
# PRINCIPLES AND CORE COMPETENCIES OF ERICKSONIAN THERAPY

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CCET-1

**The 2017 Research and Teaching Manual for Ericksonian Therapy**

Sponsored by

The Milton H. Erickson Foundation

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The Milton H. Erickson Institute of Phoenix

# PRINCIPLES AND CORE COMPETENCIES OF ERICKSONIAN THERAPY

## The 2017 Research and Teaching Manual for Ericksonian Therapy

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*"I had many patients write a letter to me, explain that they want help… and not mail it.. they went through that formal conscious process of asking for help and then their unconscious would answer them. So when I am just a memory, you will write to me and your unconscious can answer your letter."*

– Milton H. Erickson M.D., 1974

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The list of core competencies, developed for the 2017 Research and Teaching Initiative, was a collaborative effort. The *Principles and Core Competencies of Ericksonian Therapy: Research and Teaching Manual* is intended for use in the monitoring, measurement, and implementation of core competencies in Ericksonian therapy.

The international development team included: Marilia Baker, Rubin Battino, Norma Barretta, Consuelo Casula, Betty Alice Erickson, Helen Erickson, Roxanna Erickson-Klein, Teresa García-Sánchez, Steven Gilligan, Eric Greenleaf, Carl Hammerschlag, Abraham Hernández Covarrubias, Jean-Claude Lavaud, John Lentz, Camillo Loriedo, Rob McNeilly, Michael Munion, Idrissa Ndiaye, Bill O'Hanlon, Ernest Rossi, Charles Simpkins, Isabelle Prevot-Stimec, Bernhard Trenkle, and Michael Yapko.

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# Introduction to the Core Competencies Manual on Ericksonian Therapy

The Ericksonian approach to therapy represents an international community of individuals inspired by the pioneering work of Milton H. Erickson, M.D. People who identify themselves as being an Ericksonian practitioner typically have participated in a systematic program of training organized by either the Milton H. Erickson Foundation or by one of the accredited Erickson institutes located in different countries around the world.

The Milton H. Erickson Foundation, Inc. was incorporated October 29, 1979 and has since been dedicated to promoting and advancing the contributions made to the health sciences by the late Milton H. Erickson, MD. To this end, the Foundation provides ongoing education through conferences, small group trainings, and publications for health and mental health professionals.

In addition to the work of the Erickson Foundation, which is located in Phoenix, Arizona, there is also a network of Erickson Institutes that have spread around the world and also seek to advance Ericksonian therapy in their respective geographical areas. These professional groups have obtained permission from the Foundation to use Milton H. Erickson's name in the title of their organizations. They are directed by professionals that have met the Foundation's eligibility requirements, received high recommendation from affiliated professionals, and demonstrated knowledge of Ericksonian methods. The Foundation Board of Directors reviews each Institute application to ensure that they uphold the required standards.

In the same way that each individual practitioner has his or her own unique strengths, each training program has its own autonomous teaching procedures, most of which can be expected to include: education in Ericksonian principles of change and human thriving, education in both general and specific core competencies and practice with techniques that are unique to Ericksonian therapy, exposure to primary source material from Milton Erickson, and supervision or consultation for practicing therapists. Of course, any competent practitioner will also have the training and knowledge of the broader field as well as accountability to a licensing board. Because the designation "Ericksonian" is intended to signify an approach characterized by its diversity and continual growth, the most skillful and competent practitioners pursue ongoing training and consultation throughout their career.

## THE PURPOSE OF A CORE COMPETENCIES MANUAL

The purpose of this manual is to help clarify the communication, research, practice, and global standards of training for Ericksonian therapy. Although for some individuals the term "manual" brings to mind negative images of rigid protocols and cookie cutter approaches to treatment, the general intent for this manual is merely to ensure that any person who claims to practice, research, or teach Ericksonian therapy can have this claim measured against a universally agreed upon set of standards.

The knowledge and skills of a particular discipline constitute the core competencies of that approach. As defined by Marrelli, Hoge, and Tondora (2004), a core competency is a measurable human capacity that is required for effective performance. Core competencies include the knowledge, skills, and abilities that are required before the practitioner can say that he or she is using a particular model of practice. As with other evidence-based therapies, Ericksonian therapy is a conceptually distinct approach to therapy with specific core competencies that can be taught and measured in practice. It is evidence of these core competencies that makes outcome-based education (OBE) possible.

The *Core Competencies Manual on Ericksonian Therapy* consists of a series of principles covering the most important information for practitioners and institutes seeking mastery in Ericksonian therapy. These principles have been divided into relational foundations and a set of core competencies. The goal for the manual is to provide researchers and practitioners with a thorough grounding in the knowledge and skill sets that are most closely associated with outstanding clinical performance as an Ericksonian therapist.

The information contained in this manual is *generally descriptive* rather than conclusive and definitive. What that means is that this manual does not contain all that there is to know about Ericksonian therapy. Consequently, just because a technique or principle is not mentioned in this text, it does not mean that it is not Ericksonian. Rather, the manual is a collection of principles and practices that have the greatest consensus among contemporary scholars and teachers of Ericksonian therapy. Additionally, these principles and practices are unique to the practice of Ericksonian therapy, thus distinguishing it from other experiential, suggestive, or integrative therapies. At this stage in the ongoing evolution of Ericksonian therapy, the following sets of principles best encapsulate this unique form of clinical practice.

Moving forward, it is hoped that this manual will serve as a resource for the creation of new lines of research and improvement of existing training programs. The manual, relational foundations rating form, and core competencies scale will enable teachers to conduct an objective analysis of their students, and to identify areas of weakness for targeted teaching. Furthermore, seasoned practitioners, who wish to increase competency through deliberate practice, can record their own work and use the numerical scoring to identify and improve areas of weakness. These resources are meant to be shared with accredited Ericksonian Institutes around the world for training and research purposes.

## HOW THIS MANUAL WAS CREATED

Unlike other traditional schools of psychotherapy, Ericksonian therapy was not conceptualized by a single authoritative figure. Rather, this systematic method of therapy has evolved through time and practice as talented individuals, who were inspired by the casework of Milton Erickson, seek to practice and teach. Because there is no single architect of Ericksonian therapy, its progress and continued development is mostly the result of international congresses, popular books or videos, and programs of training conducted through the global network of Ericksonian institutes. It is through these means that Ericksonian teachers and scholars collectively seek to disseminate the most essential and replicable aspects of Milton Erickson's pioneering work.

Therefore, to achieve the objectives set forth for this manual, many of the field's leading Ericksonian teachers and scholars where contacted for data collection along with common practitioners of Ericksonian therapy. This information was then subjected to a systematic analysis designed to produce a comprehensive, credible description of Ericksonian therapy. The ideas developed in this manual represent the insights and experience of the following international body of respondents: Marilia Baker (USA), Rubin Battino (USA), Norma Barretta (USA), Consuelo Casula (Italy), Betty Alice Erickson (USA), Helen Erickson (USA), Roxanna Erickson-Klein (USA), Teresa García-Sánchez (Spain), Steven Gilligan (USA), Eric Greenleaf (USA), Carl Hammerschlag (USA), Abraham Hernández Covarrubias (Mexico), Jean-Claude Lavaud (Reunion Island), John Lentz (USA), Camillo Loriedo (Italy), Rob McNeilly (Australia), Scott Miller (USA), Michael Munion (USA), Idrissa Ndiaye (France), Bill O'Hanlon (USA), Ernest Rossi (USA), Dan Short (USA), Charles Simpkins (USA), Isabelle Prevot-Stimec (France), Bernhard Trenkle (Germany), Michael Yapko (USA), and Jeff Zeig (USA). While this is not all of the leaders and teachers of Ericksonian therapy, it is a broad and representative sample that is clearly capable of distinguishing Ericksonian therapy from other forms of therapy.

The following list of relational principles and core competencies of practice was arrived at by clustering items first in terms of face validity and later with the aid of Exploratory Factor Analysis (FAC). To this end, each of the experts listed above was asked to produce a list of competencies, techniques and/or principles that he or she considers most important for the competent practice of Ericksonian therapy. The request for information was broad and open-ended so as to collect as many relevant ideas as possible. Next, each distinct idea was treated as a single data point, which could then be grouped with other ideas that overlapped in meaning (i.e., face validity). These were then subjected to a two-dimensional sorting analysis that will be briefly described below and then in greater detail throughout the manual.

The first step in the analysis was designed to be inclusive of every idea submitted by the development team. These contributions ranged from a low end of 24 distinct data points to a high end of 212. The aggregate data set was then divided into the minimum number of superordinate categories required to capture every data point. This resulted in the formation of four broad categories. These four categories are meant to represent a universally agreed upon set of essential skills or practices for Ericksonian therapy:

1. Observation
2. Cultivation
3. Validation
4. Challenge

In order to achieve this level of data inclusiveness, the descriptors of these distinct skill sets are broad and nonconcrete. They tell us in general terms which clinical skills are considered essential for a competent and well-rounded practitioner of Ericksonian therapy. Although these descriptors are not specific enough for teaching and training, they provide a good starting point as we seek to build the "big picture view" of this unique form of therapy.

