which was the initial task, is rejected by the hypnotist, who assumes the responsibility only for recounting. Therefore, if the hypnotist recounts, the subject is thereby compelled to recall. Indeed, if the hypnotist can recount, and there can be no doubt about that, then the subject can, actually can, recall; a sophistical but indisputable establishment of the truth of the story to be told.</td>
</tr>
<tr>
<td><em>this</em></td>
<td>“This,” like “an,” is a definitive word that cannot be disputed; and readiness to dispute or deny must be held in abeyance.</td>
</tr>
<tr>
<td><em>event</em></td>
<td>Again a specific word</td>
</tr>
<tr>
<td><em>to you,</em></td>
<td>Second person; first it was recalled to “your mind,” and now it is recount “to you,” that is, to him as a person. Thus he is introduced so that, in his passive acceptance of the recounting, he, as a person, can assume responsibility.</td>
</tr>
<tr>
<td><em>you will</em></td>
<td>The subject is called upon to act as a person and at the same time is given a command.</td>
</tr>
<tr>
<td><em>recall</em></td>
<td>“Recall” completes the shift of responsibility from first to second person, with a final allocation of responsibility for recounting and for</td>
</tr>
</tbody>
</table>
The Complex

to forget

Explanatory Remarks

recalling.

fully and completely These are distraction words since they attract attention not to the task, but to the size or quality of the task. Hence, he must first refuse to do it “fully and completely” before he can refuse to do the task at all, and if he refuses to do it “fully and completely,” he is by implication obligating himself to do it at least in part, until he goes through the process of refusing to do it in total. All this takes so much time that there is no opportunity to go through those mental processes permitting a logical rejection of the entire task. Additionally, if he still has resistances to the hypnotic situation, he can mobilize them against these distraction words.

everything “Everything” is really a threatening word; to tell everything is something one just does not do. So here is an opportunity to mobilize resistance, since, if he is to accept this story, his resistances must first be mobilized as a preliminary to a dispersion. Also, if he refuses to tell “everything,” he is thereby affirming that there is something to tell.

that happened. The command to tell “everything” is now seemingly qualified, since it is not “everything,” but just the bald facts of “what happened,” not the meanings or personal implications. Again there is an implication of other things.

You Second person, reemphasizing the subject’s role as someone involved.

have had good reason There is not only a “reason,” but a “good reason,” at that! We all like to think we have a “good reason”; it vindicates.

to forget Now the “good reason” becomes inexplicably transformed into a “bad” reason; “good” no longer is “good,” but is really a bad sort of thing; the kind of reason one likes to forget. Also, “to forget” explains the need “to recall,” and explains the recounting. But what does one forget? Bad things, especially!

this Explicit word, intended to reemphasize the feeling of specificity.
<table>
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<tbody>
<tr>
<td>occurrence,</td>
<td>“Occurred” was a narrative word, and now the word is “occurrence,” so often a euphemism applied to bad things one forgets.</td>
</tr>
<tr>
<td>but</td>
<td>“But” always prefaces unpleasant things; “let’s have no ‘buts’ about it,” is so common an expression.</td>
</tr>
<tr>
<td>as I recall it,</td>
<td>This phrasing is a reprieve, since the first person assumes the responsibility, but he who can assume responsibility can also assign it. Thus, indirectly, the dominance of the hypnotist is assured, and the next words lead to active work for the subject.</td>
</tr>
<tr>
<td>you will remember each and every detail fully.</td>
<td>More than recall is wanted. Previously, it was “you will recall”; now it is more “you will remember”; furthermore, “remember” is in itself a simple, direct, hypnotic suggestion, similar to the suggestion of “sleep” in the opening sentence. Also, what is to be remembered is “each and every detail,” so refusal to remember has to be directed to each detail, not the whole occurrence. Thus, “each” and “every” and “fully” are distraction words, directing refusal or rejection to a quality of performance.</td>
</tr>
<tr>
<td>Now</td>
<td>“Now” harks back to the first word of the first sentence, a word that could be fully accepted. Thus, utilization is made of that first attitude.</td>
</tr>
<tr>
<td>bear this in mind,</td>
<td>Mind” harks back to the first sentence again for a similar reason.</td>
</tr>
<tr>
<td>that while I repeat</td>
<td>“Repeat” is a word which relates to a factual experience in the past, one that really occurred and is known, since otherwise it could not be repeated by someone. Also, the role of the hypnotist is clearly defined and cannot be disputed.</td>
</tr>
<tr>
<td>what I know of this event,</td>
<td>“Repeat” and “know” affirm and establish the truth, but they give an avenue of escape, because the qualification of what “I know” implies that there may be much that “I” don’t know, and therefore something additional that he does know.</td>
</tr>
<tr>
<td>you will recall fully and completely</td>
<td>This phrasing harks back and reaffirms the original allocation of responsibility to “you.”</td>
</tr>
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</table>
original allocation of responsibility to “you.”
“Fully and completely” is again a repeated
distraction, reinforcing the previous use of those
words.

everything

That meaningful, even threatening word again.

just as it happened,

A qualification that limits and comforts since it
excludes possible personal implications and
meanings.

and more

Further threatening since “more,” what “more,”
is wanted.

than that,

Still carrying the threat.

you will

A hypnotic command carrying compulsion.

re-experience the various

The thing is now defined as conflicting and as
emotional, of which things he had a plenty, all
real and, above all, emotional.

conflicting emotions

which you had at the time

A specific but unidentified “time” in the past, but
a time related to “conflicting emotions.”

and you will feel

a hypnotic command that he is to feel, which
carries a threat since it follows “conflicting
emotions.”

exactly as you did while this

The thing is defined and outlined, his course of
occurrence was taking

action indicated to be a revivification, only that,
of a past experience—not a confession, just a re-

conflicting emotions

experiencing of something that took place.

