"The practice of psychotherapy should be interesting, appealing, and charming."
— MILTON H. ERICKSON, M.D.

NYSEPH NEWSLETTER

The New York Milton H. Erickson Society for Psychotherapy and Hypnosis
P.O. Box 1390 Madison Square Station, New York, NY 10159 (212) 696-1999

FEBRUARY 1988 **VOLUME 4 - NUMBER 1**

EDITOR'S NOTE

Milton Erickson taught us that language can heal or hurt, perhaps even kill or cure. Who in this world can teach that better than Kay Thompson?

We take pride in announcing that Kay Thompson, D.D.S. will join the faculty of our NYSEPH Training program and will begin Friday evening, March 4th to teach an advanced advanced course for NYSEPH students and graduates. This is in keeping with our commitment to excellence and to our belief that integrating Ericksonian hypnotherapeutic techniques takes consistent daily practice over a relatively long period of time. Learning a way of thinking that is attunement to process permeates everthing we do. It is the ongoing awareness of the interfacing of language, the sensory motor system and states of consciousness. This is the awareness of what Feldenkrais called "The Elusive Obvious."

Use of language is a particularly poignant topic for me at this moment. Recently my husband came down with pneumonia and spent seventeen days in the intensive care unit of a large New York City hospital. The initial comfort and security of the machines and monitors, the endless chartings and the split-second staff teamwork is soon counteracted by the absence of the human connection. That "special relationship" that Erickson spoke of, so important to the healing process is non-existent. There is constant time distortion, pattern interruption, confusion, as days and nights blend together, staff rotates, as lights stay on and people wordlessly with consumate depersonalized skill pierce one vein after another, braiding and unbraiding the bottles and IV's to the steady beep-beep-beeping of the monitors. Experiencing this I was reminded of Ritterman's vigorous and thoughtful exploration of the methods of torture so carefully designed to separate people from their sense of their own identity, their families, their connection with life. The torturers design it that way; we do it unintentionally, with little awareness.

For seventeen days he sat in bed facing a closet full of hospital supplies and a nursing station where harried nurses, students, and residents only had time to talk to him when he needed something, where he watched stretchers being wheeled in, and in one

Continued on page 3

INTERVIEW WITH MICHELLE RITTERMAN, Ph.D.

Michelle Ritterman *received her Ph.D. in clinical psychology from Temple University and completed her training at the Philadelphia Child Guidance Clinic. She began studying with Erickson in 1975 and has published numerous articles on the use of Ericksonian hypnotherapy techniques in family therapy. Dr. Ritterman authored* Using Hypnosis in Family Therapy, *the first comprehensive integration of Ericksonian hypnosis and family therapy, and she has also written on problems of forced exiles and victims of torture. This is the second part of the interview we did last year.*

MR: I think people can be entranced by any number of forces, not all of them positive. I think people can be influenced by their context to behave automatically in very destructive ways. Look at the paper called "The Inhumanity of Ordinary People," that Erickson wrote which reviewed the Milgrim studies where people without anything other than a laboratory context were willing to give very severe electric shocks to people that they saw in another room expressing increasing pain. They did so without any trance induction process or pressure to do so. There's good and evil in every person and there are good and evil trances as well. In other words, the trance state I see is a neutral state that can be occupied by anything.

JP: You mean it's like a space?

MR: I see it like a space that can get filled up by bad or good. It's not an inherently moral state: it's a state whose morality would have to be determined. Certainly there is morality to be attached to these states. Are people dissociated if they know that they're sending money to Latin America that's being used to kill

Continued on page 2

KAY THOMPSON, D.D.S.
Advanced NYSEPH Course
Spring 1988
DOROTHY LARKIN, M.A., R.N.
Nurses Hypnosis Training Course
Spring 1988
AMNON NADAV, M.A.
and DOROTHY LARKIN, M.A., R.N.
Physicians Hypnosis Training Course
Spring 1988

CONTENTS

MICHELLE RITTERMAN

(Continued from page 1)

people, or are they immoral? Were we dissociated when we bombed Viet Nam? Or did we know what we were doing but pretended we didn't? At what point does cutting off from a body of information, going into a certain state of mind, and getting on automatic pilot become another way of talking about being unethical, immoral and compassionless? There are all kinds of trance states. I think that one form of trance is a state people get into when they're operating on automatic pilot. What they do in that state, and the characteristic qualities of that state, are not necessarily benevolent.

Let's look at torturers. Torture is the reverse of psychotherapy, the reverse of healing hypnotherapy, the reverse of family therapy. It is a component of a cultural unit of a society in which terror is used on an administrative basis. It is the intentional effort to systematically and strategically break a person down to make his personality and body unrecognizable and uninhabitable. It's an unarguable case of social induction of symptoms.

The torturer goes through a very interesting training process which is designed to make his personality split, so that when he is being a torturer and in the mentality and context and setting and automatic behavior of a torturer, he's supposed to cut off from the other person he is with his family and his home. A lot of them are known in their community as being wonderful people, Then they go off and torture. What happens many times, however, is the family is very much poisoned by these individuals, because they can't always split so perfectly.

Franz Fanon, an Algerian psychiatrist, wrote about a case of a young girl who came to see him, whose father had been a torturer, and was highly regarded in the community. She came to see Fanon because she couldn't stop having auditory hallucinations of the screaming of people being tortured. She had inherited the moral pollution of the part of her father that the father cut himself off from.

JP: She gave expression to what he dissociated from.

MR: He was able to split off and be one thing in public and one thing in private. To me that's the ultimate madness.

JP: The ultimate dis-integration. How specifically did you pursue the idea of torture?

MR: Well, I realized that individuals who are labeled pathological were trying to find the best way to cope with contextual demands and to juggle those demands with their personal needs. Families don't exist in a vacuum either, so I asked myself what are they up against? It became evident to me that there are very few resources and support systems around to keep families together. Certainly it seems that most things militate toward the break-up of the family. I saw evidence everywhere of the social induction of symptoms. My colleagues didn't. I thought, "Well either I'm on to something or I'm off the wall. I might as well go check this out." I said, "Okay - where do you see society breaking individuals and families down for sure, and producing pathology? Where do you see that?" I said: "In torture, without question." So I said: "Okay, go study it". So I did.

I visited Salvadoran refugees in exile in Costa Rica, and then in Nicaragua. Then I visited Chileans in Chile in April. I talked to fifty political prisoners, all of whom had been tortured. Interestingly, the most refined torture methods are psychological, and the torturers have more of an understanding about people's problems, I think, than a lot of therapists do.

That is very sad, but true. I mean, we ought to get on the stick and understand what these torturers understand. They are taking healthy people and breaking them down. We, starting from a pathological model, so often have been at a great disadvantage because we've wasted our time. Instead of looking at what has gone into breaking this person down and reversing that process, we've been analyzing the pathology, which is useless.

JP: I think that analyzing pathology tends to compartmentalize, and the elusive process of the breaking down of the system is lost.

MR: Yes. And if you want to destroy people you've got to do things to them. You've got to do a whole lot to get somebody to have a symptom. Hence, people who have symptoms have had a lot of destructive things happen to them and/or they have learned destructive ways of interpreting things. They have got to find ways that they can get out of the symptom.

JP: What kinds of things do you think therapists could learn from torturers?

MR: They can learn that specific things have to be done to people for them to produce a symptom. We ought to look at what must have happened to this person. What goes into their making them be like that instead of looking at it as some kind of disease and illness in a pejorative diagnostic sense? We need a process diagnosis. What was done? How do you play this movie, and how would you play this movie in reverse? How do you help a person step out of this?

JP: What's a specific example of this kind of thinking?