In order to achieve a greater degree of specificity and operational terminology, a second round of analysis was conducted, this time identifying only those clusters that were high frequency (i.e., those with the greatest number of data points). Any ideas that came from only one or two responders were dropped from the analysis. This created a larger more detailed set of core competencies. The six clusters that formed in the second analysis were:

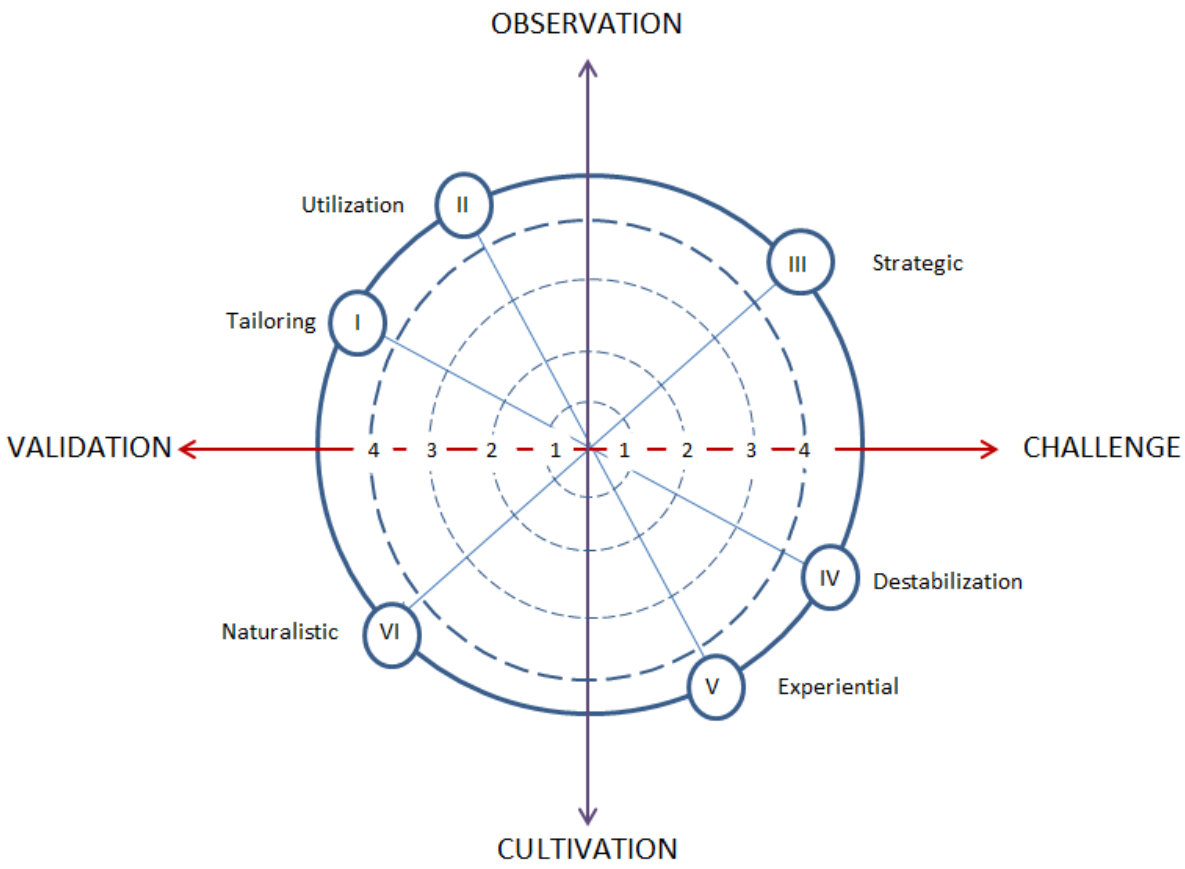
1. Tailoring
2. Utilization
3. Strategic
4. Destabilization
5. Experiential
6. Naturalistic

This is not to say that these are the only categories that can be used to define the work of Ericksonian practitioners. Rather, if you were to gather the most well-known teachers and authors on this approach to therapy and ask them to produce a list of the most essential characteristics of competent practice that are universally agreed upon, this is what the list would most likely look like.

The reason that a multi-dimensional analysis is needed to explain this complex and nuanced approach to brief therapy is due to the degree of overlap in some the data and because of the seemingly paradoxical results produced by the inquiry.

More specifically, experts agree that Erickson was above all else accepting of people and willing to validate their words and actions (i.e., a non-directive approach to therapy). Experts also agree that Erickson used provocative methods, therapeutic confrontation, and behavioral assignments in treatment (i.e., a directive approach to therapy). Subsequently, this multi-dimensional aspect of his work can be seen in today's practitioners of Ericksonian therapy.

But how does one reconcile these differences in a way that can be easily conceptualized and understood? The solution provided here is that all of the six core competencies share overlapping relational skills. The four relational skills identified here represent polarities that counterbalance one another resulting in a more nuanced and stable approach to therapy. To better understand this, imagine the range of ability in a therapist who only feels comfortable approving of people's actions, versus the therapist who only feels comfortable telling people what to do, versus the therapist whose capacity for validation is counterbalanced by an equally strong capacity for challenging individuals to do something that is in their best interest. These seemingly incompatible dualities are actually complementary forces that function together in the same way that joy and anger counterbalance and stabilize one another. This conceptual view of Ericksonian therapy is depicted in the diagram below.




As can be seen in the diagram, the core competencies of tailoring, utilization, and strategic approach require highly developed skills of observation (i.e., receptive communication). In contrast, the core competencies of naturalistic, experiential, and destabilization require highly developed skills of cultivation (i.e., expressive communication). Similarly, naturalistic, tailoring, and utilization all require a high degree of validation (i.e., soft power), while destabilization, experiential, and strategic require the ability to initiate and enforce structured activity designed to challenge established behavioral and mental sets (i.e., hard power). The importance of these complementary skill sets was briefly remarked upon by Erickson, in a teaching encounter with Jeff Zeig, when he explained his use of power stating that this type of therapy requires an iron-fist covered in a velvet glove (i.e., hard and soft power).

During data collection, one of the respondents commented, “I consider myself an Ericksonian psychotherapist, but I believe learning the nosology we have created to describe what we do, does not adequately reflect what makes the therapist competent.” This is an important point that requires more than a theoretical response. And it is why this manual includes a measurement device that has been subjected to extensive psychometric testing and found to reliably measure a set of core competencies that are inherent in the Ericksonian approach to therapy. This has been achieved with a degree of accuracy that enables raters to differentiate this type of therapy from other similar approaches. This component will be explained in greater detail later in the manual. The important point here is that the following concepts are a product of empirical investigation and, as a set, have been found to be meaningful indicators of whether or not a person is practicing Ericksonian therapy.

In summary, this manual is intended to provide a comprehensive description of Ericksonian therapy that is both conceptually coherent and empirically verifiable. There is a popular saying known amongst researchers of behavioral science: “If you cannot measure it, then it does not exist.” In other words, if you want to prove that something is real and not just a theory or superstitious belief, then you need to find a way to observe and measure it. To this end, each of the six core competencies in this manual have been explained in principle, then broken down into a minimum of four component parts, each of which are then defined using concrete operational terms.

As an integral part of this conceptual framework, two behavioral measures have been researched and developed in a summary scales format. Although each measurement device has its different strengths and weaknesses, they are conceptually congruent and can be used to numerically code videos of practitioners or students who seek to engage in the competent use of Ericksonian therapy. These resources can be found in Section IV, titled “Measurement Devices.” These tools, along with the following theory of change, model of health, and list of core principles are markers that help us better understand what gives Ericksonian therapy its unique identity.

## MILTON H. ERICKSON AND THE HISTORY OF THE ERICKSONIAN MOVEMENT

Milton Hyland Erickson (1901-1980) is considered an architect of innovations in psychotherapy that parallel those of Sigmund Freud. Whereas Freud is known as the father of modern theories of psychotherapy, Erickson is considered a landmark pioneer in the practical techniques of intervention and change. This pioneering spirit and willingness to take risks is part of his life story. Born in a dirt-floor, log cabin in a silver-mining town in Nevada, five year-old Erickson moved with his family to a farm in Lowell, Wisconsin. The journey began with a trip east in a covered wagon, an irony that Erickson enjoyed using to illustrate moving forward by doing things in a backwards fashion.

Farm life provided Erickson with many opportunities for problem solving every day necessities, patiently waiting for crops to grow, and for carefully observing the processes of nature. These qualities: pragmatism, patience and close attention, are evident in the practice of Ericksonian therapy. Tales of accepting hardship, overcoming adversity, accomplishing substantial work in increments, as well as using leverage for change, became a standard part of his teaching techniques, and are now used by therapists around the world.

