

# Burden of Responsibility in Effective Psychotherapy\*

## Milton H. Erickson

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The following case material is presented because it offers so concisely and clearly a modus operandi in hypnotherapy with the type of patient who has had a long experience in failing to derive desired benefits from extensive, traditionally oriented therapy. The three persons reported upon are typical of dozens of others that this author has seen over the years, and the results obtained have been remarkably good despite the fact that the patients were seen on only one occasion for an hour or two.

*In each instance hypnosis was used for the specific purpose of placing the burden of responsibility for therapeutic results upon the patient himself after he himself had reached a definite conclusion that therapy would not help and that a last resort would be a hypnotic "miracle." In this author's understanding of psychotherapy, if a patient wants to believe in a "hypnotic miracle" so strongly that he will undertake the responsibility of making a recovery by virtue of his own actual behavior and continue that recovery, he is at liberty to do so under whatever guise he chooses, but neither the author nor the reader is obliged to regard the success of the therapy as a hypnotic miracle. The hypnosis was used solely as a modality by means of which to secure their cooperation in accepting the therapy they wanted. In other words, they were induced by hypnosis to acknowledge and act upon their own personal responsibility for successfully accepting the previously futilely sought and offered but actually rejected therapy.*

### CASES 1 AND 2

A telephone call was received in the office from a man who stated that he wanted an appointment. He refused to give any reason except that it was for a proper medical reason he preferred to explain in person. At the interview the man stated that he was suffering from Buerger's disease, that he was a diabetic, and that he had cardiac disease and high blood pressure—"Too much for a man with a family the size of mine and only 50 years old." He went on, "That isn't all. I've been psychoanalyzed for eight months for five hours a week. During that time my insulin dosage has had to be increased, I've gained 40 pounds, my blood pressure has gone up 35 points, and from 1½ packs of cigarettes I have gone up to 4½ packs a day. I am still the psychoanalyst's patient, I have an appointment with him for Monday, but he is paid up to date. He says he is slowly uncovering the psychodynamics of my self-destructive behavior. I myself think that I'm digging my grave with power tools."

Then with utter gravity he asked, "Would it be unethical for you, knowing that I am another physician's patient, **to give me the benefit of two hours of hypnotherapy this afternoon?** My analyst disapproves of hypnosis, but he certainly hasn't done me any good."

[Rossi, 2008, comment #1: Note the client's intuitive understanding that 2 hours will be required to accomplish his inner creative work. Today I hypothesize this is an example of our natural Basic-Rest-Activity Cycle (a so called "mind-body ultradian rhythm") that usually requires 90-120 minutes in

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everyday life. While awake this is the natural rhythm of most life activities (work, play, seeing a movie, etc.). While asleep this is the natural rhythm of our Slow Wave Sleep and REM dream cycle for updating consciousness, memory, and behavior on all levels from mind to gene. I hypothesize this is why Erickson utilized about 90-120 minutes as the length of his typical sessions of therapeutic hypnosis and psychotherapy with his patients. (Rossi & Rossi, 2008 a & b)]

The simple reply was made that, from my point of view, the question of professional ethics did not enter into the situation at all, that every patient, including mine, has the right to seek from any duly trained and licensed physician whatever proper help he desires, that medical ethics should properly be centered about the patient's welfare rather than a physician's desire to keep a patient.

**He was then told to close his eyes and repeat his story from beginning to end, to do this slowly, carefully, to drop out the question of ethics and in its place to specify what he wanted from the author. This he was to do slowly, thoughtfully, appraisingly, and as he did so, the mere sound of his own voice would serve to induce in him a satisfactory trance in which he could continue to talk to the author, listen to the author, answer questions, do anything asked of him by the author and that he would find himself under a most powerful compulsion to do exactly that which was indicated.**

[Rossi, 2008 comment #2: These words in bold font are not a formal induction to hypnosis in the usual sense when patients realize they are being put into a hypnotic trance with monotonous and repetitive suggestions to "relax" and "sleep" etc. However, we can now recognize how Erickson's words are actually "trance-inducing" for this patient who is so interested in telling his own numinous story and getting help that it (1) focuses his attention with (2) high expectancy—the two characteristics of modern therapeutic hypnosis. This leads me to call these words in bold font an Ericksonian bridge between traditional therapeutic hypnosis and psychotherapy as we practice it today. Erickson often did not distinguish between formally induced therapeutic hypnosis and "The General Waking Trance" when his patients were in a state of high expectancy and focused attention. I hypothesize that this state of high expectancy and focused attention is the common denominator between Ericksonian therapeutic hypnosis and all forms of effective contemporary psychotherapy that seek to facilitate consciousness and behavior change on all levels from mind to gene (Rossi, Erickson-Klein, Rossi, 2008 a, b, c; Rossi, Iannotti, et al., 2008).]