MR: There's an Argentinian woman therapist, who, before the present government was in power, was handed a jar in which were the hands of her daughter who had been a pianist. The girl had been a political activist fighting for freedom and justice in Argentina. Not only did they torture the girl to death and cut off her hands as the symbol of her music, but they wanted to make sure to destroy the fabric of her family. So they gave the hands to the mother. They had to break up the positive flow of memories that the mother might have about the girl by making her have to see the hands now, making it difficult for her to ever be able to remember those hands playing the piano without being wretched. They understood the unconscious level at which the family needed to be broken up. They do that because they want to destroy the type of family that produced the type of mind in an individual that would resist a dictatorship. So you see, they understand the social level, the family level, and the individual, including the unconscious levels at which people operate. And they work on all of them; they work on all of them at the same time. Very few therapists do that. Yet what I think we're up against in most cases when we deal with the symptom is a three-level problem. We need to hit it on all three levels just like the maniacs in the world do.

JP: You mean the individual, the family and society - and that society in a sense is one big family.

MR: Absolutely. And that's what society used to be. Societies were kin systems, legal systems, and healing processes emerged as part of the very sinew and bone of this intact kin system. Now what we have is scattered and disorganized family units which are subject to a state power, whether it's a capitalist state or a communist state. We're subject to the government of the state, which is a cold, detached entity. It's not based on blood and blood bonds, and long-shared traditions and collective unconscious processes. It's a much more cold, detached, dissociated state that dominates over kin systems. So you can't look at kins and their efforts to deal with one another without looking at their society.

A lot of times various ethnic families like Italian and Jewish get labelled "enmeshed" in a negative sense. You have to understand the effort in the positive sense that these families are trying to make to keep together in the face of social disintegration - and state intrusion. You can become critical when a mother is intruding excessively in a symptomatic child's life, but you don't become critical without compassion for the cultural and social challenges they are trying to ward off.

I went to a prison in Chile where people are routinely tortured before they enter the so-called legal system, and the information collected during torture is used against them in the "legal process".

I remember an exceptional man who was sentenced to death and asked him how do you keep your mind? (He's not symptomatic at all, from what I can tell.) He said there are three things: He has the love of his family that keeps him going; he also has an idea in his mind that all the peoples of the world can have freedom and democracy, not just the people of the United States; third, people like you or me who bother to find out and care about other less fortunate people in the world. He's taken three ideas and built his mind around them. With such fortitude thus far he's been able to survive the electric shock torture to the genitals they do there. They're very scientific: they do it to the point of death. They call in doctors and therapists, by the way, to monitor the process.I interviewed a woman, also a political prisoner, who had just been psychologically tortured by a process which is the reverse of hypnosis. It's malevolent hypnosis and the use of drugs. They convinced her her children were dead by playing tapes when she

was drugged: they said what she was hearing was a shoot-out between the police and her children, and all her children were dead. They convinced her her mother was an agent of the torturing police, the CNI, the information police, they call them. Her children and her mother would come to see her and she didn't believe it was they. Afterwards it took her three months to have any idea that her children weren't dead and her mother wasn't an agent.

If you look at the way hypnotic suggestions work, they're only effective when the person is somehow receptive. All these torture techniques are designed to foster receptivity to negative suggestions. One of the ways that they do it is to humiliate; they strip people down, they threaten them. They'd have a hood over her head and someone would come in and would take her hand and stroke it and say "I'm your friend and I want to help you." Then after ten or twelve days getting her to be trusting, he took off her hood and she saw a needle which then went into her arm. Every time she felt trust they would elicit terror. They did it again and again and again. She said to me when I met her in the prison, "I have not been myself since I was tortured." That is the common position. Survivors of torture hold (not victims - the victims are dead,) - that they're not themselves. It's the opposite of hypnosis, which is to make you fully yourself, more fully and freely yourself.

By the way, the people who rehabilitate torture victims have been historically against hypnosis because they've said to me, "We're not interested in the domination of one mind by another," And I say: "Neither am I. Maybe if you think of what I do as the New Hypnosis, which is a wake-up-and-do-something-hypnosis, instead of sleep-and-be-sheep hypnosis, you'd understand that we're interested in the same business." The trick is that the survivor has to be completely in control of the process. I'll never ask someone to trust me over himself.

JP: So you're really exploring avenues beyond Erickson for hypnosis to be utilized.

MR: Yes I am, because I think we're all very much at risk of the totalitarian power of states, whatever the states are, wherever the states are. For example, on the Fourth of July I was invited to speak on a radio show. Whenever I said anything negative about what the United States is doing in the rest of the world, somebody called up and said, "But the Soviet Union..." and I'm sure in the Soviet Union there's... "But, in the United States." To me that is the kind of brainwashing, the kind of associative thinking I'm looking at. We have to wake up from the way the world is being defined - this East-West conflict. It's like a knee-jerk reflex. Once you have people imbued with this sort of atmosphere of us-them, anything about us has got to be qualified by the Soviet Union. It's no different than Erickson's having a cue name for a person when s/he is in trance that evokes trance: "Whenever I call you Billy you'll be asleep and you will remember this and that and the other..." All you need is that to get paired in people's minds, and they're off and running doing very stupid things that they wouldn't tolerate if they were awake.

JP: And not on automatic.

MR: And not on automatic. So that has a lot of implications for families and individuals and symptoms. I think we have to become aware of when we get entranced by social context. I think that that's a skill we've got to develop if the human race is going to survive. We've got to be able to wake up from social trances. If the human being can't do it, I think we're going to get wiped out.

JP: Erickson shifted the understanding of trance from an experience limited to only a few to a natural human activity that occurs in all of us. You are saying that in addition to being able to control bleeding or stop pain or create new patterns of thinking, people "do" trance as an unconscious collective experience, and that they have to become aware of their "doing" it.

MR: I'm saying, the individual's capacity to go into a trance state can be used or abused by others. Social systems can become imbued with the power to transform individuals and I think the main way they do that is unconscious. That's the level Reagan operates from. All I see is that he's a nice daddy; he wouldn't do anything wrong. I should just go to bed, go to sleep, and he's going to take care of Latin America and South Africa and anything ugly we do is because we have to.

JP: How do you think Erickson would react to this discussion?

MR: Erickson talked about the individual's right in the family. The individual has the right to self determination regardless of what other family members think. The family should operate in a democratic manner where everyone has the right to his own opinion. He said the terrorists in families and in the world are the people who decide that they have the right to determine how someone else should live, and that they in their moral and ethical superiority should dominate over other people.

I think, if I could have a good discussion with him, he could understand that governments can be terrorist too, and can hold people captive like the government of Pinochet. I think a dictatorship and state terrorism are equivalents on the social level of what torture is on the individual level. I think that we all have deep fears that this is the end of the world, and that we're not very much in control of that. High level officials like Haig are really willing to think about "winning a limited nuclear war." In fact they have all the structures arranged for that to happen. I'm interested in the use of hypnotic phenomena as a means of helping people become all they're capable of becoming, and I'm also interested in understanding that social circumstances create limits or break down limits to what people are capable of becoming. Think what a tragedy and travesty of all that humanity stands for, when scientists have to spend their lives doing research on torture and forced separation of families. What a waste! Scientists should be studying hypnotic blindness or the use of hallucinations in producing music.

Erickson so loved all the things we're capable of. He was able to foster the best in people. I'm interested in that too and I think it has to happen on a social level as well as the individual. I think therapists are among the best equipped, if they will only allow themselves to awaken from some neutral concept of what science is, to understand what circumstances would be best for a flowering of humanity instead of the terrible cultures of death that I have personally seen around the world.

"What is easiest to see is often overlooked."

Milton H. Erickson, M.D.

EDITORS NOTE

(Continued from page 1)

instance a body wheeled out. Doctors refer to "sundowning" or the "ICU psychosis" with a shrug of acceptance and resignation. The machine functions at top efficiency; the staff functions at top efficiency. Staff becomes machines - all with the best of intentions, all with consumate unconsciousness. Staff behaviour and communication reinforces the trances medication and fear of the unknown have already induced.

And language? A unit head said to me "He'll probably end up on a respirator"; a nursing supervisor used "wind up" instead of "end up". A resident in the ER said in front of the patient: "If he doesn't go to the ICU he might take a breath and die" - only a few examples of the continuous flow of what can be heard as hypnotic suggestions by patients who are already in an altered state.