At age 17, Erickson was stricken by poliomyelitis. While lying in bed paralyzed and fading in and out of consciousness, Erickson overheard a doctor advising his mother, "The boy will be dead by morning." This statement had a profound effect on Erickson and yielded a powerful emotional response. He did not believe anyone had the right to say this to a mother, let alone his mother. In a state of defiance, Erickson found sufficient physical energy to not only survive the night, but to survive the illness as well. The polio virus affected his entire body, and for a while his only voluntary control was over his eyelids. Erickson recalled this time as one of intense awareness – awareness of his own limitations and of his surroundings. He used months of tedious rehabilitation to learn about the interplay between mind and body, and during this period of confinement he became astutely aware of the patterns of behavior of

those around him, such as recognizing who was coming by the sound of the footsteps, and anticipating their emotional status prior to actually seeing them.

To complete his recovery, Erickson embarked on a six-week canoe trip down the Mississippi and back upstream. He was barely able to stand without crutches, incapable of portaging the route unassisted, and had minimal financial resources. Rather than asking for assistance directly, Erickson found that he could stimulate the curiosity of others and evoke unsolicited offers of help. Many nights, he "earned" his supper by telling stories to fishermen along the river. The practice of indirect suggestion and evoking resources as well as storytelling remain prominent features of the Ericksonian approach.

Upon graduation, Erickson took a series of positions in state hospitals working with seriously mentally ill patients. It was within the institutional setting that Erickson recognized the importance of humor, hope, and interpersonal connection. He found ways to benevolently confront patients with their own symptoms by either watching them performed by others or by having the patient intentionally perform the symptom behavior. Because he lived in housing located on the hospital grounds, Erickson was able to witness on a day to day basis any changes in his patients' condition. With this observational advantage, Erickson was able to see the effects of pattern interruption as well as the effect of changes to interpersonal context, and the effect of changes in perspective. He soon came to recognize that many of these served as a springboard for additional therapeutic progress.

A prolific writer, Erickson's contributions to the professional literature were ongoing; he became known for ideas and works. He was considered revolutionary by some and alarming by others. After moving to Arizona in 1948 and starting a private practice, other professionals sought to learn from him as his reputation grew both nationally and internationally. Despite debility from the severe after effects of polio and his increasing age, Erickson continued teaching up to the time of his death, leaving a broad influence on the field that has continued to thrive over the subsequent decades.

The reason Erickson's life story appears at the beginning of a manual on Ericksonain therapy is not for curiosity's sake. Rather, his life story is a source of inspiration, leading others to discover the sort of hope and resilience by which this therapy is characterized. Even in the worst moments of his life, Erickson never lost hope and faith in human potentialities. His illnesses and how he healed himself are clear examples of what hypnosis can do in the treatment of pain, depression, in healing traumas and losses, and in transforming despair into meaningful life. Even before his death, in 1980, the casework and principles of practice taught by Milton Erickson lead so many of his students into their own process of creative discovery. Excited by changes in their own life, and the lives of those with whom they have worked; Erickson's students have continued to expand his work in ways that do not necessarily match what he did. However, this new growth is still fruit of the original tree, and therefore Ericksonian.

# I. Theoretical Foundations

## Overview of Theoretical Foundations

Section I of this manual, on Ericksonian therapy (ET), both defines ET and describes the theoretical foundations that identify its practice, training, and ongoing research. The relationship between theory and practice within the Ericksonian community has always been controversial. Erickson taught his students to be skeptical of theory and any academic constructs that limit a practitioner's flexibility or stifle creativity. While the conventional wisdom within the research community is that good practice should be driven by theory, this is not the position taken by most scholars and teachers of ET. Rather, they emphasize the importance of knowledge developed through concrete experience and direct observation. As some have said, "It is the client who informs the therapy, not a textbook." Practitioners of ET consider clinical practice to be an ongoing research process, with greater value than overly reductionist models elaborated by people who have no direct knowledge of the client, therapist, or the immediate circumstances they face. From the earliest days, the formation of ET's theoretical foundations has followed Erickson's pioneering and inspirational work, rather than the reverse. The necessity of subsequently attaching abstract theory to concrete practice is analogous to attaching a street address and a phone number to one's home. These are not what make your house a home, but without them, others will have difficulty finding you. In that spirit, the following theoretical foundations are meant to locate ET among other schools of thought and define it as a professional practice.

### Ericksonian Therapy Defined

- *An experiential, phenomenologically based approach to problem solving that utilizes existing client attributes while evoking natural processes of learning and adaptation.*

### Theory of Health and Human Thriving

- *People have both universal and idiosyncratic needs that are innate, that drive behavior, and that produce a sense of flourishing and physiological wellbeing as these needs are satisfied*.

### Theory of Change

- *All of psychotherapy involves some form of reorientation, which is achieved by means of adaptive self-organizing processes.*

### Theory of Progress

- *Transformation is viewed as a paradoxical process that begins with the absolute acceptance of clients, for it is they who will suggest the answers to the therapist and often the problem becomes the solution.*

## ERICKSONIAN THERAPY DEFINED

Ericksonian therapy is broadly classified as any goal-oriented, problem solving endeavor grounded in methodology inspired by the teachings and casework of Milton H. Erickson, MD. More specifically, *Ericksonian therapy is defined as an experiential, phenomenologically based approach to problem solving that utilizes existing client attributes while evoking natural processes of learning and adaptation.* Meaningful therapeutic change can occur across multiple systems (e.g., cognitive, behavioral, affective, subconscious, autonomic, and social systems) as symbolic or directly lived experiences are used to destabilize maladaptive patterns and bring forth inherent resources that can be utilized for immediate and future problem solving endeavors. Hypnosis and/or hypnotically derived methods are central. Utilizing inherent resources that may be obscure to the client is essential; while an explicit theory of personality and the interpretation of past patterns are not.

Ironically, Ericksonian therapy is sometimes referred to as a theory of change that has no distinct theory, or a collection of techniques that includes anything that works. Similar to the paradox in a Zen koan, Erickson's approach to therapy rests on the premise that doubt and generative creativity are more important than intellectual certainty and standard procedures. That having been said, through time and continued development, a systematic set of principles has evolved that are both cohesive and universally agreed up. As will be seen shortly, it is the principles, rather than the exact practice, that defines the Ericksonian approach.

In contrast to many traditional schools of therapy, Ericksonian therapy is not a systematic set of procedures or treatment protocols, but rather a constellation of principles that guides the therapeutic process. The core of Ericksonian influence is the very permissiveness that makes it difficult to define. While the roles of practitioner and client remain distinct, neither are constricted by orthodoxy or protocol; rather each are free to explore any ethical direction or possibility elicited through the process of therapeutic discovery.

In this regard, Ericksonian therapy is a *perspective* of learning, healing, and growth that fosters flexibility in an ongoing adaptive way. Thus, practitioners are admonished to exercise great flexibility and creativity as they work *collaboratively* with the client. The standard by which progress is measured is subjective and established by the client relative to his or her personal goals (i.e., phenomenological).

In this approach, the therapeutic relationship exists for the sake of meeting the client's needs. During this cooperative endeavor, the therapist accepts and encourages the client's attempts to direct and influence the therapy process. In turn, the client is more open to the influence of therapy. Thus the relationship, which revolves around cooperation, can be described as reciprocal and self-reinforcing.

In the same way that the scientific method is used by all scientists and generally agreed upon; the core competencies listed in this manual are used by Ericksonians around the world and generally agreed upon. However, just as there is no canonized version of the scientific method, there is no single document that authoritatively defines Ericksonian therapy. Rather, it is a mostly democratic and continually evolving set of ideas that have in common the inspiration provided by the pioneering casework and teaching of Milton H. Erickson. While all forms of psychotherapy arguably change with time, this fundamentally human process of evolution is built into the design of Ericksonian therapy,

which promotes ongoing change at the level of micro interactions, as the therapist adapts the therapy to the changing needs of the individual on a session by session basis; and it is designed to evolve at the macro level as ET adapts to meet the needs of a changing society and to derive benefit from emerging research in the health and social sciences.

In 1979, Erickson famously commented to Ernest Rossi, "To initiate this type of therapy you have to be yourself as a person. You cannot imitate somebody else, but you have to do it your own way." This mandate set in motion a system-wide process of self-exploration that is reciprocally enjoyed by the therapist and client alike. Because individual autonomy is a core principle in Ericksonian practice, it is expected that Ericksonian teachers and practitioners, from around the world, will conduct therapy in somewhat similar though uniquely different ways. While the methodology is expected to vary across cultures, regions, therapists, and individual cases, the core principles of Ericksonian therapy act as a hub around which all of the work of therapy revolves. In other words, there is no pure methodology or orthodoxy by which an individual's skills can be measured. However, there are a universally agreed upon set of values that are reflected in the core principles and that can be used to discern competency in the practice of Ericksonian therapy.

Once again using the scientific method as an analogy, while there is no one "right" way of doing science, skillful researchers are trained in the most widely adopted experimental protocols, they have read the work of the most celebrated philosophers of science, and they expose their work to the scrutiny and correction of their peers. Similarly, skillful Ericksonians are familiar with widely adopted Ericksonian techniques of therapy. In addition to studying the numerous theoretical constructs used to explain these techniques, they have familiarized themselves with Erickson's original ideas and casework. Skillful practitioners are willing to have their own work observed either within the context of supervision and ongoing consultation or objectively measured for the sake of deliberate practice and training.