Now

Harking back to the opening word, repeated later
for its acceptance values immediately after the
assignment of a task, and once again repeated
here at a similar point.

the particular event

“An event,” “an occurrence,” now becomes a
highly specific item.

of which I am going to tell you is

“I” can tell only what little “I know,” a casual
this:

statement, transitional in its use, reassuring in its

implications.

Some time ago

“Not long ago” redefined, but still vague and

elusive of contradiction.

you met a man

Indisputably true and acceptable.

prominent

We like to know “prominent” people, an initial

appeal to narcissism.
<table>
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<tbody>
<tr>
<td>in academic circles</td>
<td>A narrowing of the identification of the man, but safely so!</td>
</tr>
<tr>
<td>who manifested an interest in you</td>
<td>A strong appeal to narcissism.</td>
</tr>
<tr>
<td>and who was in a position</td>
<td>A tentative threat, because “position,” synonym of power, can be used favorably or unfavorably.</td>
</tr>
<tr>
<td>to aid you</td>
<td>Narcissism reinforced and reassured, but more than that, the subject now wants to know, to identify, the man, hence is open readily to suggestion.</td>
</tr>
</tbody>
</table>

in securing a certain research fellowship in which you were much interested. | Highly specific but not definitive. |

A true statement in that he was interested in a fellowship, actually any fellowship, but this statement offers no opportunity to take issue or dispute, since each item is progressively qualified, and each qualification requires dispute before the initial premise can be attacked, and his narcissism requires that he accept each time in the suggestions. Thus, resistance is dispersed. Additionally, the man is “interested,” the subject is “interested,” there is a common denominator, and the reality of the subject’s interest radiates to and substantiates the man’s interest.

He | A third person taking all responsibility. Therefore, the subject can listen receptively, since the story is about a third person. |

made an appointment with you | This is a disputable statement, hence is to be qualified in more and more detailed and specific fashion, thus to preclude any upsurge of resistance or rejection, and each little item to be added must have a cumulative effect that takes the subject ever farther from the essential point. |

to see him at his home | A qualification as to place. |
<p>| and on that day | A qualification as to a specific day that must be selected out of the past. |
| you called at the designated hour. | “Designated” is so specific, final, absolute, and yet so indefinite. |
| | A final specific qualification for the appointment, and it is most important to establish that appointment. Thus the subject is led to a home, to “that day,” to a “designated hour.” With such |</p>
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<td>detail not even a thought can flash obstructively in his mind, since the only measure open to him in the hypnotic situation is to reject a “designated hour” of a specific day at a home of an interested man who, narcissistically, he wanted. Thus, an idea has been offered, and its acceptance literally forced. Therefore, an opportunity to resist something about this rapidly growing story must be given him in return for being forced to accept some ideas.</td>
<td></td>
</tr>
<tr>
<td>When</td>
<td>A challenging word, anything can happen “when.”</td>
</tr>
<tr>
<td>you</td>
<td>Second-person active, giving opportunity for him to get set for action.</td>
</tr>
<tr>
<td>knocked at the door</td>
<td>A brief item of detail, momentarily obstructing action.</td>
</tr>
<tr>
<td>you were met</td>
<td>“You” is second-person passive—thus he is forced from the active to the passive role. “Were met” is a dogmatic declaration which is the opening for all resistance and rejection, an opportunity to interpolate from past experience, a wide-open door for dismissal of the entire story, and thus a chance for him to construct his own account.</td>
</tr>
<tr>
<td>not</td>
<td>A negative word, emphatically negative.</td>
</tr>
<tr>
<td>by this gentleman</td>
<td>Apparently, it is unnecessary to deny, reject, or dispute the story, since the hypnotist is doing that by the implications of “you were not met.” Thus, the subject’s resistances have been built up and then lulled into inaction, rendered futile by the negations employed.</td>
</tr>
<tr>
<td>but his wife</td>
<td>“But” used a second time, this time in close association with a woman to reinforce possible previous unpleasant associations, in a wife is a sexualized woman. Also, this is another disputable statement, but before he can remobilize his resistances, the to a situation is completely changed by the next words.</td>
</tr>
<tr>
<td>who greeted you cordially and was very friendly</td>
<td>A tremendous appeal is mad3e to his narcissism, already stimulated previously. Only lie to be treated cordially by a “prominent” man’s wife.</td>
</tr>
<tr>
<td>The Complex</td>
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<tr>
<td>making you feel</td>
<td>“Feel” means “respond emotionally,” a safe, secure situation for responding narcissism. Also, the word is a direct call for narcissistic response. At the same time there is given the simple direct hypnotic command of “you feel.”</td>
</tr>
<tr>
<td>that her husband had given a good account of you to her.</td>
<td>Full opportunity offered for unrestricted narcissism in a safe, secure fashion. All that has been told now rests upon secure foundation of narcissistic satisfactions. He needs this story.</td>
</tr>
<tr>
<td>She explained apologetically</td>
<td>An indirect attack upon his narcissism—is this gracious woman who flattered him now becoming apologetic? That must not be so because whatever that cordial woman does must be right, and he will make it so. Apologies and praise in that combination are not good.</td>
</tr>
<tr>
<td>that her husband had been called away</td>
<td>A faint, remote realization that he was alone with a woman who was a wife and hence a recognized sexual object.</td>
</tr>
<tr>
<td>for a few moments</td>
<td>A limitation of the danger, and hence he is safe, although alone with a woman.</td>
</tr>
<tr>
<td>but that he would return shortly, and had asked that you be made comfortable</td>
<td>“Shortly” is so specifically vague and reassuring. “You,” the person, introduced again.</td>
</tr>
<tr>
<td>in the library.</td>
<td>Gracious man, gracious woman, narcissistic satisfactions reinforced.</td>
</tr>
<tr>
<td>You accompanied her to this room where she introduced you to a charming girl</td>
<td>A distraction phrase. Yet, to be made comfortable by a lone woman in the safe confines of a library is like inviting a girl to meet you in the sitting room of your hotel suite—a faint suggestive implication.</td>
</tr>
<tr>
<td>Second-person active.</td>
<td>For him there can be no greater threat in all the world than a charming girl. A terrifying, threatening situation, loaded with tension firmly established by his past.</td>
</tr>
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<tr>
<td>who was obviously rather shy and reserved</td>
<td>The threat castrated, and he was master. Thus, his fears were aroused and immediately lessened.</td>
</tr>
<tr>
<td>and who, she explained,</td>
<td>First she explained apologetically and unacceptably, now she explains in relation to a threat will these displeasing explanations never end? A direct opportunity for relief of tension, directed against unnecessary social amenities conducted in such a terrifying situation, but serving to introduce another antagonism.</td>
</tr>
<tr>
<td>was their only daughter.</td>
<td>A very special kind of daughter, all the more threatening despite the castration. Thus, a useless, only temporary castration was performed, and while it did relieve his tension briefly, that tension has been revived and intensified.</td>
</tr>
<tr>
<td>The mother</td>
<td>An immediate shift from the threatening daughter to the displeasing mother, permitting his tension to increase.</td>
</tr>
<tr>
<td>then requested your permission</td>
<td>This cordial, gracious, apologetic woman led him into a trap; she was nice, and certainly he would do anything for her, especially since it would change the total situation by letting him deal with the mother and not the daughter.</td>
</tr>
<tr>
<td>to go about her work,</td>
<td>Work is a far cry from social pleasures, remote and distant, and thus she was removing herself far from him, leaving him alone with danger.</td>
</tr>
<tr>
<td>explaining</td>
<td>That unpleasant word again, first used to rob him of narcissistic pleasure, then to lead him into a danger situation. What now?</td>
</tr>
<tr>
<td>that the daughter</td>
<td>Special, precious, only daughter—charming girl. A peculiar threat, challenge, and danger all combined.</td>
</tr>
<tr>
<td>would be very happy to entertain you while you waited.</td>
<td>To be entertained by a charming girl with the mother’s connivance!</td>
</tr>
<tr>
<td>You assured</td>
<td>“Assured” carries connotations about risks and dangers.</td>
</tr>
</tbody>
</table>
The mother Who led you into a trap, a danger situation—opportunity for intense resentment and tension relief.