In this issue the presentation of two nurse clinicians is a hopeful counter to these gloomy examples of the lack of awareness of the power of language in hospitals. In their presentation, part of which is excerpted in this issue, Dorothy Larkin, R.N. and Rothlyn P. Zahourek, R.N., M.S., C.S. describe how nurses can impact medical care by their sensitive and conscious communication.

With the introduction of Kay Thompson's utilization of language into our program we continue to grow and recommit to the rigor and vigor of the human connection that Milton Erickson generated.

Jane A. Parsons-Fein, CSW

The Incest Survivor, Ericksonian Hypnosis, and Progressive Retrieval of Emotions and Memories

On Tuesday, January 6, 1987, Marty Pollens, CSW, discussed utilization of Ericksonian hypnosis with incest survivors. Pollens is a Senior Faculty Member, Psychoanalytic Psychotherapy Study Center and in Private Practice.

Pollens began by describing the "clinical flags" that often identify incest survivors:

- The incest survivor blames him/herself for the attack.
- The incest survivor presents as a very isolated and extremely lonely individual.
- The incest survivor works (overtime)to protect the offending family member.
- The incest survivor will protect the technically non-offending parent — the mother.
- And, most significantly, the incest survivor most often has an almost total lack of recall of the traumatic incident.

The principal focus of Pollens' presentation was on the effectiveness of an Ericksonian hypnosis approach in lifting this almost total repression of memories and feelings surrounding the incest event.

The patient Pollens described did not know early childhood sexual abuse as one of her problems. In fact, he worked with this patient for nearly two years before the material emerged. In the initial phases of treatment the patient worked successfully on separation problems. However, her sense of confidence, self-worth and her deep anxieties often manifested themselves in sleeplessness and shaking which had not diminished. The patient suspected that there was something very powerful lurking in her unconscious that was creating severe symptomatology and originally suggested utilizing trance to "see what would come up." The patient had already developed a trusting "working alliance" with the therapist; she felt that he would "not be thrown" by anything that emerged in the trance.

In his discussion of the hypnotherapist's role, Pollens referred to Alice Miller's concept of the therapist as the " patient's advocate" who can identify with and empathize with the "child within." In this protective hypnotic "holding environment" the patient can explore the inner environment. The patient had an excellent talent for dissociative work, and almost immediately established a good hypnotic connection. Beginning with the first session, visual and auditory imagery emerged in historical sequence and so began the process of lifting the repression of this woman's early traumatic sexual abuse by her father. The patient reported that she felt like she was "reliving the experience." She had never imagined that it "had gone that far." The hypnosis sessions, which were emotionally exhausting for the patient, took place over a period of two years. For the first time in treatment, the severe shaking, trembling, and guilt that were characteristic of the patient's earlier behavior almost disappeared. Her ability to speak up and be more appropriately assertive increased exponentially.

Pollens indicated that diagnostically the patient was struggling with a "traumatic neurosis" such as Freud and Breuer described. The abreaction — the reliving of the event — and putting it into words was one aspect of the healing process. The hypnotherapist is not just a technical clinician providing an abreaction service. The hypnotherapist joins the patient in a profound therapeutic alliance that makes it possible for the patient to process out the pain and to integrate the bonding experience into the personality.

Later discussion by the professional audience in attendance corroborated almost total repression of memories of the incest event. When they do begin to emerge, the incest victim typically tends to question their authenticity and veracity. In a group experience, other patients find greater validity in the emerging memories than the patient who is reporting them. Pollens suggested that greater utilization of Ericksonian hypnosis in work with incest survivors would shed further light on the nature of the repression process.

Martin S. Pollens, C.S.W.

Application of Ericksonian Approaches in Health Care

by Dorothy Larkin, MA, R.N.
and Rorry Zahourek, R.N.,MS.,C.S.

On June 2, 1987, Dorothy Larkin and Rorry Zahourek gave a paper they presented at the Phoenix Congress. Dorothy is on the Faculty of Associate Trainers of Clinical Hypnosis, is Pain Management Consultant of Cabrini Hospice and in private practice. Rorry is Coordinator of Consultation and Education in Alcoholism at St. Vincent's Hospital and in private practice and she has edited two books: "Clinical Hypnosis and Therapeutic Suggestion in Nursing" *and* "Relaxation and Imagery: Tools for Therapeutic Communication and Intervention." *Following are excerpts from Dorothy's presentation on Emergency Room and Intensive Care practice. Many of these are printed in the aforementioned books to which Dorothy is contributing author.*

The essence of nursing is to help people heal, and hypnosis is a viable adjunctive tool. The word healing implies improvement at any level; the word "nursing" includes anyone who helps patients improve.

I first learned hypnosis in nursing school by sneaking into a semester course taught at the medical school eight years ago. Since then I've studied Ericksonian approaches and have applied the premises in my work as a nurse in burn centers, intensive and cardiac care units, a pediatric leukemic and bone marrow transplant unit, emergency rooms, labor and delivery, a pain management center, and more recently, hospice care for the terminally ill. Each of these areas provided ample opportunities to communicate therapeutically with patients who are stressed and in pain. What I have noticed is that every conversation I have with patients has some potential for reframing, or altering the way they view and experience their situation, and that when patients are more content, they are generally more compliant with their prescribed treatment. This makes my work easier. I have also noticed that nurses who utilize these approaches generally enjoy their job more. Nursing becomes more rewarding in the intellectual sense - each patient interaction becomes an opportunity to restructure therapeutic reality - so that patients' perceptions of their situation can be improved in some way.

Illness is a period of crisis; hospitalized patients are frequently already in a trance and ripe for utilization, especially in acute care situations, such as emergency rooms and labor and delivery. Other more long-term patients can learn to create their own trances, whenever they need to, whenever they want to, during whatever unpleasant treatment is inflicted on them.

Even if you choose to offer the Ericksonian approach of boring your patients into a trance, that too can be therapeutic. The new Lynch research indicates that when patients listen, high blood pressure subsides. I overheard an emergency room resident telling a patient that all his problems were related to stress, that there was nothing medicine could do for him, that if he continued experiencing this stress, it would kill him, and maybe he should go home and take a hot bath. After the resident left, I walked in and told the patient there are a variety of ways to reduce stress, and that if he would just lie on that stretcher, I would teach him a very quick technique. I spoke about a very basic relaxation technique combined with imagery of a special, peaceful environment and the ability to retrieve this experience whenever he needed or wanted it. His blood pressure reduced from 180/100 to 150/76. It was five minutes of professional intervention. Cost containment would support this.

The process of reframing, or changing the meaning of a situation, can be utilized daily. One example of reframing that I use quite often is when patients ask me for some pain medication. I say, "What, don't you have enough pain already? Wouldn't you prefer some comfort medication?" This generally confuses patients for a moment, alters their thought processes, and then redirects their attention toward comfort. It also frequently makes them laugh, which is another therapeutic response.

Another example of reframing was when a daughter of a hospice patient tearfully relayed how she felt she was a failure because her father had wanted to go home and had instead died in the hospital. I told her that when some of our patients say they want to go home, they actually mean they want to die. Her relief was obvious, both in her words and expression. She now had another interpretation of the experience.

Many times in nursing practice there isn't time for an extended hypnotic conversation with patients, especially in acute care situations, such as emergency rooms. These are when Erickson's principles, interspersed in daily conversations with patients, are particularly helpful. For example, when patients come to the ER, they are generally experiencing some degree of fear and anxiety. My initial assessment includes asking them why they came to the ER, and the, while taking their vital signs I tell them something about their body that is properly functioning. "Your pulse is a good rate - nice and steady," "You've got a very healthy blood pressure," or "That bleeding has been cleaning out that wound properly, so it can heal better." These comments are consistent with the utilization approach, in that they accept and utilize something the patient is experiencing. Additional suggestions to lead the patient can then be offered, for example: "And when you have this gown on with the opening to the back, you can sit here and be comfortable and the doctor will see you shortly." This suggestion includes the implied directive "when you put this gown on", the permissive "you can", and an interspersed direct suggestion, "sit here and be comfortable" . Patients that receive this simple type of introduction generally are more patient and compliant while they wait and continue to wait in the ER.