Arriving at a universally agreed upon definition and classification of Ericksonian therapy has been challenging, to say the least. However, Ericksonian therapy certainly exists for the thousands of its practitioners around the world and the even larger number of people whose lives they have helped improve. And because it is different from other forms of therapy, it can therefore be identified and measured.

## THEORY OF HEALTH AND HUMAN THRIVING

While all individuals are assumed to have differing needs and uniquely constructed values and beliefs, any general plan for providing therapy must be organized around some core assumptions about mental health and human thriving. These core assumptions serve as a sort of beacon in the distance, such that as the therapist seeks to maneuver in accord with the idiosyncrasies of each individual client, a familiar destination is always kept in sight.

In line with other forms of drive theory, Ericksonians generally recognize a large class of instinctual needs that are highly relevant to health and wellbeing. Most agree *that people have both universal and idiosyncratic needs that are innate, that drive behavior, and that produce a sense of flourishing and*

*physiological wellbeing as these needs are satisfied.* Thus human thriving is in great part a subjective experience derived form an ongoing process of need fulfilment.

While there is no single doctrine of Ericksonian therapy that endorses a specific list of needs, the following list of seemingly inborn tendencies is inclusive of universal needs that are commonly identified by Ericksonian experts and scholars as being closely associated with the inspiring work of Milton Erickson. These are the needs that are most commonly utilized in contemporary practice and that help provide a "big picture view" for the sake of clinical judgment and strategic planning:

> The Need for Survival: to seek safety and a felt sense of security for the sake of self-preservation as well as propagation of the species. Survival can be physical or symbolic and therefore includes reproduction, protection of family and of communities, and creating a legacy that extends beyond one's lifetime.
>
> The Need for Altruism: to exercise compassion, generosity, and self-sacrificing for the sake of others (even to the point of endangering one's own life to save a stranger). Erickson believed that people are naturally altruistic and thrive while helping others. It is also assumed that altruism is present from birth (i.e., people are born good), is intrinsically rewarding, increases happiness, and is driven by unconscious processes (i.e., it can be swift and automatic, before there is time for thought or reason).
>
> The Need for Belonging: to establish outside confirmation of our identity, outside confirmation of emotional realities, and the meaningfulness of our lives. Belonging can be established through marriage, families, friendship, teams, and groups that share common beliefs, or any other gathering of people that is capable of building affiliation and promoting altruism (i.e., giving and receiving love).
>
> The Need for Meaning: to be a contributing member of society and to find meaning in existence. To be able to structure one's daily life with purpose driven activities that ultimately serve the causes of survival, altruism, and belonging. Meaning can also come in the form of increased learning, meaningful labor, expanding self-awareness, and the cultivation of interpersonal relations.
>
> The Need for Novelty & Creativity: to be growing, learning, discovering, and uniquely designing our life experience. Problem solving is meant to be a creative endeavor that is both progressive and flexible, as the individual seeks out and responds to meaningful challenges (i.e., the brain and body are made for novel stimulation rather than rigid repetition and stereotypic problem solving). For these reasons, people are most likely to thrive when afforded exposure to novelty and opportunities for creative learning.

With this knowledge, the practitioner is able to improvise techniques of therapy and respond flexibly to the immediate needs of the client without becoming lost or confused about the overarching therapy process. Still using navigation as a metaphor, we could say that these five points are analogous to the points on a compass. They help the Ericksonian practitioner and client keep from getting lost while searching for a meaningful destination.

### *Therapy as Problem Solving*

Given the previous definition of health and human thriving, the process of Ericksonian therapy essentially becomes a matter of strategic problem solving. The overarching strategy of Ericksonian therapy is to provide a context in which the client produces his or her own solutions. Thus a core element of the Ericksonian approach is to focus on and amplify existing strengths and motivation to engage in the task of solving problems.

While there are many forms of therapy that seek to empower their clients, the Ericksonian approach is uniquely focused on helping people develop unconscious resources as well as conscious deliberative skills that are employed for the sake of resolving unmet needs. Similar to the practice of physical therapy in medicine, once these psychological resources have been identified and developed, it is assumed that the client will continue to use them throughout a lifetime of problem solving, but without requiring the special assistance of a therapist.

### *Pathology-Centered Problem Solving versus Need-Centered Problem Solving*

Following the ideology of the medical model, many schools of therapy have been built around the task of identifying and curing client pathology. However, in contrast to pathology-centered problem solving (i.e., diagnosing and treating disorders), need-centered problem solving is primarily concerned with the agency of the client (rather than the agency of some drug, procedure, or knowledge of the person providing care). Thus, one of the important ways that Ericksonian therapy distinguishes itself is through its focus on learning, increased motivation, and utilization of existing strengths and resources.

It would be incorrect to state that Ericksonian practitioners never make use of diagnostic categories. Rather, the practitioner is careful to avoid using diagnostic labels in a manner that creates learned limitations or loss of motivation. Problem identification is generally recognized as a useful step in problem solving. Clients often report feelings of relief when a vague sense of distress is recognized and put into words. But for most Ericksonians, real therapeutic achievement does not occur until the client is pointed in the direction of being able to do something about the identified problem.

In keeping with Erickson's pragmatic approach to problem solving, Ericksonians are reluctant to spend time or energy on explaining to clients why they do not already have the salient resources for effective problem solving. Rather, emphasis is placed on helping people locate and develop them.

Erickson believed that most of his patient's problems were due to learned limitations. This is a pragmatic perspective that focuses attention on what can be achieved as a result of new learning. For example, the limitation could be an underestimation of one's innate ability to overcome challenges and achieve desired results, or an underestimation of the availability of social and environmental resources needed to increase one's capacity to meet a given challenge, or an underestimation of one's ability to adapt to immutable circumstance. When viewed from this perspective, any disease, situational challenge, or even death itself, becomes a secondary concern to the task of learning more about what one can do. Thus the emphasis during problem solving is shifted away from finding "the cure" to finding the will to build and indefinitely pursue a good life.

### *Therapy as a Process of Experimentation and Discovery*

As has already been mentioned, ET distinguishes itself from the medical model in certain key ways. One of these is that it does not propose ready-made solutions or research-based answers to the problems faced by clients. Rather, the client and therapist join together in a collaborative process of experimentation and discovery. Paradoxically, it is this position (of not holding the answers) that makes the Ericksonian practitioner best suited for helping clients find solutions.

In this regard, Ericksonian therapy can be described as a process of experimentation and discovery. Effective problem solvers generate many possible plans of action prior to attempting a problem solution. In Ericksonian therapy, the client and therapist collaborate to create alternative plans of action and a means of identifying successful outcomes. This spirit of experimentation is important for increased flexibility and resiliency, when results are not forthcoming. From this perspective, the process of therapeutic problem solving then becomes the consideration, selection, and application of various solution hypotheses intended to facilitate the client's own problem solving capabilities. Even more important than resolving the presenting problem, Ericksonian therapy aims at the discovery of human potential and unrealized abilities—a discovery that is open to the client and therapist alike.

Since the time of James Braid (1848) hypnosis has been defined in terms of the fixation of attention. But within ET the act of fixating attention is not as important as what the client's attention is fixated on. The ET approach is implicitly positive. The implication behind all attempts at hypnosis and suggestion is that the person can focus on the things about themselves that are positive and good. These focal points include what the client believes in, values, or deeply appreciates. Rather than acting as an exogenous agent of change, Ericksonian hypnosis is used as a form of evocative communication in which the client is prompted to respond to the subjectively interpreted meaning of the communication, which is then used to elicit and utilize unconscious resources as well as conscious resources. Thus, Ericksonian hypnosis is the art and science of the communication of expectation to enhance health and happiness for people. Indeed, all aspects of the Ericksonian approach are aimed at doing just that.

## THEORY OF CHANGE

### Self-Organizing Change

Erickson viewed the human organism as a complex, ever-changing, organized collection of intellectual, emotional, and biological processes, which have both conscious and unconscious dimensions. He taught that all humans possess impressive self-organizing, adaptive abilities that should be evoked and brought into service in therapy. As explained by Erickson, "*the locus of creative transformation in all forms of psychotherapy is actually within the patient's own mind and body – not the therapist's – the burden of responsibility for effective psychotherapy is the patient's own inner work.* How to facilitate the patient's

own creative inner therapeutic work is the burden of the therapist's responsibility in effective psychotherapy."[1]

In traditional schools of thought, the theory of change will typically target a single aspect of the human experience that is considered crucial for wellbeing. The enterprise of that therapy is then focused on changing that one thing (e.g., CBT=changing dysfunctional cognition). Ericksonian therapy, by contrast, is intended to be inclusive of all aspects of the human experience. It is designed to address a person's conscious beliefs, unconscious beliefs, inner self-dialog, interactions with others, memories, dreams for the future, muscular activity, functioning of the autonomic nervous system, the immune system, and any other aspect of human functioning that is impacted by the mind.