that you would be very comfortable “Comfortable” with a girl? Past history proves the mockery of that.

and even now Harking back to the first “now” and reutilizing its “present” values.

you can recall Harking back to the first use of “recall” and thus tying everything tightly together.

the glow of pleasure you experienced Harking back to “re-experience the various conflicting emotions.” If there were conflicting emotions, some were glows of pleasure, and now his situation is one of a conflict, of attractive and shy, of charming and only daughter, of mother coming and not staying and praising and apologizing, pleasure and unpleasure.

at the thought of having the daughter “Having the daughter,” possessing the charming girl-synonymous phrases.

as a hostess Dance-hall hostess? He had had hostesses before, and now there is given the suggestion that he have the “daughter as a hostess.”

as the mother left the room A distraction by shifting attention away from the immediate threat of the girl, and hence readily accepted even though it leaves him alone with his danger.

you set about conversing Second person introduced. “Set about” implies action, doing something. “Conversing” is a safe activity, but it is a euphemism, and what thinking one can do as he converses!

with the girl Alone with a dangerous girl brought to full realization.

and despite her shyness and bashfulness, Despite those qualities, what else? What danger threatens?

you soon found Continuation of the threat.

that she was What was she? An only daughter, a charming girl, a daughter as a hostess?

as attractive conversationally as she Safe, yet unsafe, physically pleasing, capable of
<table>
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<tr>
<td>was pleasing to the eye.</td>
<td>conversation, capable as a hostess.</td>
</tr>
<tr>
<td>You</td>
<td>Second person again.</td>
</tr>
<tr>
<td>soon learned</td>
<td>He had learned much about her, too much, and now what more was to be learned about this charming girl so pleasing to the eye?</td>
</tr>
<tr>
<td>that she was much interested in painting</td>
<td>Repetition of the word “interested.” In what could she, in this danger situation, be interested?</td>
</tr>
<tr>
<td>had attended art school, and was really profoundly interested in art</td>
<td>“Painting”? Painting the town red? A euphemism?</td>
</tr>
<tr>
<td>she</td>
<td>A shift from him to her.</td>
</tr>
<tr>
<td>timidly</td>
<td>A dangerous girl being timid? Girl-boy behavior, coy, luring behavior?</td>
</tr>
<tr>
<td>showed you some vases she had painted.</td>
<td>Presented to you.</td>
</tr>
<tr>
<td>A symbol innocuously introduced, and with the word “painted” establishing their common interest in doing something.</td>
<td></td>
</tr>
<tr>
<td>Finally</td>
<td>This is a threatening word. It establishes a moment surcharged with finality—a grand finale is about to be!</td>
</tr>
<tr>
<td>she showed you a delicate little glass dish which she had painted in a very artistic manner explaining that she had decorated it as an ashtray for her father, to be used</td>
<td>Previously, she timidly “showed,” but now where is that timidity? The situation has changed!</td>
</tr>
<tr>
<td>Fragile, precious thing, easily shattered by masculine strength, so like the girl.</td>
<td></td>
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<tr>
<td>Something on which she had lavished attention.</td>
<td></td>
</tr>
<tr>
<td>Lavished care in a special sort of way that he and she together could both appreciate.</td>
<td></td>
</tr>
<tr>
<td>That word of previously unsatisfactory connotations.</td>
<td></td>
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<tr>
<td>Charming girl, precious possession, father’s owner-ship and priority.</td>
<td></td>
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<tr>
<td>There is something in this danger situation to be</td>
<td></td>
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<td>------------------------------------------------</td>
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<tr>
<td>used!</td>
<td></td>
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<tr>
<td>more as an ornament</td>
<td>An ornament can decorate a pleasing body.</td>
</tr>
<tr>
<td>than as an actual ashtray.</td>
<td>It’s not an ashtray! It’s something different. Thus, the symbolic value is clearly established. It is just called an ashtray, but it is an ornament belonging to her and over which the father exercises some undetermined undefined authority.</td>
</tr>
<tr>
<td>You admired it</td>
<td>“It” was what she had; she was attractive, pleasing to the eye.</td>
</tr>
<tr>
<td>very greatly.</td>
<td>Redundant superlative! In other words a special significance is to be attached to this symbol, significance in relation to admiration in the presence of a physically attractive girl.</td>
</tr>
<tr>
<td>This mention</td>
<td>Some things are just “mentioned,” hinted at, not said in a forthright manner.</td>
</tr>
<tr>
<td>of using the dish as an ashtray</td>
<td>But it is not a “dish,” it is not a vase, it is not even an ashtray-it is just an ornament that belongs to her and to her father in a peculiar sort of way.</td>
</tr>
<tr>
<td>made you desirous</td>