All drugs can be given with suggestions for their effective therapeutic action. For example, "Mr. Smith, this medication will help open up those blood vessels in your heart, so more oxygen will nourish the area, and you should begin to feel comfortable very soon." Therapeutic interventions can also be offered with suggestions, for example, "This neck brace will help remind you to keep your muscles relaxed and comfortable while they heal properly." Asthmatic patients frequently present to the ER in acute physiological and psychological distress. As an adjunct to the traditional medical treatment with oxygen, epinephrine, alupent treatments and possible aminophylline drips, I teach patients how to breath diaphragmatically. I usually begin the conversation with a discussion of Eric Peper's research in California...how "patients who breathe this way somehow can open up those tubes, somehow those tubes that bring air to your lungs open up. Like this (hand demonstration). The patient is then asked to join me in this breathing, with his/her hand on his/her stomach, "to show you how to do it right, so those tubes can open up to give you more air." I diaphragmatically breathe with the patient, pacing and leading, observing and commenting about what he/she is doing right, and clarifying as needed. I ask the patient to practice and demonstrate to me later "how well you can do it," and "to notice the feeling as those tubes open up." I leave them with a generalized referential index suggestion that, "People who breath this way usually find it relaxing, too." When I return, I ask for a demonstration, and when they are breathing correctly, I offer a double-bind future-oriented suggestion that "I don't know whether your stomach will tell and show your mind when you need to breathe this way first, or perhaps your mind will direct your stomach to breathe this way, and open up those tubes..., It probably doesn't even matter how you choose to breathe this way, because you know how to do it, and you can do it whenever you need to, maybe without even thinking about it..." I've utilized variations of this basic conversation with patients ranging from age 4 to age 79. Most patients that correctly demonstrate diaphragmatic breathing have a significant reduction in wheezing in a much shorter than medically expected time frame.

A four year old boy was in our pediatric intensive care unit after a truck had fallen and crushed him from the waist down. I met him while the surgeon was removing pebbles from his wounds. I told him who I was, looked directly into his eyes, lifted his unafflicted left hand and said in a deep voice, "And while that hand stays up there like that, the rest of you can stay comfortable. Did you know you can do that?" And I repeated it once. Four days later, his regular nurses came to me and asked if I had done anything special with that little boy, because he had not complained of any pain since then, had not required any analgesics, and that his right hand remained slightly elevated off the bed.

A 67-year old female recovering from gynecological surgery was in the hospital weeks after her expected discharge, because she was unable to void and required catheterization every six hours. I was working as a perdiem nurse, had not yet met the woman, and entered a room filled with visitors to introduce myself. I asked her how she was feeling and she replied, "Fine, I just can't urinate." I replied: "Of course not, certainly not while your guests are here!" I was accepting and utilizing the symptom while reframing its meaning to be approporiate that she's not urinating while her guests are all around her. I told her I would return later and we would work with it. A few hours later, when it was time for her catheterization, we went into the bathroom and I spoke about how it was interesting that when we tense some part of the body, other parts spontaneously relax, and that somehow those muscles know how to do that when they need to, and when while you pay attention to the muscles tightening in that knee, others can somehow respond differently. During a three-minute conversation in this vein, the patient spontaneously voided.

The following is an example of the confusion technique and utilization:

A six-year old girl with leukemia was thrasing in her bed while three nurses were attempting to change a dressing on her leg. I was asked to help assist them in holding her down. I had not met her before, and another nurse introduced us with, "Tina, have you met Dorothy? - She's a new nurse here." She paused in her yelling and looked at me..., I got down and looked intently in her eyes and said in a deep voice, "Is it all right if I call you Fred?" She looked at me, shocked - an altered thought process - and then screamed, "NO!", which was accepted and utilized with, "Oh, well OK, how about George?" She looked at me imploringly and then said, "I'm a girl!" I said, " Yes, well I'm a girl too, and it's alright if you call me Fred." The implication here is that just because something is indisputably what it is, doesn't mean it can't be made to seem different.

I then sat behind her and hugged her with gentle restraint. While the other nurses were quickly cutting away her dressing, I whispered secret, challenging questions into her ear. "Bet you don't know how many muscles you use when you lift that leg." That's an interspersed direct suggestion, "you lift that leg." ' In order for her to find out how many muscles were needed to lift that leg, she had to lift it, which she did. As she began to demonstrate her counting ability, the other nurses pulled off her dressing. This evoked another altered thought process and she responded by squirming and crying, "Ouch!", which was accepted and utilized by my counting the ouches and then asking her to jump from four to six ouches without saying five. This confused her for a moment, altered her thought process, and then her attention was redirected to another kinesthetic percepetual experience, of how it felt when she said those ouches, did she have to push her tongue against her teeth to make an ouch - and what happened to her mouth when she made an ouch, and what happened to her mouth when she made long ouches, as compared to those short ouches. And then I suggested that "that hurt could last as short as you make those ouches." The dressing change and wound cleansing progressed with the little girl giggling and emitting tiny little ouches.

A burn patient was scheduled for his first post-op tanking and dressing change. His physician loudly informed the staff and the patient, "Get the thrombin ready, he was just debrided and he's going to lose a lot of blood." To counter this non-therapeutic conjunctive suggestion, I quietly and emphatically stated at his ear level, "Although I wonder how little you need to bleed. Perhaps just the amount needed to clean the burns properly so they can heal quicker. After all you have been stopping the bleeding all your life, and even if you don't fully understand how to do it, you do know how to do it, and maybe you could just watch to see how it's done properly this time." These suggestions were indirectly re-emphasized throughout the procedure with interspersed suggestions for relaxation, deep breathing, and enhanced comfort. The patient was relaxed, compliant, and required minimal thrombin. Actually, I don't think he needed any thrombin. I think the very little thrombin was a treatment for the physician. Dorothy Larkin, M.A., R.N.

Social Trance: The Roots of Self Deception

by Daniel Goleman, PH.D.

Dr. Daniel Goleman, PhD., gave a provocative presentation on the "Social Trance: The Roots of Self Deception" and related this concept to the Ericksonian hypnotherapeutic model at the NYSEPH meeting in March of 1987. Dr. Goleman is a writer for the NEW YORK TIMES, an ex-editor of PSYCHOLOGY TODAY, and a published author, his latest book entitled, VITAL LIES AND SIMPLE TRUTHS: THE PSYCHOLOGY OF SELF DECEPTION.

Goleman stated that its not a trivial fact, but a compelling one that we are all in a trance. He defined social trance as "The one that we are all in, the one that we share at this moment, the one we have been inducted into as we learned to be decent men and women in the society." He cited news, largely ignored, reported in the State of the World Report by the World Watch Institute, "a grim litany of facts" such as the fact that global military outlays last year exceeded income of the poorest half of humanity, that malnutrition and dirty water kill 14,000 children every day, about 1 in every 7 seconds, that the world spends 1.7 million dollars every minute building arsenals and that our ecological deficits are growing rapidly. For the first time in history,with the growing ecological deficit and the nuclear arms race we can see the end of history. The trigger is cocked. We are caught in an insane predicament. "Despite this we continue to live our day-to-day lives as if nothing had changed. Our lives are not altered by this turn of events. I attribute that fact to the social trance," he said. He went on to explore how we all became entranced, why the trance serves us well and how the mind can play such tricks on itself.