As stated by Erickson, *all of psychotherapy involves some form of reorientation, which is achieved by means of adaptive self-organizing processes*. This reorientation can occur as a change in *perspective*, such as when a person develops new attitudes or beliefs, a change in *frame of reference*, such as when a person gains new life experiences or has new information, a change in *central nervous system activity*, such as when intense anger is aroused, relaxation is induced, or pent up tears are released. Then there are also changes in key *situational factors*, such as when a person decides to get a new job, get married, or go back to school, which can stimulate a reorientation in all the domains listed above.

Whereas many therapeutic approaches emphasize a reorientation in emotional experiencing or cognitive processing, Erickson used social and contextual resources to create an experiential process designed to facilitate self-organizing change. Thus, Ericksonian practitioners often employ experiential, physical, or situational activities to achieve reorientation across numerous domains at both conscious and unconscious levels.

As stated above, Erickson believed that change can and often does take place on an unconscious level. This deep form of healing and growth involves unseen processes of reorganization, re-association, and adaptation. Ericksonian interventions are often targeted to the realignment and reorganization of pre-existent internal resources, an awakening of previously unknown capabilities. To the greatest extent possible, these experiences are tailored to the needs of the individual. Thus, it is the principles of Ericksonian therapy that remain fixed, while the method of implementation is by necessity fluid and flexible.

## THEORY OF PROGRESS

### Nonlinear Paradigm of Learning and Progress

In Western thought, cause-and-effect relationships are often considered in linear terms. In therapy, it is natural to assume that intervention "A" will consistently lead to outcome "B". For Erickson, cause and effect were seldom linear. Rather, *transformation is viewed as a paradoxical process that begins with absolute acceptance of clients, for it is they who will suggest the answer to the therapist and often the*

[1] This quote is taken from a classic paper, *The Burden of Responsibility in Effective Psychotherapy,* by Milton H. Erickson, 1964.

*problem becomes the solution.* Thus, progress is said to occur when clients discover previously unrecognized capabilities that can be employed in some meaningful way.

In this regard, Ericksonian therapy often follows a nonlinear path of change. Erickson explained that sometimes you must go backward in order to move forward. For example, gaining control over involuntary behavior by doing it intentionally, or helping a person recognize productive behavior by engaging in unproductive behavior, or prescribing relapse as a mean of encouraging long-term progress, etc. This again is an experiential process that engages parts of the mind that cannot be understood with conscious intelligence. Therefore, rather than attempting to explain why failure is sometimes needed for the sake of progress, or why confusion is necessary for learning; the Ericksonian practitioner recognizes the value of a nonlinear paradigm of learning and progress.

# II. Relational Foundations

## Overview of Relational Foundations

Section II of this manual, on Ericksonian therapy (ET), consists of a series of four superordinate skill sets that encapsulate the relational foundations upon which the practice of ET is formed. In addition to making ET a dynamic and interpersonally engaging form of therapy, these four skill-sets help inform everything else that is to occur during the course of therapy. The goal for this part of the treatment manual is to provide practitioners with essential interpersonal objectives from which all aspects of clinical judgment and client motivation are derived. Well-trained Ericksonian practitioners are continually seeking to enhance the following four skill-sets:

### Skill Set 1: Observation

- *A willingness to be intimately perceptive in relation to others*

### Skill Set 2: Validation

- *A willingness to be accepting and supportive in relation to others*

### Skill Set 3: Cultivation

- *A willingness to be evocative and inspiring in relation to others*

### Skill Set 4: Challenge

- *A willingness to be directive and motivational in relation to others*

## Relational Foundations

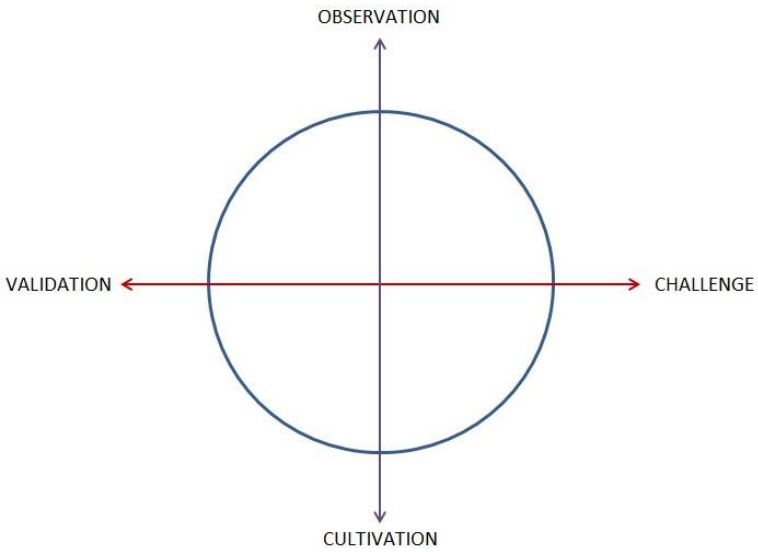
If there is any single skill that might be used to summarize all else that is Ericksonian, it would be the general ability to connect with others in deep and compelling ways. Whether you are describing the therapist's use of effective communication, interpersonal flexibility, skillful observation, or love and compassion, it all comes back to the therapist's ability to form a meaningful attachment with those who are otherwise lost or isolated in some problematic life-circumstance.

As stated earlier, in ET successful problem solving is not attributed to use of a curative technique, rather a special state of relationship is formed. It is said that Ericksonian therapy is done WITH rather than TO the client. This statement implies a collaborative underpinning that exists in support of every technique. Erickson often spoke of the primary importance of securing the client's trust and cooperative involvement as a prerequisite to any other therapy methodology.

This emphasis on relational foundations has now been recognized in the broader field as a common factor in all successful therapies. This common factor is generally referred to in terms of building a *therapeutic alliance*, which in the context of hypnosis has historically been described as rapport, and in more recent times also referred to as attunement and attachment.

In addition to these two important dynamics (i.e., collaboration and alliance), it has been argued that the primary benefit of Ericksonian therapy is the model it provides for engaging the heart and opening the mind. The relationship that forms during Ericksonian therapy is designed to be both emotionally deep and highly motivating. Using the language of state theory, this heightened interpersonal experience has been described as a "performance state" that produces mutual benefit for both the client and therapist. The basic idea is that clients must feel at deep levels that their therapist cares and is acting on behalf of their wellbeing, in order for the rest of therapy to yield positive results. All of the techniques of Ericksonian therapy are assumed to be helpful only when conducted within the context of this special form of relationship.

As will soon become obvious, the elements of a deeply felt connection (within the client) cannot be measured by asking the therapist what he or she intended to achieve. A person can intend to be highly observant, and still miss things that are really important to the client. Similarly, an impartial observer cannot rate the effectiveness of the therapist's observation. Rather, meaningful measurement must come from the client. In the same way that therapeutic alliance is commonly measured by asking the client to comment on his or her subjective experience; the relational foundation that underlies all other Ericksonian interventions must be reported by the client. For this reason a rating scale has been included in this manual. Unlike other measures of therapeutic alliance, this device has been designed to measure key relationship dynamics that Ericksonian therapists consider most essential.




During the 2016 survey of teachers and scholars of Ericksonian therapy from around the world, there were four broad categories of interpersonal engagement that were commonly endorsed. These ideas have been grouped under the umbrella terms: observation, validation, cultivation, and challenge. Each of these will be described in greater detail in the following sections.

## OBSERVATION: A willingness to be intimately perceptive in relation to others

The first relational foundation is the use of careful observation. It has been argued that some of the most important core competencies in Ericksonian therapy (e.g., individualization, problem solving, and utilization) require highly developed skills of observation. More than reading nonverbal behavior or facial expression, careful observation is meant to serve as the basis of inspiration and clinical judgment. When one of Milton Erickson's students, Norma Barretta, asked him for the three most important aspects of doing effective clinical work, Erickson's reply was, "Observe…observe…observe."

Because the Ericksonian practitioner really looks and listens attentively to everyone's unique story, he or she is better prepared to tailor the therapy and utilize unrecognized skill sets and resources. Because the Ericksonian practitioner listens not only to what is said, but also for what the client has avoided saying, and because the therapist watches for reoccurring patterns in behavior, he or she is able to make surprisingly accurate estimates about past and future actions. This type of predictive ability is necessary for strategic problem solving, which requires planning and preparation. Other observational skills include learning how to see strength, where others only see weakness; or learning how to identify resources, where others only see limitations. These are all essential to the problem solving endeavor.

A useful way to conceptualize therapeutic observation is as a *receptive communication skill*, which includes careful listening. Observational acuity is recursively linked to cultivation (which is an expressive communication skill). What this means is that the therapist cannot express therapeutic ideas skillfully unless there has been careful observation. Also, the skillful expression of important ideas will necessarily be followed by careful observation so that their effect can be determined.

In contrast, a client can sit in front of an unskillful therapist and not feel seen or not feel heard. When this happens, the motivation needed to engage in any other therapeutic process will be sorely lacking. An equally detrimental rupture to the relationship occurs whenever the client feels judged or misunderstood. For this reason, Ericksonian practitioners observe without interpreting. If a behavior or experience needs to be interpreted, it is the client rather than the therapist who makes sense of what has occurred. Not only does a therapist interpretation risk distortion of the client's own self-exploration, it also interferes with the process of validation, which will be described in greater detail below. These are some of the many reasons why those who studied directly under Erickson were taught to quietly observe, accept, and utilize whatever a client brings to therapy.