<td>One wishes to smoke but becomes “desirous” in the presence of a pretty girl.</td>
</tr>
<tr>
<td>of smoking.</td>
<td>A euphemism, a safe, conventional way of giving expression to the feeling of being “desirous,” actually a pattern of behavior taken out of his past, since smoking was used by him in his problem situation as a distraction.</td>
</tr>
<tr>
<td>Because of her youth</td>
<td>Not “youth” really, though she was fresh and pretty and youthful, but something that “youth” connoted, something not to be expressed.</td>
</tr>
<tr>
<td>you hesitated</td>
<td>One may eye an attractive girl and be “desirous” and “hesitate.” Thus, a sexual motif becomes more evident. Besides, one does not hesitate to smoke in the presence of youth.</td>
</tr>
<tr>
<td>to give her a cigarette.</td>
<td>A symbolic ashtray, an ornament belonging to her in which both she and he were “interested” in a special way, with a father lurking in the background. The words “desirous,” “smoking,” “youth,” “hesitate” all constitute a background for a symbolic cigarette that fits a symbolic</td>
</tr>
<tr>
<td><strong>The Complex</strong></td>
<td><strong>Explanatory Remarks</strong></td>
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<tr>
<td>Also,</td>
<td>There is something else left unsaid as yet, an implication repeatedly established by transitional words.</td>
</tr>
<tr>
<td>you did not know how her father might feel about such things and yet you wanted to observe the courtesies of smoking</td>
<td>Father lurking in the background reinforced. What are “such things” in the presence of a youthful girl that might arouse a father’s ire? A long history of “wanting,” “wanting” in the presence of every pretty girl A euphemism, since what else can be said?</td>
</tr>
<tr>
<td>As you debated this problem you became increasingly impatient.</td>
<td>One does not debate about smoking, one debates for deep reasons, one strives against and tries to controvert the forces against him in a debate. He had a “problem,” a most troublesome problem in relation to girls, and he is “debating” a “problem” in a girl’s presence. Not over smoking does one become “increasingly impatient,” but only over vital problems.</td>
</tr>
<tr>
<td>The girl did not offer you a cigarette and thus solve your problem and you kept wishing that you might offer her a cigarette.</td>
<td>“The girl” follows “increasingly impatient,” and by that juxtaposition a relationship is established between “the girl” and the feelings described. She failed him like all other girls he had known, equating her with those other girls who did not solve his “problem.” “Wishing” just “wishing” in direct connection with a girl who had failed to solve his “problem,” an old, old story for him. If only he “might,” really “could” do something. “They satisfy,” was one of his clichés, and he did want satisfaction. The conventional and the sexual motifs intermingled—satisfaction in relation to a girl, a symbolic ashtray, being “desirous” and his “problem.”</td>
</tr>
<tr>
<td>Finally in desperation</td>
<td>Another final moment, with implications of other things. Strong, bitter, frustrated emotions constitute desperation, and it does not derive from being</td>
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</table>
you asked her permission to smoke, which she granted very readily, and you took a cigarette but did not offer her one. As you smoked you looked about for an ashtray and the girl, noticing your glance, urged you to use the ashtray she had designed for her father.

Hesitantly you did so and began talking on various topics. As you talked you became aware of a rapidly mounting impatience.

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The Complex

you asked her permission deprived of a cigarette.

to smoke, A long history of smoking in his “problem” situation to cover up and conceal his disability.

which she granted very readily, A permissive, willing girl, readily granting favors—another item taken out of his past history.

and you took a cigarette That was all he could do, and which he had so often done in the past.

but did not offer her one. She had no pleasure, she was unsatisfied. Past history still being utilized.

As you smoked He couldn’t do anything else, as be bad proved many times.

you looked about for an ashtray and the girl, noticing your glance, Did she notice? Did all those girls of the past notice your glance, your look? “For an ashtray and the girl,” making them in this juxtaposition a single object to be looked for. Also, another cliché was “ashes hauled.”

urged Not only permissive, but urgent, active, aggressive.

you to use the ashtray she had designed An “ashtray she bad designed” for what’? She bad only decorated it for father.

for her father. Father’s special thing, unused by him and not, intended for his use, but only an ornament over which be exercises an undefined authority.

Hesitantly Again he “hesitates,” but more than that, the word “hesitantly” implies insecurity, uncertainty, even fears.

you did so “Hesitantly, you did so—in other words, disposed of “ashes” in a forbidden object.

and began talking on various topics. A technique of self-distraction and of distraction for the girl often employed in the past.