He described a schematic based on information processing research of how the mind takes in information. "I talk: what you hear goes into a sensory filter. The information then goes into the unconscious and then comes into awareness, then, one response can be conscious, one can be unconscious. You decide to make a voluntary action, such as raising a finger, as declaring your love. The brain activates .3 seconds before you become aware of the intention, that is, the executive function is the unconscious. Between intention and execution, in awareness you have .2 of a second to decide whether or not to act. This is a veto function. In other words the unconscious generates innumerable acts and the conscious acquiesces or does not. This state of the art understanding of how the mind works fits very well with hypnosis...Here's a minor miracle, I have no prior sense of how my sentence will move as I speak. I do it all the time - it goes straight from the unconscious and we are aware of only a tiny fraction." Goleman cited current research supportive of his view that the unconscious has the "executive function," actually dictating the act approximately one quarter of a second before the act is executed. Conscious awareness then becomes a veto power of awareness. "Erickson knew the power of the unconscious," stated Goleman, and concurred with Erickson's belief that we know far more then we think we know.

"An induction is suggesting what script or response can be [used] without the veto power of awareness" stated Goleman. He then applied this to group behavior. "The price of admission to any group is three basic attentional rules: (1) Here's what we notice, (2) Here's what we call it, and (3) Here's what we don't notice." An example of this is the family engaged in "collective denial," disclaiming that mother is an alcoholic by "looking over there and refusing to notice what is here." Goleman referred to R.D. Laing's analysis of the "game of the happy family" in which one person communicates his unhappiness, then denies it , and then colludes with others so that the state of denial can be maintained. "So much of who we are is what we've been hypnotized to be," stated Dr. Goleman. He also pointed out something that Erickson repeatedly addressed — that the most lasting impressions are the attributions assigned to us as children within the family unit and that being told one is good or bad is akin to a most powerful hypnotic suggestion. "Family therapy," said Goleman, "is untrancing the family."

Goleman sees the phenomen of social trance as having both negative and benign consequences. In addition to the heretofore - mentioned "grim litany of facts" is our day-to-day denial of the horrors with which life greets us — our homeless and helpless members of society, being two examples. "The terrible dilemna," says Goleman, "is those who feel the pain have no power and those who have the power feel no pain." The really courageous act, therefore, is to "begin to speak truth to power," which involves risking eviction from a given group, whether it be a relationship, a family, or collective society.

Golemen added that "a large part of social trance is benign and quite positive." For example part of the "divine diagram" is how endorphins, released by the neuropeptide system, are designed to blunt pain and substitute a sense of well-being in "mollusks to man." He cited examples in which denial can be positive as in the case of a hospital study in which patients prior to surgery were interviewed and separated into two catagories — those who worried about everything that was to happen and those who "had faith" in their doctors and the success of the operation. The latter group healed significantly faster than the former.

In conclusion, Goleman stated that "it takes a much greater act of will to bring into full awareness the nature of the social trance let alone the courage to change it." "A critical intelligence," he continued, "is an antidote to the way we have fallen asleep collectively." People's instincts are actually very good in the right direction, but they feel hobbled by covert acts that make them feel powerless." When asked about being a good samaritan while living in New York City, Goleman responded by saying that he thought the answer lay in "being a smart samaritan rather than a good samaritan." Even though fear has a reality base, he reflected that New York is a city that tends to overgeneralize from fear and that each of us must develop abilities to discriminate given the particular circumstance.

Goleman ended on a constructive note by quoting Krishnamurti: "A single pebble can change the course of a stream." He made clear his appreciation for Erickson, stating that he was a master at "altering schemas unconsciously," adding that his brilliance lay in his ability to not be swayed by what the patient thought was going on, but by "what happens here in the unconscious." "Allow yourself to see what you don't allow yourself to see," Goleman concluded, echoing the wisdom of Erickson.

Mary Kay Christian, M.A.

Hypnosis and the Family Trance: A Look at Satir's Family Reconstruction Process

Jane A. Parsons-Fein, C.S.W.

On April 7, 1987 Jane Parsons-Fein presented "Hypnosis and the Family Trance: A Look at Satir's Family Reconstruction Process." Using Virginia Satir's Family Reconstruction Model and videotaped excerpts of her own ongoing Family Reconstruction Group Jane Parsons demonstrated how Satir works with what she calls "the right brain," or altered states.

Rossi has pointed out that Erickson often evoked hypnosis for short periods of time, then brought the subject to a conscious level, then back into trance again. This refractionation is a deepening technique. Parsons, referring to this process in Satir's work, calls it "weaving". Satir constantly shifts the focus of attention from external to internal to external to internal, alternately eliciting experience on conscious and unconscious levels and by this process integrates multi-level experience.

We carry within us from earliest childhood unconscious myths and messages communicated to us from our parents who received them from their parents. Children spend a lot of time in trance; parents were children once; parents are hypnotizees and hypnotists. The family is a hypnotic unit in which the family metaphor is trance-mitted from one generation to anoth-

Continued on page 7

Announcements

Jeff Feldman, Ph.D. will present an invited workshop on Ericksonian Indirect Suggestion at the American Group Psychotherapy Association meeting, New York City, Feb. 11, 1988.

Gary Greenberg Ph.D., and **Deborah Zeigler,** MA gave a presentation at a recent meeting of the New Jersey Society of Clinical Hypnosis on "Hypnosis in Project-Oriented Psychology and Personal Development Groups."

Mary Kay Christian, MA. is giving a workshop at the Open Center on "Trauma and Sexual Healing: An Ericksonian Hypnotherapeutic Approach."

Rita Sherr, A.C.S.W., is offering a self-hypnosis workshop that will run for four sessions on Wednesday evenings from 6-8 p.m. For further information please call (212) 873-3385.

Trude Gruber, M.S., CSW., gave a presentation in July at the Psychiatric Grand Rounds at Our Lady of Mercy Medical Center, New York City on Ericksonian Approaches in Psychotherapy.

Nancy Napier, M.A., in addition to giving a workshop at the Open Center, offers training for professionals on working with parts of the self including the child within and the future self. Contact Nancy at 212-877-2594.

Jim Wernke, M.S.W., did a training seminar at the Cliffwood Mental Health Center, Englewood, New Jersey and did a presentation to the Paramus Chapter of Parents Without Partners. Both presentations were on Ericksonian approaches.

Sidney Rosen, M.D., conducted a five-day workshop in St. Etienne, France in September and reports that interest in Erickson is very strong there. He will return in March '88 for a follow up workshop and in October 8 to conduct a joint workshop with Ernest Rossi.

Jane Parsons-Fein, C.S.W. did a weekend workshop on Erickson and Feldenkrais at INTERFACE in June and a five-day workshop on Satir Communication at OMEGA INSTITUTE in July. She will conduct a workshop with Kay Thompson in August 1988 in The Hague with the 11th International Congress of Hypnosis and Psychosomatic Medicine. She is beginning a second ongoing Family Reconstruction group on March 5. Those interested please call (212) 873-4557.

"Allow yourself to see what you don't allow yourself to see." Milton H. Erickson, M.D.

Hypnosis and the Family Trance

Continued from page 6

er. The Family Reconstruction utilizes work with the unconscious to enable people to free themselves from unconscious dysfunctional learnings and patterns that were absorbed from the family of origin. In altered states people can experience the family history and family patterns in new ways, can reconnect with the inner child and then discover the rich human resources that lie within their own roots. The Family Reconstruction Group is a safe and loving context in which this work can take place.The videotaped segments demonstrated the "weaving" process — how people put each other in and out of trance and how this awareness can be used therapeutically.

Kay Thompson, D.D.S Advanced Course

Kay Thompson, D.D.S. will teach a twenty-hour fourth tier course for NYSEPH Graduates on Friday, March 4th (7 pm-11 pm); Saturday March 26th (9 am-1 pm); Saturday, April 9th (9 am-1 pm), Saturday, April 23 (9 am-1 pm) and Saturday, April 30, (9 am-1 pm). Cost will be $350.00. Enrollment will be limited.

Doctor Thompson completed her B.S. and D.D.S. degrees at the University of Pittsburgh. She worked with Dr. Erickson for over twenty-seven years. She has written extensively and has been conducting seminars and workshops on hypnosis and pain management in the disciplines of medicine, dentistry and psychology since 1960. Dr. Thompson is currently in part-time practice. She is an Adjunct Professor, Department of Psychiatry, School of Medicine, and on the Continuing Education Faculty, School of Dentistry, at the University of Pittsburgh. She is also a Clinical Associate Professor, Department of Community Denistry, at the West Virginia University School of Dentistry.