## VALIDATION: A willingness to be accepting and supportive in relation to others

The second interpersonal dynamic that has been closely associated with Erickson's work is that of acceptance and finding value in what has been said or done. In reading the transcripts of Erickson's work with clients, it is interesting to note that the word he repeats far more frequently than any other is the word "yes," which is often expressed more fully as, "Yes…that's right". This was Erickson's common reaction to any act of self-disclosure. Whether it was an emotional disclosure or an intellectual opinion, Erickson's immediate response was to demonstrate support and find value in whatever had been expressed. This is the operational definition for therapeutic validation: *to demonstrate support and find value in what has been expressed by the client*. (Although the word "validation" has been used here to describe this skill, other terminology includes: accepting the individuality of the client, honoring subjective realities, and ratifying the uniqueness of the client.)

If a primary objective in therapy is to elicit a full and uninhibited expression of the client's individuality, then total acceptance of the client's responses to therapy is a given. In this regard, validation is an important means of connecting deeply with the client at both conscious and unconscious levels. This type of connection then gives clients the ability remain open to new ideas and the willingness to hear and accept what is being suggested. This special state of heightened suggestibility is carefully protected by refraining from any negative judgments or rejection of the client's self-disclosure(s). Thus, practitioners of ET are reluctant to disagree with anything the client says or thinks, unless there is some motivational value (e.g., restraining methods/"not yet," evocation of constructive anger, etc.).

One of the clear mandates of Ericksonian therapy is that it is respectful of the individual. As part of this respect, the person is not expected to conform to socially mandated norms but instead is free to explore unique ways of knowing one's self and interacting with the world. The therapist then seeks to provide validation of the behavioral manifestations of the client's internal responses, which leads to more self-disclosure and increased interpersonal influence. The more the client feels welcomed and accepted for whom he or she is, the more the collaborative process is reinforced and the change process naturally engaged.

If the therapist takes the proper perspective, then all that occurs in therapy can be endorsed as the "right" outcome. For those who do not do much during therapy, a validating reply is, "Your careful,

contemplative response to therapy is a really good sign!" (Any response is good as long as the therapist is not completely ignored). For those who burst into tears during therapy, a validating reply is, “Your body is releasing tension, this is going to bring you great relief.” For those who do not believe success is possible, “Your unconscious mind is going to have to hide your success. You will not be able to see your success, not until you are ready.” It is especially important to validate progress. For example, if the client looks happy and excited, and asks the therapist "Was that supposed to happen during trance?" the validating reply is, "Yes! It was supposed to happen exactly that way."

The skillful therapist is always mindful of the threat of rejection or shame and instead strives to communicate acceptance. This level of protection is not possible when seeking to control the client, even in the smallest regard. Instead, the Ericksonian practitioner not only accepts but also finds value in everything the client does (i.e., validation). Although validation can be spoken, or expressed nonverbally, it is mostly *a receptive communication skill that is dependent on an earnest desire to understand others and to see the significance of their existence*. Once again, this general ability is recursively linked to a willingness to challenge the status quo, which is an expressive communication skill that focuses on the experience of change.

## CULTIVATION: A willingness to be evocative and inspiring in relation to others

Another essential relational foundation is *the expectant cultivation of unrealized potential*. In addition to the combined qualities of curiosity and patience, cultivation is a readiness to give the client the same type of care a parent would show for a growing baby or a farmer for a newly planted crop. Some of the most important core competencies in Ericksonian therapy (e.g., destabilization and experiential learning) do not make sense unless the therapist is willing to engage the client in a process of learning and growth. These are expected to take place within a relational context that promotes self-exploration and self-organization at levels beneath conscious awareness.

When one of Milton Erickson’s students, Ernest Rossi, commented on the importance of self-exploration during therapy, Erickson explained, “Life isn't something you can give an answer to today. You should enjoy the process of waiting, the process of becoming what you are. There is nothing more delightful than planting flower seeds and not knowing what kind of flowers are going to come up.” When a therapist is able to take similar delight in the growth of clients, then the dynamic of cultivation is present.

Among Ericksonian practitioners, the idea of planting seeds is important. This agricultural analogy is used to distinguish the naturalistic approach to hypnosis from other more authoritarian approaches. Although it is not prerequisite, most Ericksonian therapists have studied the principles and practice of hypnosis and use these formally or informally throughout the course of therapy. This is seen especially in using the naturalistic approach, experiential learning, and destabilization. Each of these can facilitate altered states of consciousness even without a formal induction procedure. When techniques such as permissive suggestion or hypnotic metaphor are used to suggest a meaningful possibility, the subsequent process of self-exploration and discovery is often referred to as “seeding.” As with plants, humans seem to require certain environmental nutrients in order to thrive. Within the context of

therapy, essential nutrients include kindness, patience, positive expectancy, the gift of hope, and the liberal use of humor. Each of these qualities becomes closely associated with a way of engaging the client that encourages the flowering of ability.

Built on a philosophy that recognizes an innate human tendency toward health and wellbeing; the Ericksonian approach views clients as having the ability already inside of them to bring about healing and growth. Cultivation is thus a matter of expressing confidence in this ability and positive expectancy for what it will yield. If the therapist views this as a circular process, rather than unilateral, then therapy provides opportunity to cultivate growth in the therapist as well.

As opposed to "interventions," which are unilateral, cultivation is a two-way street. The therapist does not know in advance how he or she will grow while working with a particular individual. However, if therapy is embraced as a growth opportunity, then the therapist's own tendencies toward growth and learning are also activated. The resulting creativity and positive energy not only becomes a powerful force for the person receiving therapy, but it is also what electrifies those who offer the therapy.

## CHALLENGE: A willingness to be directive and motivational in relation to others

This final category of relating is the least well-defined in the Ericksonian literature and subsequently one that received the least amount of attention during the 2016 survey. Perhaps this is because a misunderstanding of what it means to challenge others (in a respectful and therapeutic manner) can lead to disastrous outcomes. But without this element of relating, the relationship cannot progress beyond passive recognition, with the therapist acting more as a follower than a leader. Or to use a sports analogy, the therapist becomes more of a cheerleader and less of a coach.

What does seem to be universally agreed upon is the identification of Ericksonian therapy as a directive rather than non-directive approach to therapy. It is also agreed that the Ericksonian practitioner will seek evidence of commitment to therapy, which includes participation in some effortful activities. The most classic example comes from Erickson instructing new patients to climb Squaw Peak (which is a steep hiking trail) and then call back to schedule the first appointment. This example provides some idea of what it means to challenge the client.

The basic assumption is that where challenge is lacking, motivation begins to wan. The practitioners who do therapeutic challenges well seem to understand how to calibrate it to fit the individual. When the challenge is too great it results in anxiety or a sense of being overwhelmed. But when the element of challenge is missing, motivation is replaced with boredom.

The means of challenging clients can come in many different forms. In some cases, challenge means speaking the truth to the client when the truth is difficult to hear. In other instances, challenge means evoking strong emotions that have been previously denied and perhaps feared. For some individuals, the challenge may be to tolerate kindness that is directed their way or to listen to someone list their positive qualities. Whatever the individual case may be, the Ericksonian practitioner stands ready to stimulate further responding within the context of a cooperative and respectful relationship.

In order for a task or homework assignment to be therapeutic, versus abusive, it must always be safe, respectful of all involved, and freely chosen. First and foremost, the Ericksonian practitioner must always seek to do no harm, either physical or emotional.

It should be recognized that any of these four relational dynamics can be problematic if not properly counter-balanced. Without sufficient grounding in the polarity of validation, a therapist's efforts to challenge the client could result in poor relating. But when the iron fist is covered in a soft velvet glove, then even the most fragile of individuals can be handled without damage.

# III. Core Competencies

## Overview of Core Competencies

Section III of the treatment manual on Ericksonian therapy (ET) consists of a series of six defining principles that subsume most of the techniques and clinical strategies unique to the practice of ET. In addition to giving ET its distinctiveness as a unique form of therapy, these six principles represent common factors found in most therapy sessions across a wide variety of clientele and presenting complaints. The goal for this part of the treatment manual is to provide practitioners with a thorough grounding in the knowledge and skills associated with competent practice. Well-trained Ericksonian practitioners are proficient in the following six areas:

### Competency I: Tailoring

- *A readiness to individualize treatment*

### Competency II: Utilization

- *A readiness to utilize intrapersonal and interpersonal dynamics as well as situational factors*

### Competency III: Strategic

- *A readiness to create a self-organized problem solving context*

### Competency IV: Destabilization

- *A readiness to disrupt stable psychological patterns to encourage flexibility and learning*

### Competency V: Experiential

- *A readiness to prioritize open-ended experiential learning*

### Competency VI: Naturalistic

- *A readiness create the expectation that change will occur naturally and automatically*

## I. TAILORING: A readiness to individualize treatment

One of the basic tenets of Ericksonian therapy is that every client is a unique individual who requires a unique therapeutic treatment. Unimpressed with the results produced by treatment standardization and replication, Erickson viewed the individualization of treatment as a therapeutic imperative. He objected to protocols of how therapy should proceed. Instead, Erickson emphasized the importance of observation and flexibility as he used immediate knowledge of the client to guide intervention, rather than theoretical knowledge derived from a diagnosis.