As you talked you became aware of a rapidly mounting impatience “Mounting” is a word he often used with special significance. He was always “impatient to mount” before “something happened” that meant the end of the attempt to succeed. Incongruous words!
The Complex

for her father’s return.

Shortly you became so impatient

that you could not enjoy smoking any longer,

and so great was you impatience and distress

that instead of carefully putting out your cigarette and then dropping it in the ashtray, you simply dropped the lighted cigarette into the ashtray and continued to converse with the girl.

The girl apparently took no notice of the act

but after a few minutes you suddenly heard a loud crack,

and you immediately realized that the cigarette you had dropped into the ashtray had continued burning and had heated the glass unevenly, with the result that it had cracked in pieces.

You felt very badly about this, but the girl very kindly and generously insisted that it was a matter of small moment

Explanatory Remarks

“What choice is there between “father

This only another “impatient” situation, thereby it is equated with other “impatient” situation.

Past history repeated. Was that why the slogan “they satisfy” was his cliché?

‘Those words can describe only something more vital than smoking. They are pertinent to past experiences.

‘The whole performance was of no value—it was futile, useless, hopeless, fraught with distressing emotion. “lighted cigarette” and ashes just dropped futilely.

Past history, in that he could only conclude by conversing with the girl.

“Apparently” carries a weight of hope.

There are acts, and then there is “the act,” and this was an act that preceded his despairing resignation to mere conversation with a girl, a girl who “took no notice,” a parallel of many previous instances.

“‘The crack that never heals” was a paraphrase from a song often employed by him to vent sadistic reactions.

He had often bitterly described his repeated efforts and failures on a single occasion as an attempt “to take a crack in pieces.”

Redundancy, strained superlative to carry extreme emotional weight.

“This” is one thing, “the girl” is another—juxtaposition of two items that are to be equated.

Permissive, granting, urgent, now maternally kind and forgiving—copies from past experience.

An unnamed “it.”

Past history again, carrying the same load of bitter ironic significance. What he did was of “small moment.”
<table>
<thead>
<tr>
<th><strong>The Complex</strong></th>
<th><strong>Explanatory Remarks</strong></th>
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<tbody>
<tr>
<td>that she had not yet given the ashtray to her father</td>
<td>Further ironic truth.</td>
</tr>
<tr>
<td>that he would not know anything about it and that he would not be disappointed.</td>
<td>“Not anything,” a secret was to be dept, a guilty secret. Still an unnamed “it.”</td>
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<tr>
<td>Nevertheless, you felt exceedingly guilty about your carelessness in breaking the ashtray and you wondered about how her father would feel about it if he ever learned of it.</td>
<td>“Nevertheless” implies the existence of certain other facts. Fitting words, but not for the superficial content.</td>
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<td>Your concern was plainly evident, and when the mother came into the room you tried to explain, but she graciously reassured you and told you that it really did not matter.</td>
<td>A seriously tense situation does not warrant such a mild word as “disappointed.” “Disappointed” is a euphemism and at the same time signifies that the situation warrants the mockery implied by “small moment.”</td>
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<tr>
<td>However, you felt most uncomfortable about it, and it seemed to you that the girl felt badly too.</td>
<td>A euphemism, since exceeding guilt does not attach to an ashtray. How many times had he “wondered” in similarly emotionally charged situations? Man of power, authority, prior rights.</td>
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<td></td>
<td>Not think about “fee,” since this was a matter for profound emotion.</td>
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<td></td>
<td>“Ever learned” — a continuing threat implied.</td>
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<td></td>
<td>How many times in the past had his concern been evident?</td>
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<td></td>
<td>Maternal retribution, forgiveness, or what?</td>
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<td></td>
<td>You really did try, you’ve always tried, but it always ends the same old way.</td>
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<td></td>
<td>Forgiveness, not retribution, always forgiveness as in the past.</td>
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<td></td>
<td>“Small moment” ironically brought home by the one who should be most bitter.</td>
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<td></td>
<td>A conventional way of saying something too vital to be put into words.</td>
</tr>
<tr>
<td></td>
<td>Like other unsatisfied girls who masked their disappointment by maternal behavior, who did not reveal that they had been “badly” used.</td>
</tr>
</tbody>
</table>
The Complex

Shortly after this a telephone call was received from the father stating that he was called away for the rest of the day and asking your permission to see you on a later day.

You left the house very gladly, feeling most wretched about the whole situation and realizing at the time that there was nothing you could really do about it.

Now after you are awakened, this whole situation will be on your mind. You will not consciously know what it is but nevertheless, it will be on your mind, it will worry you and govern your actions and your speech although you will not be aware that it is doing so.

I have just told you of a recent experience of yours, and as I recounted it to you, you recalled it in detail, realizing the whole time that I gave you a fairly accurate account of the situation, that I gave the essential story.

After you awaken, the whole situation will be on your mind, but

Explanatory Remarks

not reveal that they had been “badly” used.

A reprieve, a postponement.

“You permission,” when he has been wronged and violated in relation to his only daughter. The whole situation now radiates beyond the room, reaches out into the fabric of the social situation, the educational situation, infringes upon and enters into everything, and continues to a “later day.” Hence, it is not ended yet, but reaches indefinitely into the future.

That was all it was, a “whole situation.” A pun upon another cliché he employed when distressed about his disability.

A final, despairing repetition of the teachings of the past.

The original “now” situation continuing into the immediate future with the repetition of the word “now” reestablishing the original receptive attitude.

Pun repeated in relation to the immediate future. Hypnotic suggestion, with careful emphasis upon the second-person pronoun.

A brief summary of first- and second-person activities with allocation of responsibilities and definition of roles reiterated.

A final shifting of all action upon the second person and repetition of hypnotic suggestions.
The Complex
you will not be conscious of what it is, you will not even be aware of what it might be, but it will worry you and it will govern your speech and your actions.