The man was taken aback at these unexpected instructions, but leaned back in his chair, closed his eyes, and slowly began his recitation with pertinent additions. Shortly his voice began to trail off, indicating that he was developing a trance, and he had to be told several times to speak more loudly and clearly.

No mention was made of the question of ethics, but with a wealth of detail *he outlined the therapy which he thought to be indicated*. He was asked to repeat this several times, and each time he did so more positively, emphatically, and inclusively.

After four such repetitions the author pointed out that he, as a physician, had offered no advice or therapeutic or corrective suggestions, that every item in that regard had come from the patient himself, *and that he would find himself under the powerful compulsion arising from within him to do everything that he thought was indicated*. To this was added that he could remember any selected parts of his trance state, but regardless of what he remembered or did not remember *he would be under a most powerful compulsion to do all that he himself thought to be indicated*.

He was aroused, a casual conversation initiated, and he left.

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A year later, in excellent physical shape, he brought in an old childhood friend of his and stated very briefly, "I eat right, I sleep good, my weight is normal, my habits regular, my diabetes is under good control, my Buerger's disease has not progressed, my blood pressure is normal, I never went back to my analyst, my business is better than ever, I'm a new man and my whole family thanks you. Now this man is my boyhood pal, he's got emphysema, a very bad heart, look at his swollen ankles, and he smokes like a chimney.

He's been under a doctor's care for years." (This man was smoking one cigarette and had another out of the package ready to light.)

"Treat him the way you did me, because I told him you talked to me in a way that just takes complete hold of you."

He left the office with the new patient remaining. Essentially the same procedure was carried out, checking against the first patient's file as this was done, and almost precisely the same words were used that were applicable.

At the close of the interview the man left, leaving his cigarettes behind him. Six months later a long distance call was received from the first patient, stating, "Well, the news is bad but you should feel good. Joe died last night in his sleep from a coronary attack. After he left your office, he never smoked another cigarette, his emphysema was much better, and he enjoyed life instead of worrying all the time about running out of cigarettes and about the cigarettes making his condition worse."

### CASE 3

A telephone call was received early in the morning. A man's voice said, "I've just realized that my condition is an emergency. How soon can I come in?" He was told that a cancellation had just been received and he could be seen in one hour's time. At the specified time a 32-year-old man walked in, smoking a cigarette, and stated hastily, "I'm a chronic smoker. I need help. I've been in psychotherapy twice a week for two years. I want to quit smoking. I can't. Look! I've got six packs in my pockets right now so I can't run out of them. My analyst says I am making progress, but I was only carrying two packs a day when I first went to him. Then slowly I increased my reserve and emergency supplies until it is up to six packs a day. I'm afraid to leave home without at least six packs in my pocket. I read about you. I want you to hypnotize me out of smoking."

**He was assured that *this could not be done*, but that the author would like to have him retell his story slowly, carefully, with his eyes closed, and to give it in good detail, letting his unconscious mind (he was a college graduate) take over all dominance, and that, as he related his story, he was to specify in full and comprehensive detail exactly what it was he wished in relation to cigarettes, but that during his narrative he would find himself going unaccountably into a deep and deeper trance without any interruption of his story.**

The procedure and results were almost exactly comparable to the two preceding cases. Two years later another telephone call was received from the same man asking for a half-hour appointment at noon and volunteering to pay an hour's fee. He again declared it to be an emergency.

Exactly at noon he came striding into the office and remarked. "You won't recognize me. You only saw me for an hour two years ago. I am Mr. X, and I had had two years of analysis for excessive smoking with only an increase in my smoking. I can't remember what went on when I saw you, but I do know that I

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haven't smoked a cigarette since then. It's embarrassing, too, because I can't even light one for my girl. I've tried many times, but I can't.

"But I went back to that analyst, and he took all the credit for my stopping smoking. I didn't tell him about you. I thought I needed to see him about what he called a character defect in me. Here I am with a college education, and the longest I've worked at a job has been three months. I can always get a job, but I'm 34 now, and four years of psychoanalysis has wound up with my last job lasting only five weeks. But I'm 34 now, and I've got the promise of another job with a future to it. Now I want you to do something about whatever is wrong with me because I've quit the analyst. I've had better jobs than the one coming up, but there is nothing to hold me to it. It will be the same old story. Now, hypnotize me and do what I should have had you do two years ago, whatever that was."

His former case record was looked up to refresh the author's memory. As precisely as possible the technique of the previous occasion was followed, and he was again dismissed. Two years later he was still at the "new job" but had been promoted to a managerial position which he has held for over a year. A chance meeting with him disclosed this fact and also that he is married and a father and that his wife voluntarily gave up smoking.