Ericksonians do not engage in formulaic therapies or "one size fits all" techniques. Of course, this does not mean that practitioners cannot repeat useful methods. However, during the course of individualizing treatment, the Ericksonian practitioner modifies every technique to make it the best fit possible for the immediate situation.

While standing firm in this principle, it is essential to remain absolutely flexible in the applied methods. As explained by Erickson (1979) while teaching Ernest Rossi, *"Psychotherapists cannot depend upon general routines or standardized procedures to be applied indiscriminately to all their patients. Psychotherapy is not the mere application of truths and principles supposedly discovered by academicians in controlled laboratory experiments. Each psychotherapeutic encounter is unique and requires fresh creative effort on the part of both therapist and patient to discover the principles and means of achieving a therapeutic outcome.*" The most perfect instance of tailoring means that you found just the right thing to do, at just the right moment, for this one unique individual. The goodness of fit expires the minute it has been used.

Because each person is an individual, each session is a unique creation. When the therapist and client first meet, they create a relationship that did not exist before. In this new system, each will influence the other in potentially unexpected ways. This natural opportunity for creativity can be resisted by the therapist, if he or she turns to a script taken from a treatment manual or begins to recite a rehearsed protocol. However, in Ericksonian therapy creativity itself is seen as an important mechanism of health and therefore it is embraced at every opportunity. Because there are relatively few theoretical mandates to guide and structure the therapy session, the therapist is forced to rely more heavily on his or her own observational skills and creative insights as well as the insight and creativity that is waiting to be discovered within the client.

As stated earlier, skillful observation is a crucial component in several of the core competencies. This is especially true for individualization of treatment, which requires discernment of how the client is special and different from others; recognition of hidden strengths and resources that can be utilized in therapy; and an appreciation for the client's passions and unique interests. Furthermore, it is important to inquire about what the client considers to be his or her idiosyncratic qualities, favorite memories, long-term dreams, most important needs, strongest values, and deepest desires or wishes. All of these are a meaningful part of the client's total identity and therefore a powerful engine for change.

Other important factors to observe include the client's focus of attention; sudden shifts in thought; the avoidance of certain topics or the change in voice tonality when certain words are mentioned; unacknowledged emotions that can be seen on the face or skin; how the problem is framed by the

client, the repetition of certain words, iconic gestures, or metaphors. Each of these represents special states of awareness, any of which can be explored and/or altered to produce new possibilities for the discovery of a solution. Thus the therapist seeks to learn the client's unique individual ways of responding and then uses the knowledge to modify all subsequent therapy. This will lead to a tailored and unique therapy and will naturally result in a special relationship with each single client.

Using the lexicon of the broader field, this entire process could be classified as a form of assessment. Certainly, Ericksonian practitioners recognize the importance of assessment not only during the initial visit but throughout the duration of the therapy. However, the goal of assessment is not to arrive at a diagnosis but rather to collect as much information as possible about the unique needs, resources and perspectives each person brings to therapy. All interactions by the therapist are designed to meet the needs of the client. Therapy is never random or reactionary. While the first priority is to learn the client's conceptualization of needs as expressed with language, it is assumed that explicit knowledge provides an incomplete picture. Observations of unconscious processes such as implicit logic and unconscious emotion are made by studying innuendos, patterns of behavior, and non-verbal expression. This information is then used to formulate a carefully tailored approach to therapy.

## Central Assumptions of Tailoring

There are a number of central assumptions that undergird the process tailoring and govern a therapist's clinical decision making and behavior towards the client. Knowledge of these assumptions enables the practitioner to operate in accord with the spirit of the intervention rather than mechanically reproducing established techniques –

- Every client requires unique therapeutic treatment
- Creativity itself is an important mechanism of health and therefore essential to therapy
- Immediate knowledge obtained by observation is more valuable than theoretical knowledge derived from academia
- Some of the most meaningful messages between people are nonverbal
- All people operate from a logical framework that makes sense to them and that should be used to help them make sense of therapy
- The words chosen by clients have special meaning and important emotional associations, therefore those are the words that are best suited to convey therapeutic messages
- The client should not have to modify his/her behavior to fit the needs of the therapist; rather it is the therapist's responsibility to adapt his/her style of relating to fit the needs of the client
- Therapeutic progress occurs when the client feels ready and able to work, which is something that cannot be outlined in a rigid schedule or treatment protocol
- The client's needs can change on a day-by-day basis as might his or her goals, therefore therapy is an ongoing process of careful observation and constant recalibration

## Operational Examples of Tailoring

What does Tailoring look like?

| **Tailored the language of therapy to fit the client** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used the client's words. Did not substitute terms. | Used a great deal of psychological jargon or substitute terms. |
| Built understanding from the client's first-hand experience: used examples and analogies from the client's experience (i.e., reflected the client's experiential language). | Introduced ideas by mostly referencing research or academic theories. |
| Used metaphors, symbols and analogies referenced by the client and converted these forms of communication into ideas for solutions. | Introduced ideas by mostly referencing analogies or metaphors that are personally meaningful to the therapist. |

| **Tailored the style of communication to fit the client** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Matched the client's use of gesture and nonverbal language. | Remained out of rhythm relative to the client. |
| Matched the client's emotional tone (i.e., facial composure, rate of breathing, etc.). | Used a blank-screen approach (showing hardly any emotion) or countered-balanced the client's negative emotions with more positive emotions. |
| Matched the overall manner of communication. For example, was direct with those who speak in a direct or blunt manner, was indirect with those who are very private or avoidant; or was symbolic with those who used symbolism and metaphor. | The therapist had his/her own unique style of communication that did not match the client's. |

| **Tailored the pace of therapy to fit the client** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Made some attempt to assess the client's readiness for emotional work, self-disclosure, and/or vulnerability. | Followed standard therapy protocol. |

| | |
|---|---|
| Offered permission for privacy or to adjust the emotional impact of therapy. | |
| Was able to be quiet and wait for the right moments to speak (i.e., pausing). | Kept the conversation moving at a consistent pace. |
| Made some attempt to assess the client's readiness for change. Offered permission to change now or later, a little or a lot. | Pressured the client to demonstrate some form of change. |
| Offered permission for the client to decide on the duration and frequency of treatment. | Told the client the standard scheduling procedures. |
| Altered therapy procedures to accommodate resistant behavior (e.g., a client who refuses to speak is told to spend time silently contemplating the reasons for being in therapy). | Entered into power struggles with the client. |
| Acknowledged the client's limitations. | Made no mention of client limitations. |

| **Tailored the logic of change to fit the client's values, belief system and personal experience** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Asked questions about the client's uniqueness--the ways in which the client is special and different from others and used this information to create a unique therapy experience. | Focused mostly on research, or the therapist's background of experience while working with other clients. |
| Asked yes/no questions that had been tailored to elicit consecutive "yes" responses (i.e., "yes" set). | Often made statements that the client disagreed with explicitly, or privately. |
| Made assertions that contributed to an atmosphere of agreement and mutual understanding. | Made assertions that left the client feeling misunderstood, ignored, or judged. |
| Framed new ideas within the client's existing system of values. | Made no reference to the client's existing system of values. |
| Used the client's beliefs to convey therapeutic messages. | Argued over "truth" or contradicted the client. |

## II. UTILIZATION: A readiness to utilize client attributes, interpersonal dynamics, and situational factors

The concept of utilization is considered by many to be one of Erickson's greatest contributions to psychotherapy. Simply put, *utilization is a psychotherapeutic strategy that engages circumstances, habits, beliefs, perceptions, attitudes, symptoms, or resistances in service of the overarching goals of therapy*. Thus, the Ericksonian practitioner learns to become "response ready," a special state of heightened observation and inclination toward validation that helps the therapist reduce conflict while working toward meaningful outcomes.

In contrast to optimism, utilization is a creative energy that goes one step beyond a hopeful attitude to answer some problem for which there is a ready solution. For example, the therapist who is optimistic might respond kindly and patiently to a client who refuses to talk, hoping that soon the client will find something to say. But for the therapist who is response ready and seeking to utilize the client's natural behavior, the suggestion is made, "As you sit there, in silence, you will find that a lot of important thoughts come to mind, thoughts that are not easy to think about but that deserve your full attention." This is utilization of behavior and of the total situation for the good of the client.

While an attitude of acceptance is a necessary element of utilization it alone is not sufficient. Utilization takes acceptance one step further by turning it into goal-oriented action, an action tailored to fit the immediate situation. The basic logic of utilization is to seek cooperation from clients in a way that the individual is ready and able to cooperate. For example, relaxation might be used with someone who is exhausted, quiet reflection with someone who does not wish to speak, or teaching for someone who wishes to learn new skills. Similarly, highly compliant individuals are asked to comply, whereas resistant subjects asked to resist. Those who can't stop a behavior are asked to perform the behavior to a point of fatigue and those who are ready to take charge of their therapy are given the space to do so. The expectation is that whenever the therapist is able to negotiate an ongoing series of cooperative exchanges, a reorientation is achieved within the client as adaptive processes engage and self-organization once again seems possible. If this subconscious activity could be put to words, it would probably sound something like, "Hey! What I do matters!"