Do you understand?

Explanatory Remarks
person and repetition of hypnotic suggestions.

A final command, request, and plea that in itself signifies that there is much to be understood.

CONCLUDING DISCUSSION
That all of this labor was warranted in devising a complex is, at first thought, questionable. Previous experience (Huston et al, 1934) had disclosed that complexes could be devised easily which would exert significant influences upon the behavior of hypnotic subjects. However, such influences were found to be uncertain, unreliable, and unpredictable. Additionally, that same investigation, as well as other experimental work had shown that hypnotic subjects could reject complexes for even minor reasons or mere whims.

In this particular experiment, however, the total situation made heavy demands. Not only was the subject to accept the complex and to have his behavior influenced by it, but he was also to be induced to develop an artificial neurosis which would in some way parallel his actual neurosis. Thus, the experimental situation required of the subject a highly specific type of behavioral reactions, determinable only by the personality structure of the patient, and which would be expressive of responses at a symbolic level to the implications rather than to the actual content of the story.

Just what forms such responsive symbolic behavior would take was entirely a matter of speculation. For example, phobic reactions about smoking were anticipated, but it was not realized these phobic reactions would lead to a ready acceptance of a cigarette for smoking and then result in a fearful dusting of the ashes into his trousers’ cuff, with a subsequent spontaneous equating of this specific behavior with the consequences of a premature ejaculation. Such symbolic equating of two different types of behavior in relation to his trousers can be explained only in terms of the intended special meanings of the complex story, and hence, the results suggest that, at least in this type of interpersonal communication, the method by which a story is told may be even more important than its content.
IV. Hypnotherapy with Psychotics

One of the enduring misconceptions about therapeutic hypnosis is that it is either dangerous or ineffective with patients experiencing a psychotic episode. Certainly there are special dangers and difficulties in applying any therapeutic approach with psychosis because we still know so little about it. Therapeutic hypnosis and psychotherapy can be useful with psychotics, however, when they are applied with sensibility.

The cases in this section come from an early period of Erickson's career. Like much of his later work, they involve exploratory-clinical approaches. The major problem, as in all therapeutic approaches with psychotics, was in securing attention and rapport with the patient. This is particularly evident and is described in detail in the first case of Laskarri, where Erickson uses some traditional approaches in an innovative manner. There are some interesting similarities between this early case and the case of Edward (see "Hypnosis: Its renascence as a treatment modality" in section one of volume two of this series). Both men were catatonics, and both manifested superficially similar ward behavior. But their educational levels and family structures were different. Both were able to work out their essential inner life problem by dreaming it over and over again under hypnosis with a different set of characters and situations that gradually provided growing insight that led to an eventual resolution of their psychotic process. There were clear examples of Erickson's prescient application of concept #6 (Dreaming and Creative Neural Replay), #7 (Memory trace reactivation and reconstruction), and #8 (Creative Replay and Reconstruction on the Molecular-Genomic Level) outlined in the Editor's Neuroscience Edition Preface of this volume.

Dr. Jeffrey Zeig provides a particularly interesting theoretical analysis of Erickson's work in his presentation of the second case in this section. This analysis in terms of "symptom prescription" is another way of understanding Erickson's utilization approach, which is found to be as useful with psychotics as it is with any other diagnostic category of patients.
Hypnotherapy with a Psychotic

Milton H. Erickson and Ernest L. Rossi

Unpublished manuscript, circa 1940s, edited by E. L. Rossi

Laskarri had been diagnosed on the psychiatric ward as suffering from schizophrenia of the mixed catatonic-hebephrenic type. He was moderately disturbed in his behavior; several times a day he would shout gibberish apparently at hallucinatory figures and race back and forth and around and about the dormitory beds or scramble frantically under and over them. Or in the dayroom comparable behavior might be manifested in relation to the chairs and tables. Otherwise, he merely mumbled and muttered when questioned, despite the fact that he had a college education. Another item of great interest was his alert, intelligent gaze when not disturbed emotionally. He seemed to be intently studying his fellow patients and the interpersonal relationships between patients and the nursing and medical personnel. Yet when approached directly, his interest seemed to vanish and his gaze became veiled.

INDIRECT TRANCE INDUCTION

Made curious by “this” Laskarri’s behavior, the writer approached a passively obedient, rather stuporous patient and maneuvered him into a chair nearby so that Laskarri would have a full view of him. The writer then took a chair slightly to one side so that his primary view was of the stuporous patient but his secondary, somewhat sidelong glance permitted an adequate view of Laskarri. In effecting this seating arrangement the writer spoke earnestly and intensely to the unresponsive stuporous patient, but was well aware of Laskarri’s intent observations. The writer then gave the stuporous patient a series of suggestions to induce attentiveness, relaxation, a state of restfulness, a state of attentive sleep, restful sleep during which one might hear, understand, wish to respond, to communicate, to tell things of interest, to need to tell one’s thoughts and feelings, to express one’s need to ask for help, to do so comfortably even while asleep and without fear.

Previous experimentation with the mildly stuporous patient, who tended to stand about immobile with a vacuous expression in his eyes, had disclosed that he would, if seated in a chair, loll comfortably and seemingly go to sleep. No interpersonal contact had yet been made with him, but he could be used as a suggestive example for Laskarri.

Peripheral vision and sidelong glances soon disclosed that Laskarri, as is common among normal people, was responding to the suggestions he apparently thought were addressed to the subject. Shortly Laskarri gave every appearance of being in a trance, and he manifested catalepsy upon being tested. Slowly the tempo of the hypnotic “sleep” suggestions was decreased, and there was a gradual replacement of them by increasingly urgent suggestions that sometime, somewhere, somehow, courage be found to tell a little,
just a little about what happens when you run, you twist, you turn, you crawl over, crawl under, run, twist, shout, sometime soon, somehow, must some way ... will ... must ... can ... must ... tell what happens when crawl, run, rush, shout, go over, go under.