To register please send $75 to:

Jane Parsons-Fein, C.S.W.
275 Central Park West, 4B
New York, New York 10024

Nurses Hypnosis Training Course

Dorothy Larkin, M.A., RN., is offering a ten-hour hypnosis introductory training course for nurses and other health professionals on Wednesday evenings from 6:30 p.m. to 8:30 p.m. Call NYSEPH for further information at 696-1999. Cost of course is $175.00. To register please send $50 to:

NYSEPH Mary Kay Christian,
379 Park Avenue South 4-A
New York, New York 10016

Physicians Hypnosis Training Course

Therapeutic Communication: Facilitating Patient Management.

Amnon Nadav, M.A. and Dorothy Larkin, M.A., R.N. are offering a one-day workshop for physicians to develop the new language skills, including indirect suggestion, to increase their effectiveness and comfort in relating to their patients. Special emphasis will be on management of the difficult patient, on prescription compliance and on emergency situations. The course will meet on Saturday, February 27. Cost is $110. Call NYSEPH for further information at 696-1999. To register please send $50 to:

NYSEPH: Mary Kay Christian,
379 Park Avenue South, 4-A
New York, New York 10016

"Are you sure-really really sure that you're not in a trance?" Milton H. Erickson, M.D.

NYSEPH-Sponsored Courses in Ericksonian Hypnosis: A Sequential Training Experience for Professionals in the Mental Health Field

The program of courses is designed to provide a systematic yet flexible training experience for practitioners interested in developing a thorough grounding in Ericksonian hypnosis.

This course is limited to mental health professionals with graduate degrees (M.D., M.S., Ph.D., M.A., M.S.W., D.D.S., etc.) in health-related fields from accredited institutions, and to graduate students in accredited programs in the above field who supply a letter from their departmental chairperson certifying their student status.

Fee: $350 for ten two-hour lessons.

I. INTRODUCTORY

The course is designed to provide a comprehensive introduction to Ericksonian principles and techniques, as well as to enable participants to develop basic competence in the use of hypnosis. While didactic instruction is provided, the primary emphasis is upon direct supervision of practice exercise and inductions. The material covered includes but is not limited to: The preinduction interview; hypnotic induction methods including pacing and leading; utilization of voice quality and response language; utilization of resistance and hypnotifc responses; disassociation; confusion technique; interspersal technique; reframing; metaphors; and the uses of hypnosis for therapeutic work, such as ego strengthening, habit control, phobias, and pain management.

II. INTERMEDIATE

The course is designed to provide continued practice and consolidation of introductory skills as students integrate Ericksonian approaches into their own unique style. The material covered will include the use of language patterning, movement, double-bind, paradox, confusion, and the use of metaphor and other forms of indirect suggestion. The use of these techniques will be developed within treatment issues.

III. ADVANCED INTERMEDIATE

A continuation of the intermediate course in which students define specific goals in the development of their hypnotic skills and artistry. In working toward these goals, participants are encouraged to develop a requisite variety of approaches and flexibility to individualize their treatment commensurate with the patient's needs, and to increasingly trust their unconscious. Case materials, demonstrations exercises and sometimes videotapes of Dr. Erickson are used to help facilitate this purpose.

IV. ADVANCED

A concluding course designed to consoldiate prior learnings. Advanced methods are examined, including time distortion, corrective regression, automatic handwriting, the advanced use of stories and metaphors, and further techniques of self-hypnosis. Participants are encouraged to go beyond techniques and trust their unconscious in their efforts to utilize the conscious and unconscious resources of their patients.

FACULTY BIOGRAPHY

Dr. Sidney Rosen, M.D., who graduated from the Medical School of the University of Western Ontario in 1948, is a board certified psychiatrist, certified psychoanalyst, on the faculty of the American Institute of Psychoanalysis (Karen Homey), and Assistant Clinical Professor of Psychiatry, N.Y.U. of Medicine. For over 20 years he was Psychiatrist-in-Charge of Rehabilitation Psychiatric Service, N.Y.U. Medical Center. In 1979 he wrote the Foreword to *Hypnotherapy, An Exploratory Casebook* by Erickson and Rossi (Irvington Press 1979. The author of *My Voice Will Go With You: Teaching Tales of Milton H. Erickson* (New York, W.W. Norton 1983), Dr. Rosen is the Founding President of the New York Milton H. Erickson Society for Psychotherapy and Hypnosis. He was on the invited Faculty of the First and Second International Congress on Hypnosis and Psychotherapy held in Phoenix, Arizona in December 1980 and 1983. He participated in workshops in Ericksonian Approaches at Cornell Medical School and at the American Orthopsychiatric Society. He was selected for the faculty of the Erickson Foundation Seminars in Dallas 1982 and in L.A. in 1984. He was the Invited Keynote Speaker at the first International European Congress on Ericksonian Hypnosis and Psychotherapy in October 1984. Dr. Rosen is in the full-time practice of psychiatry in New York City.

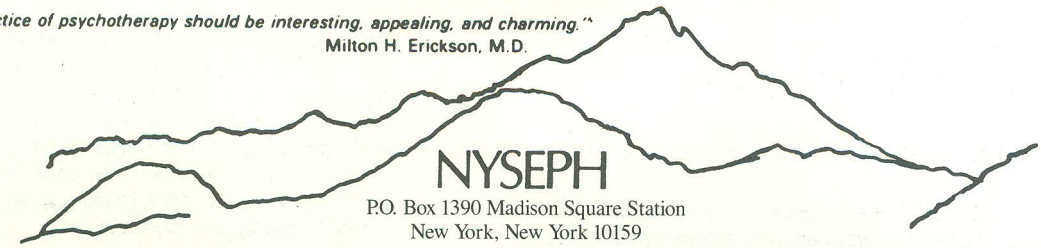
Jane Parsons-Fein, C.S.W. is a psychotherapist in independent practice in New York City specializing in individual, group, family and couples treatment. For twelve years she was a psychotherapist in the Department of Psychiatry of Mount Sinai Hospital and a member of the Group Therapy Department. She has studied with Milton Erickson, trained with Virginia Satir and is a certified Feldenkrais Practitioner. She has conducted workshops in Ericksonian hypnotherapy at Esalen Institute, Omega, The the Open Center, and given presentations at the University of California Medical School and various hospitals and medical schools in New York City. She is Vice President of NYSEPH and Editor of its Newsletter and a Founding Advisory Editor of the Erickson Monographs.

Jeffrey Feldman, Ph.D., a clinical psychologist, is in independent practice in Manhattan specializing in short-term psychotherapy, hypnosis and stress management. He is co-director, Pain Management Center, Brooklyn, N.Y., as well as a consultant to the Children's Aid Society and other agencies. Formerly on the staff of N.Y.U. Medical Center and the faculty of Long Island University's Post Graduate Institute of Behavior Therapy, Dr. Feldman has presented papers on Ericksonian therapy at the 1982 American Psychological Association meeting, as well as at the Second International Congress on Ericksonian Psychotherapy and Hypnosis. He is Administrative Vice President of NYSEPH.

Rita M. Sherr, C.S.W., is a psychotherapist in independent practice in New York City. She is one of the founders as well as the coordinator of the Hypnotherapy Treatment Service at the National Institute for the Psychotherapies where she is also a member of the faculty and supervisor. She was formerly a member of the faculty of the New York Counseling and Guidance Service and a member of the staff at Hillside Hospital. For the past eight years she has been teaching courses, conducting workshops and supervising students in hypnotherapy. She is Director of Education for NYSEPH.

Please return to: Rita M. Sherr, C.S.W., 440 East End Avenue, New York, NY 10024—(212)873-3385

"The practice of psychotherapy should be interesting, appealing, and charming."
Milton H. Erickson, M.D.