### SUMMARY

Three of a long series of similar cases are reported here to illustrate the use of hypnosis as a technique of deliberately shifting from the therapist to the patient the entire burden of both defining the psychotherapy desired and the responsibility for accepting it. Often this is the most difficult part of psychotherapy. In all the patients this author has handled successfully in this manner, all had a history of a steady, persistent search for therapy, but a failure to take the responsibility of accepting it. Additionally, all such patients with whom the author has had a known success were of a superior intelligence level.

**In traditional ritualistic and conventional psychotherapies much, often futile, effort is made to induce patients to assume adequately the responsibility for their own behavior and for future effort. This is done without regard for the patients' consciously thinking and firmly believing as an absolute truth the futility of any effort on their own part.**

**But utilizing hypnosis as a technique of deliberately and intentionally shifting to the patients their own burden of responsibility for therapeutic results and having them emphatically and repetitiously affirm and confirm in their own thought formulations and their own expressed verbalizations of their own desires, needs and intentions at the level of their own unconscious mentation, forces the therapeutic goals to become the patient's own goals, not those merely offered by the therapist he is visiting.**

That this procedure always is successful is not true. There are many patients who want therapy but do not accept it until adequately motivated. There are other patients whose goal is no more than the continuous seeking of therapy but not the accepting of it. With this type of patient hypnotherapy fails as completely as do other forms of therapy.

[Rossi, 2008, comment #3: This is an example of the essence of Erickson's original thinking and contributions. It is fundamentally different from previous concepts of "traditional ritualistic" hypnosis and most "conventional psychotherapies." Erickson originally called this his "naturalistic and utilization" approaches to therapeutic hypnosis and psychotherapy (Erickson 1958, 1959/2008).

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Another of Erickson's most original contributions was his invention of "hand levitation" in facilitating the induction of therapeutic hypnosis and psychotherapy (Rossi & Rossi, 2008a). What was most innovative about Erickson's hand levitation approach is that he replaced the traditional hypnotic induction via "passivity-inducing" suggestions for relaxation and sleep with the exact opposite: hand levitation is a rather paradoxical activity that usually requires an "active effort by the patient." Erickson would typically offer positive suggestions for achieving positive therapeutic goals while the patient was experiencing the active effort of hand levitation.

Erickson (Erickson & Rossi, 1981/2006) frequently commented that successful hand levitation requires activating muscle tonus (the slight continuous contraction characteristic of a muscle at rest) on a deep physiological level. Erickson's patients would often tremble, vibrate, shake, sweat and feel hot with the strain they were experiencing) – the opposite of the traditional passive hypnotic induction via quiet suggestions for relaxation and sleep. Erickson's hand levitation technique activated the patient's mind and body while they were receiving positive inspiring suggestions for therapeutically reconstructing themselves. Erickson, of course, did use the traditional passive eye fixation techniques with relaxation suggestions when they were appropriate but there was always a special twinkle in his eyes when he used his active hand levitation approach that he seemed most proud of – he got his patients to work and sweat just as farmers and laborers did! What was the patient's work and sweat all about? There seemed to be some secret and unexpected therapeutic efficacy associated with activating the patient's mind-body while administering positive therapeutic suggestions. What could this secret be?

It was while searching for the source of this secret efficacy of associating positive therapeutic suggestions with hand levitation and thereby activating the patient's mind-body that Rossi (1986/1993, 2002) accidentally stumbled upon the concept of "activity-dependent gene expression and brain plasticity" in the new neuroscience of psychobiology, The Basic Rest-Activity Cycle, etc. (Lloyd & Rossi, 1992, 2008). It suddenly seemed intuitively obvious that Erickson's activating hand levitation approach was turning on what the molecular biologists and neuroscientists were calling "activity-dependent gene expression and brain plasticity." Could this really be the secret of the therapeutic efficacy of Erickson's hand levitation approach?

Rossi (2002, 2004, 2007) simply generalized Erickson's activity-dependent hand levitation approach to an ever growing potpourri of "novel activity-dependent hand mirroring approaches" to therapeutic hypnosis and psychotherapy. A pilot study recently documents these therapeutic approaches are efficacious in turning on gene expression in the consulting room (Rossi, Iannotti, et al., 2008). The broader cultural and educational implications of such research is that all novel, fascinating, awesome, mysterious, and numinous psychological experiences of art, beauty, and truth turn on gene expression and brain plasticity when we are creatively engaged while awake as well as when we are updating and re-constructing our mind, memories, and well being during our dreams when asleep.]

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