These suggestions were repeated many times—softly, gently, insistently, urgently—and they were followed with cautious slowness, “... and head will nod, nod, nod, yes ... yes ... yes ... yes ... slowly nod yes ... slowly ... will do ... will do soon.”

Shortly Laskarri’s head nodded “yes” gently, perseveratively, and further suggestion was offered that he sleep restfully for a while, since he might want to say something that afternoon. The afternoon of that same day the writer slowly made ward rounds, finally seating himself in a chair beside Laskarri and waited patiently. Within 20 minutes Laskarri leaned over slightly and murmured, “Big Joe—you—put Joe asleep—put him asleep—different way.”

What Laskarri meant was readily recognized. Some 10 days previously Big Joe, six feet five inches tall and 275 pounds, had become increasingly restless and had announced finally, in the writer’s presence, his intention of “singing and yelling for about an hour” and then “smashing the ward and everybody in it.” There had been previous such experience with him. Immediately the writer secured a syringe with 15 grains of sterile intravenous solution of sodium amytal and took a seat in front of Big Joe’s chair. Suspiciously Big Joe inquired if an intravenous injection was planned. He was told that none was planned, but that if he were to sing and yell for about an hour, his mouth would get dry, but the writer could squeeze a small stream into his mouth without interrupting his singing and yelling and his mouth would not get dry and sore. Big Joe nodded his head agreeably, tipped his head back, and began his bellowing. Little by little the sodium amytal was squirted into Joe’s mouth. He swallowed it as he sang and soon lapsed into sleep.

Having thus oriented the writer to his needs, Laskarri’s requests now became more personally meaningful. The writer moved his chair closer and Laskarri said, “Sleep—I dream awful dreams—you help.” Suggestions of hypnotic sleep were offered, and soon Laskarri was in a trance. He replied to questions of what he should do by answering, “Just let me sleep here in chair—awful dream—hurt—hurt.” Taking a chance, I told him, “Sit here in chair, don’t move, don’t wake up, just don’t hurt—just dream awful dream and then tell me.”

He seized my wrist, shuddered, perspired, and kept on shuddering and moaning. After some 15 minutes he aroused, stating, “My dream—I had it—I got to keep dreaming until I find out.” What it was he had to find out he could not tell. But the next day he could tell the content of the dream, and he begged for further help because he must dream until he found an answer. The content of the dream was that he was being forced, shoved, pulled, yanked, twisted, and thrown through an endless, lightless corridor crowded and filled with bramble bushes, thorny bushes, crucifixion thorns, barbed wire, jagged spikes, long, penetrating slivers of glass, swords, daggers, all manner of painful lacerating, cutting things—a journey that would come to a sudden end with the knowledge that again
he would have to traverse that painful way until he “found it.” Though approached many times, Laskarri never had revealed anything verbally to any of the hospital personnel. [MHA’s original manuscript was left in an incomplete form at this point. Questioning by Ernest Rossi completed the case history in 1978]

R: What was the next step of your therapy with Laskarri?

E: The next dream was of a similar character. I then told him to dream the same dream again with a different set of characters. In his next dream, instead of bramble bushes, he found himself dealing with a net full of fishhooks.

R: This variation of the dream indicated that his unconscious was receiving your suggestions and that he had enough control within his inner processes to actually modify them in accordance with your suggestions.

E: He repeated that dream with a number of people in it. He did not know who they were or even their sex, but they were fishing. Somehow or other they would snag him in that net full of fishhooks. In the next dream it was the same situation with another cast of characters on a grassy bank of a river with four people there all fishing. Three of them (two women and a man) kept catching him with their fishhooks. The fourth person, a man, caught a fish. He then fried this fish, and it smelled good.

The final dream was of an older brother of his who protected him; he was the one who caught and fried the fish that smelled so good in the previous dream. The other three people who caught Laskarri were his mother, father, and sister. These three were the hurtful people in his earlier life.

R: Did you interpret that dream to him?

E: No, he interpreted it to me! He said he could never get along with his father, mother, or sister, but he could get along with his brother, who always did good things for him. Then we discussed what he ought to do when he left the hospital.

R: Most of his personality was intact; he just needed this insight. The bad dreams of the dark corridor with sharp cutting things were symbolic of the hurt arising from his early family situation. Do you agree that insight was the curative factor in this case? This was a case where the unconscious did have to be made conscious, as Freud believed.

E: Yes. Familiarity breeds contempt. When you go through a painful situation again and again in a dream, changing it a bit each time, it becomes less painful.

R: Yes, that is the desensitization technique of behavior therapy.

E: I got into a lot of trouble over that case. The staff said I had no right to engage in the “unethical and unprofessional act” of sedating Big Joe that way while he was singing.
R: But that act not only protected the ward, it also helped Laskarri gain a positive transference to you as that protective older brother.

E: When he saw the difficulty I got into with the nurses and doctors over my undignified way of sedating Big Joe, that also helped him sympathize and establish rapport with me. The hospital staff did not realize I was actually carrying out Laskarri’s first request to put Big Joe asleep in a “different way.”
Symptom Prescription for Expanding the Psychotic’s World View

Milton H. Erickson and Jeffrey Zeig

This paper is a portion of “Symptom Prescription and Ericksonian Principles of Hypnosis and Psychotherapy” presented by Jeffrey Zeig, Ph.D., to the 20th Annual Scientific Meeting of the American Society of Clinical Hypnosis, October 20, 1977, Atlanta, Georgia.