NYSEPH
P.O. Box 1390 Madison Square Station
New York, New York 10159

In order that we can place you in the course appropriate to your skills and needs please fill in the following:

Name _____

Address: _____

Phone: _____

1. My educational background and degrees: _____

2. My additional study/workshop/training in psychotherapy and/or hypnosis: _____

3. My experience in the practice of psychotherapy: _____

4. My experience in the practice of hypnosis: _____

5. The context in which I am presently working: _____

   Practice _____

   Theoretical _____

6. My particular interests: _____

7. What I want to learn from these courses: _____

Time Available - Please list Preferences as (1), (2), (3) Beginners class starts Mon. April 20 6-8 pm

	Mon.	Tues.	Wed.	Thurs.	Fri.
Morning					
Afternoon					
Evening					

Please return to: Rita M. Sherr, C.S.W., 440 West End Avenue, New York, NY 10024 — (212) 873-3385

Smoking Addiction: the Use of Hypnosis

by Kathy Gantz, C.S.W. and Donald Douglas, M.D.

On February 3, 1987, Kathy Gantz, C.S.W., and Donald Douglas, M.D. presented "Smoking: the Unwelcome Cure." Donald is a Psychiatrist and Neurologist Associate at Lenox Hill Hospital. Kathy is a hypnotherapist specializing in behavior modification. Following are excerpts from their presentation:

Hypnosis has emerged as a significant and effective form of treatment for cigarette smoking. How it may best be used and to what extent it is effective are still subjects for debate. Various authors have reported numerous hypnotic techniques for smoking with widely varying and often flawed research methodologies. Sanders has aptly described smoking behavior as a multidetermined habit consisting of individual characteristics of the smoker himself, his belief about smoking and his environment. Many standardized approaches are limited to one session. Approaches that are individualized show a higher rate of success. With individualized approaches, success rates of up to 80% have been reported. Erickson was adamant about the importance of individualized therapeutic approaches. Individualized approaches work better because each personality is unique and because symptomatic behavior occurs for idiosyncratic reasons. It has been concluded that four factors increase the percentage of abstinence: (a) an intense personal interaction, (b) suggestions designed to capitalize on individual motivation, (c) telephone contacts, (d) several hours of treatment. To individualize one's approach, you must pay attention to salient personal factors.

I write down all of the patients' answers as exactly as I can so that I can learn the patients' linguistic style and use his own rephrased words to create therapeutic suggestions during the induction. In addition, I am careful to maintain an attitude of expectancy in regard to change. Diagnosis is critically important, and, in diagnosing motivational factors, it is important to realize that individuals have unique reasons both for smoking and for quitting. Taken together, these principles help assure that the therapeutic approach is geared toward the motivation.

Kathy Gantz, C.S.W.

* * *

The nature of smoking is different enough from other addictions to merit a classification as a "para-addiction" or as an addiction without the intoxication and the high that accompanies substance misuse, gambling and some other addictions. This is not clear, however. What is significant is mainly that it is very probable smoking addiction is essentially an organic one with physiologic changes which bypass any attempt at simple psychological opposition. In addition to this, there are two other essential features in the resistance to stopping smoking and it is my belief that these may be the most important:

a. Smoking is gradually conditioned by the smoker to the thought and then the effort to stop smoking. Almost every smoker sooner or later begins to think "I must stop." This thought is very frequent and most frequent with the urge to take a cigarette and at the beginning of lighting up a cigarette. It seems to escape almost every smoker, however, that the thought and the effort to stop is conditioned to the smoking itelf so that, when effort is reversed and put into stopping, the smoking drive becomes ever stronger.
b. In addition to this is the very important matter of the misdirection of resentment. In alcohol addiction there is a very important parallel: the relative frequently "enables" the alcohol addict by calling in sick for him on Monday mornings, by loaning money, by covering up various lapses and misdeeds, by obtaining liquor and by general, emotional and other support. This is done to "help" the addict. This practice of enabling is extremely destructive and a whole organization exists to retrain the friends and relatives of alcohol addicts and similar organizations exist for other forms of addiction. This means that the folie-a-deux between addict and enabler is broken up and a very powerful step taken towards recovery. In the case of smoking enabling does not usually develop so that the smoker feels ongoing resentment against those who attempt to help him stop. Whether it is physician, friend or relative, the smoker not only resents the loss of the support of the cigarette, he needs to ceremonialize this loss frequently and consciously or unconsciously.

In addition he needs to undertstand that he feels something is being taken from him against his will. It is extremely helpful to review this at length with the patient and to objectify the real culprits - those who will sell him the deadly cigarette and profit from it. The phrase "the smoker is a sinking ship shooting at the rescuers" is useful in this connection. In addition, it is very helpful to personalize the suppliers in a variety of ways that are vivid, understandable and convincing and will perhaps redirect the resentment and resistance.

It is also worth mentioning that for many patients, the word "smoking" or even a fairly indirect allusion to it, especially during the trance work is disruptive and leads to increasing the obsessive thinking about it. I prefer to use terms such as "It" or various other allusions that permit total revivication such as "That feeling" (color, size, shape, etc). This kind of terminology is then readily applied to dissociative techniques to follow.

Donald Douglas, M.D.

Letter from Elizabeth Erickson

On Monday, May 2, 1983, the New York Milton H. Erickson Society for Psychotherapy and Hypnosis held a dedication ceremony of fifteen purple smoke bushes in honor of Milton H. Erickson, M.D. (1901-1980), which were planted in Central Park near Belvedere Castle. Mrs. Elizabeth Erickson attended the ceremony. We have kept in touch with her since than and with her permission we are printing a letter she sent to us recently:

October 4, 1987

Dear Jane,

You may recall that some time after you gave me the beautiful photo album that you had put together of that wonderful memorial service in Central Park you sent me a collection of additional photos you had taken, some at different times of the year. I got out the album and realized that, with all good intentions, I had set aside the additional photos but had not as yet mounted them.

So I am writing this to tell you what I have just finished doing. First, I put the memorial service pictures a little closer together on the pages. This gave me plenty of empty pages, and I have now mounted those lovely extra ones, with the Belvedere Castle in many of the backgrounds - the autumn colors - the lake - as well as some nice shots of our good friend Elijah. [Elijah David Herschler, sculptor of Ribbons in Space]

I had a number of pages left, so I made a special section in which I mounted snapshots, cards, letters and announcements I had collected of trees planted for Milton as bithday gifts to him, for his enjoyment, and some in his memory. These range from trees in Israel to Hawaii, Japan, Australia, and elsewhere. I thought this album was a very suitable place for these items. As you know, the first few pages of the album contain transcripts of the talks given at the Central Park meeting. The album is certainly a real family treasure.

I hope you are well, and that all is going well. I am fine - continuing to take some exciting trips. I've been to Kenya, Costa Rica, the Galapagos Islands - various parts of South America. My son Allan and family are back in Australia so I'm going to go back there right after Christmas. Last time I climbed Ayers Rock in the "outback." This time I'm going to cross the desert on the train.

I hope to get to New York again some day.

Love and good wishes,

Betty

Love, Medicine and Miracles

By Bernie S. Siegel, MD
New York, Harper & Row, 1987

Editors note: Dr. Siegels' book has provoked much controversy and interst. In the following review, Dr. Douglas presents one position. We welcome your response. Please address your letters to: Jane Parsons-Fein, Editor, 275 Central Park West, New York, NY 10024

The message of this best seller is that disease, herein notably cancer, can be affected or even cured by thoughts, emotions and faith. For unknown ages religion, magic and science have all been invoked to explain how the patient's attitudes and beliefs become capacities for life and death. Here the emphasis is on the rapport between the patient and doctor with many fleeting case vignettes to illustrate the miracles brought about by love in the practice of medicine.