This example is from my initial meeting with Milton Erickson in 1973. It is the first case that Erickson discussed with me in explaining his therapeutic approach. The case description contains some of Erickson’s own rationale for his technique, and is quoted directly:

E: Concerning psychotherapy, most therapists overlook a basic consideration. Man is characterized not only by mobility but by cognition and by emotion, and man defends his intellect emotionally. No two people necessarily have the same ideas, but all people will defend their ideas whether they are psychotically based or culturally based, or nationally based or personally based. When you understand how man really defends his intellectual ideas and how emotional he gets about it, you should realize that the first thing in psychotherapy is not to try to compel him to change his ideation; rather, you go along with it and change it in a gradual fashion and create situations wherein he himself willingly changes his thinking. I think my first real experiment in psychotherapy occurred in 1930. A patient in Worcester State Hospital, in Massachusetts, demanded he be locked in his room, and he spent his time anxiously and fearfully winding string around the bars of the window of the room. He knew his enemies were going to come in and kill him, and the window was the only opening. The thick iron bars seemed to him to be too weak, so he reinforced them with string. I went into the room and helped him reinforce the iron bars with string. In doing so, I discovered that there were cracks in the floor and suggested that those cracks ought to be stuffed with newspaper so that there was no possibility (of his enemies getting him), and then I discovered cracks around the door that should be stuffed with newspaper, and gradually I got him to realize that the room was only one of a number of rooms on the ward, and to accept the attendants as a part of his defense against his enemies; and then the hospital itself as a part of his defense against his enemies; and then the Board of Mental Health of Massachusetts as part, and then the police system—the governor. And then I spread it to adjoining states and finally I made the United States a part of his defense system; this enabled him to dispense with the locked door because he had so many other lines of defense. I didn’t try to correct his psychotic idea that his enemies would kill him. I merely pointed out that he had an endless number of defenders. The result was: the patient was able to accept ground privileges and wander around the grounds safely. He ceased his frantic endeavors. He worked in the hospital shops and was much less of a problem.
There is a discernible pattern to Erickson’s series of interventions. A comparable pattern can be seen in many of Erickson’s cases (cf. Haley, 1973). This pattern can be divided into three major elements, which occur in the following sequence: (1) meeting the patient where the patient is; (2) establishing small modifications that are consistent with, and follow from, the patient’s behavior and understandings; and (3) eliciting behaviors and understandings from the patient in a manner that allows the patient to initiate change. These elements are discussed below in relation to the case that Erickson describes.

Initially, Erickson meets the patient where the patient is. In an “anxious and fearful” manner the patient has demanded protection. By assisting the patient in the process of reinforcing the iron bars with string, Erickson provides protection in a manner that is consistent with the patient’s frame of reference and indirectly communicates a number of powerful messages. For example, he implicitly establishes a high degree of empathic rapport. The patient is given the opportunity to experimentally understand that Erickson really realizes his dilemma. (The importance of empathy in the psychotherapeutic process has been addressed by researchers [e.g., Carkhuff & Berenson, 1967]. Such researchers have traditionally emphasized the importance of overt and verbal empathic responses on the part of the therapist.) Erickson incorporates a style of using indirection to demonstrate empathic rapport to the patient.

In assisting the patient in reinforcing the bars with string, Erickson enters the metaphor that the patient is living, thereby showing the patient that he respects the patient’s integrity and behavior. There is no attempt to interpret the patient’s delusion or force him to change his behavior immediately. Rather, Erickson goes along with the patient and thereby begins the therapy on the patient’s level of behavior and understanding. If such an initial intervention were made in a sarcastic manner, or from a frame of reference of trying to trick the patient out of his symptom, the positive outcome would be limited. An attitude of empathy and respect on the part of the therapist is crucial to ensure successful change.

After meeting the patient at his level, Erickson makes use of the patient’s psychotically based behavior to increase rapport and establish a base for future change. Erickson begins a process of making modifications (finding the cracks in the floor and door) that are in accord with the patient’s view of the situation (i.e., the need to protect himself from his enemies). Erickson even seems to immerse the patient more deeply in his psychotic understandings by pointing out the other possible weaknesses in his defense (e.g., the cracks in the floor). However, this maneuver has a paradoxical effect, because by pointing out weaknesses in the patient’s attempts to defend himself, Erickson becomes an undeniable defender. He then builds on this small change and subtly aids in the transfer of the protector role to other persons and institutions, until the patient himself can come to the conclusion that he is safe. Moreover, the modifications that Erickson makes seem to have the effect of reframing institutions that the patient may once have feared by emphasizing their protective nature in a manner the patient can account and realize.
The establishment of small modifications by the therapist paves the way for future understandings on the part of the patient that can be oriented in a more positive direction. It can be assumed that most patients have some desire to function in a more effective and enjoyable manner. Through the use of the small modification technique, the patient can avail himself of his desire to function more effectively.

It can further be assumed that the patient has resources in his personal history that can be used to effect change. These resources (past learnings) can be elicited by the therapist in such a way that the patient can avail himself of them. Erickson does not have to teach this patient overtly how to behave in a nonparanoid manner. Rather, he can trust that the patient has years of experience with nonparanoid behavior, and that given the right circumstances, the patient can discover that he can again behave in a nonparanoid manner. In this way the cure is elicited from within the patient.

The initial process of psychotherapy with this patient was based on meeting the patient within his frame of reference and then establishing modifications that the patient could use to establish a new level of functioning. This process is akin to a dance in which one partner begins by synchronizing his steps to the steps of his partner and then (and only then) by beginning to take the initiative and lead.

Overall, the cornerstone of the therapeutic process with this patient is built around the symptom prescriptive approach. In a manner that is basically implicit the patient is encouraged to continue symptomatic behavior until, on the basis of new understandings promoted in part by the modification provided by the therapist, the patient changes his own behavior. While some therapists might engage in such therapeutic practices in a way that is based on trickery or coercion, that is not the case here. Rather, the patient is given the opportunity to recognize and change his behavior to a more constructive and less self-defeating pattern.