The author's basic thesis is the sub-title of the book: "Lessons Learned About Self Healing From a Surgeon's Experience With The Exceptional Patient". There is even one chapter devoted to "Becoming Exceptional", a process recognized by this reader as usually classified in five major groups: as the spiritual awakening basic to recovery from addiction; under various names in certain specific disciplines, e.g. as Kensho or Sartori in Zen practice; as the "enlightenment" or "illumination" of some mystic teachers; for many people and circumstances as "The Varieties of Religious Experience" in the classic text by William James; and in a rather different form reported as "out of body experience" by those recovering from comatose and other clouded states. In short, all these experiences are the "death of the ego" — a turning about at the center: metanoia. What the author does not deal with is the inescapable tautology in "becoming exceptional" and so surviving or dying with grace and serenity — or not "becoming exceptional" and so dying because of not wanting to live — because of an unconscious death wish, because of passivity or even hatred or revenge.

Whether we seek the explanation from divine grace, genetics or any other of the biosciences or simply from human relationship and love as enabling or even causing the patient to be "exceptional", the reason for being "exceptional" can be found only in exceptionality, no matter what the source. The author gives many inspiring examples of his compassionate care directed towards helping his patients become "exceptional," but even this cannot justify explaining the course of illness by illness by the patient's wishes. It also leaves us in another inescapable tautology: people who are healthier to begin with — who for example have the biological resources to overcome their disease — will display very clearly all of the better beliefs, attitudes, thinking and emotions which are looked upon as causing them to be healthier.

I believe that Dr. Milton H. Erickson was not the first nor the last to point out that the approach as described in this book to the problems of cancer and other diseases may be potentially valuable, but has not yet been proved. Removal of stress can release the patient from powerful negative forces that have been lowering immunity and inducing depression and illness — excellent practice in caring for the patient, but that does not necessarily mean that love can cure. We must remember that the onset of cancer especially in some specific forms, and indeed of some other diseases, can begin with no other symptoms than a depression that is quite indistinguishable from the so-called "endogenous depression".

Certain mental and emotional states not uncommonly appear to be the cause of an illness when in fact they are the results of it; compare this with the more familiar fatigue and depression that follow and so are explained by some common illnesses as, for example, some forms of influenza. If the depression came first there might be a great deal of theorizing and inspirational writing about the cause of influenza.

There is another very important consequence, now not uncommon, of attributing the cause and/or course of illness to state of mind and emotion: The patient comes to believe that "Because I had wrong thoughts I brought this on myself." Anyone who works with chronically ill patients must soon experience their self blame and guilt, particularly in those who are persuaded that their thoughts and feelings have been responsible for their illnesses.

The author of this book sincerely seems to try to help such patients to true self-reliance and relationship to reality and to release them from the stress of self blame. A number of examples and descriptions including analyses of drawings and dreams and careful examinations of the patient's history and behavioral and life patterns are all given to illustrate the author's approach to achieving the self understanding and metanoia which is the turning about at the center necessary for the spiritual experiences that form both the goal and the basis of his work with patients. All of this is a very great task indeed for which the author has received much well-deserved credit. Nevertheless, this reader cannot help but feel that important as these matters are, they have not been adequately investigated. Relief from the stresses of faulty communication, long continued resentment and painful misunderstandings of relationships and from beliefs and fears and self-induced guilt and blame — surely such relief is very valuable but I don't think it means that love can cure — no matter how much it seems so.Surely in this field objectivity is needed as much as involvement.

What is significant for us as hypnotherapists is the immense potential that remains to be explored. Can we increase the delivery of medication to disease sites? Can we reduce blood flow and temperature to these diseases sites? Can we hypnotically replicate medication effect on diseased tissue? Will we learn to dissect out the capacities of the personality to function selectively as in multiple personality, and then to make useful application of these and other of the extraordinary phenomena revealed by hypnosis? What is recovery from disease and where does hypnosis belong in this process? There are many more questions to ask and to answer and more to review and evaluate in this book. The main value it has for us as hypnotherapists is that it calls upon us to develop all that hypnosis has begun to open up.

We have just begun.

Donald Douglas, M.D.

"What is easiest to see is often overlooked."

Milton H. Erickson, M.D.

New NYSEPH "Coffee Clatches"

In response to the many requests NYSEPH is announcing our "monthly coffee clatches" to provide an informal learning environment, complementary to the presentations offered on the first Tuesday of every month.

These new meetings will be held at the home of Mary Kay Christian, located at 379 Park Avenue South, between 26th and 27th street on the east side of the street, third floor by the stairs. The content will vary, our goal being to provide an opportunity for all interested persons to interact with NYSEPH board members and to learn from the experience of Ericksonian practitioners while enjoying a relaxed and comfortable group setting.

These meetings will be held the third Tuesday of every month from 8 p.m. to 10 p.m., beginning on March 15, 1988. To find out what is on the agenda for any particular meeting, please call NYSEPH at 212-696-1999. Attendance is $3.00 for NYSEPH members, and a fee of $8.00 is required of all non-members. These meetings will prove to be highly informative, whether it be watching tapes of Dr. Erickson loaned by board members, or a supervisory panel to whom you can direct your questions. Please let us have the pleasure of meeting you!

Mary Kay Christian, M.A.

"Discover their patterns of happiness."
—MILTON H. ERICKSON, M.D.

New York Milton H. Erickson Society
For Psychotherapy and Hypnosis
P.O. Box 1390 Madison Square Station,
New York, New York 10159
(212) 696-1999

Address Correction Requested
Return Postage Guaranteed

Non-Profit Org.
U.S. Postage
PAID
New York, N.Y.
Permit No. 05394

NYSEPH Presentations for Year 1987-1988

The first Tuesday of every month
Place: Ethical Culture Society,
2 West 64th Street, New York, New York
Time: 8:30-10:30 PM
Fee: Members free; Non-Members $8.00

October 6,1987-"Detrancing and Retrancing the Herpes Patient", Oscar Gillespie, Ph.D., Co-founder of "N.Y. Help"; Author of *Herpes: What To Do When You Have It;* Assistant Professor of Psychology at Fordam University

November 3, 1987-"Aids: The Devastating Illness: What Ericksonian Techniques Can We Use in The Face of It?", Dava Weinstein, C.S.W. Private Practice: specialty in Family Treatment, Addictions, and Sexuality issues.

December 1, 1987-"The Psychology of Illness and the Art of Healing". Bernie Siegel, M.D., Yale University; work with "exceptional" cancer patients. Reknowned author of *Love, Medicine, and Miracles,* on New York Times best seller list top; Presenter at OMEGA.

January 5, 1988-"Evoking The Healing Abilities: Issues and Methods for Personal and Professional Use." Jacob Jaffe, Ed. D. Independent Practice specializing in Hygeology, Stress Reduction, Family and Professional Issues.

Febraury 2, 1988-"The Timeless Unconscious - Part II: The Future Self". Nancy Napier, M.A. - is a psychotherapist in private practice in Manhattan, and specializes in corrective regresson and work with the inner child.

March 1, 1988-"Creative Awareness and Practical Action: (Helping Indiviuals Learn How to Think)". Mel Bucholtz, M.A., has trained with Milton Erickson, M.D. and is co-founder of Noomaad University and the Returning to Earth Institute, a transformational wilderness experience. He maintains a private practice in Cambridge, MA.

April 5, 1988-To be announced

May 3, 1988-"The Phenomenonological Differences Among Self-Hypnosis, Mindfulness Meditation and Imaging", Gerald Epstein, M.D. Dr. Epstein is Assistant Clinical Professor of Psychiatry of Mount Sinai School of Medicine. He is the author of three books and many articles on imagery and imagination and has had a training center for professionals in waking dream therapy. Dr. Epstein will be joined by a NYSEPH panel.

June 7, 1988-"Mastering the Inner Resources: An Ericksonian Attitude Format." Rabbi Herschell Jaffe, author of **"Why Me, Why Anyone?"**

Please call Rafi Echeverria (212) 288-6767 for suggestions and proposals

Registration NYSEPH Membership

☐ Full Member	$50.00
☐ Associated Member	45.00
☐ Student Member	25.00

Name _____ **Phone** _____

Address _____

Degree(s) _____

Type of practice _____

Mail check to NYSEPH
P.O. Box 1390 Madison Square Station
New York, New York 10159

Are you already on our mailing list ☐ **No**
☐ **Yes**