### Central Assumptions of Utilization

There are a number of central assumptions that undergird the process utilization and govern a therapist's clinical decision making and behavior towards the client. Knowledge of these assumptions enables the practitioner to operate in accord with the spirit of the intervention rather than mechanically reproducing established techniques –

- Every client requires acceptance and appreciation for what he/she can do
- All behavior has value if given the right context and a suitable objective (this includes symptomatic behavior, unproductive behavior, resistance to therapy, etc.)

- Becoming actively engaged in meaningful activity is itself an important mechanism of health and therefore essential to therapy
- Cooperative engagement begins with the therapist accepting whatever the client is doing
- Therapy begins by accepting with equanimity what cannot be changed
- Behaviors that the client has tried to inhibit or suppress are more easily managed once they are performed with conscious intention
- Therapy should not attempt to isolate people from the background of learning coming from their personal experiences within a family, profession, culture, or religion.

## Operational Examples of Utilization

What does Utilization look like?

| **Used the client's need to exercise choice and discernment** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Provided the client with a choice between two alternatives, either of which would serve the needs of the client (i.e., double bind). | Tried to persuade the client to follow a path chosen by the therapist. |
| Had the client decide which parts of the symptom to keep and which parts to eliminate (i.e., disambiguation). | The therapist seemed to approach change from an all-or-nothing perspective. |
| Suggested the importance of action that is imminent or already occurring (i.e., taking over). | Sought to change behavior chosen by the client. |
| Described the client's immediate behavior and framed it as an expression of choice (i.e., tracking). | Ignored the client's immediate behavior. |
| Linked progress to behaviors that would otherwise be perceived as undesirable (e.g., refusal to speak is linked to thoughtful contemplation and deeper therapy). | Made an attempt to teach the client how to do therapy correctly. |
| Had the client discern when and where he could intentionally engage in involuntary behavior (the client is instructed to intentionally perform the "uncontrollable" behavior at a time when it will not cause problems). | Most of all of the therapy was aimed at eliminating or suppressing symptom behavior. |

| Used the underlying energy/direction of the presenting problem to achieve some desirable end | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Asked the client to intentionally perform some part of the symptom complex (i.e., symptom prescription). | Discussed the symptom behavior but never made an experiential study of it. |
| Changed the context in which the symptomatic behavior was occurring and in this new context the behavior was more functional (i.e., sublimation). | Discussed the symptom behavior but never made an experiential study of it. |
| Used the symptomatic behavior as a solution for some other area of concern in the client's life (e.g., insomnia is used as an excuse for the person catch up on reading). | Discussed the symptom behavior but never made an experiential study of it. |
| Used symptomatic behavior for ego-strengthening (e.g., "I have never seen anyone handle this severe of a depression so well…your coping ability is remarkable."). | Discussed the symptom behavior but never made an experiential study of it. |
| Used resistance to therapy as a means of deepening the client's involvement in therapy (i.e., prescribing resistance) | Either ignored resistance to therapy, interpreted the resistance, or sought to eliminate the resistance. |

| Used unexpected behavior or unplanned events to further some therapeutic objective | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used an unexpected response to therapy as a starting point for progress (e.g., The client is told this reaction is a good sign and encouraged to use it to further the therapy). | Treated the unexpected response as a negative outcome. |
| Used an embarrassing or undesirable behavior to a positive end (e.g., a client who cries and then blushes is told how important vulnerability is for therapy). | Either ignored embarrassing or undesirable behavior or politely excused it. |
| Used reports of failure to increase expectation for future success (e.g., framed a relapse and subsequent emotional distress as proof that the person is ready to change). | Offered empathy or acceptance but failed to increase expectation for positive outcomes in the future. |
| Acknowledged self-derogatory comments or character faults asserted by the client and added therapeutic benefit (e.g., "That took courage to admit."). | Did not accept the client's self-derogation, instead attempted to offer encouragement or compliments. |
| Used negative reactions to the therapist to build the alliance (e.g., "I needed to hear this, to help you."). | Became defensive when criticized by the client or blamed the client. |

| Used the environmental context to support and enrich therapeutic processes | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used outside events as a platform for therapy. For example, vacations with family members, trips to a park, or educational programs at a local community college (i.e., therapeutic milieu). | Most of the therapy discussion was confined to the office. |
| Used elements from the natural universe to tell stories filled with possibilities, such as “sacred objects,” puzzles, animals, or other novelty items located in the therapy room. | The conversations seemed clinical or academic. There was not much connection to the outside world. |
| Met with the entire family and made changes to the dynamics that occur in the home (i.e., restructuring) | Focused exclusively on treating the client. |

## III. STRATEGIC: A readiness to create a self-organized problem solving context

In addition to emphasizing the importance of accepting the uniqueness of each individual, ET also recognizes the innate design of human beings as self-organizing creatures or "life builders." Erickson believed that human beings are purposeful organisms oriented toward survival and growth with an innate need for mastery of internal and external life experiences. This results in a striving to overcome obstacles and challenges while drawing from organic knowledge and a life-time of learning. Therefore, in ET it is assumed that all individuals have an elemental need to seek out challenges of their choosing, to strive toward personally meaningful goals, to build a preferred future, and to exercise personal will in regard to one's identity, relationships, and world view. This is collectively referred to as "self-agency."

Strategically creating the experience of self-agency involves shifting the ownership of change to the client. This is what makes the problem solving endeavor transformational. Speaking on this subject, Erickson explained that there is a clear, "shifting from the therapist to the patient the entire burden of both defining the psychotherapy desired and the responsibility for accepting it." Thus the locus of therapeutic problem solving is within the client's mind and body. Any success that is realized as a result of therapy then rightfully belongs to the client rather than the therapist.

*Problem resolution is not intended to be achieved by the therapist*. Instead it is the responsibility of the therapist to discern how to facilitate the client's own inner work using a creative process that takes place beneath conscious awareness. As explained by Erickson, "…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."[2] Any arousal of emotion, recollection of memory, or exercise of imagination is designed to achieve this particular effect. Throughout the therapy process, the therapist solicits sufficient feedback to determine what effect has been achieved. Because the client's spontaneous insights and breakthroughs are intentionally created, this special type of problem solving context is generally referred to as the strategic approach.

### Central Assumptions of a Strategic Approach

There are a number of central assumptions that undergird the process of strategic therapy and govern a therapist's clinical decision making and behavior towards the client. Knowledge of these assumptions enables the practitioner to operate in accord with the spirit of the intervention rather than mechanically reproducing established techniques–

- Clients are more likely to change when they see their world from a place of possibility and hope
- People change and grow in response to challenges
- Clients have a greater ability to achieve their goals than they recognize

[2] This quote is taken from a classic paper, *The Burden of Responsibility in Effective Psychotherapy,* by Milton H. Erickson, 1964.

- Clients' expressed (intellectual) goals may not be as important for therapy as unexpressed goals that are implicit in action and emotion
- People need to develop their own problem solving skills in order to thrive outside of therapy
- Psychological problems are often problems of focus; people focus on what's wrong, not what's right, or they focus on why they are unhappy instead of focusing on building a better future
- Problem solving should be focused on the future rather than the past
- The motivation to comply with therapy is built into the process of identifying deeply felt needs and encouraging the client's unique solutions
- Interpersonal *action* is considered to be a wellspring of therapeutic effect

## Operational Examples of Strategic Approach

What does Strategic look like?

| **Made the client's role as the primary agent of change explicit** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Explained to the client that he/she holds the key to change or that the answers he/she needs will be discovered from within (i.e., internal attribution for change). | The client requested that the therapist make him/her change behavior and the therapist agreed. |
| A majority of the time in therapy was spent on discussions about the client's ability to take action to resolve the problem. | A majority of the time in therapy was spent collecting on history, explaining diagnostic possibilities, or explaining a philosophy of change. |
| Defined the client's role as the problem solver and the therapist role as a source of support (i.e., defining roles). | The therapist tried to help by offering creative solutions. |

| **Directed problem solving energy toward the most central problem or most urgent need, as defined by the client** | |
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| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Asked the client to state in clear concise terms what he/she considers as the primary problem. | Used tests or other diagnostic procedures to determine the clinical problem. |
| Asked for enough detail about the problem, and | The therapist rushed to conclusions or acted |

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| prioritized accurate understanding to the point that the client could be confident that the therapist knows their problem and is invested in helping them resolve it. | as if he/she knew more about the client's problem than the client. |
| Inquired whether there is anything else he/she should know for therapy to be effective. | Seemed to rush to conclusions. Did not allow enough time for the client to explore his/her thoughts. |
| Quoted statements by the client about what he/she perceived to be a problem. | Focused on educating the client about his/her problem. |
| Engaged in some process designed to detect features of the problem that exist outside of conscious awareness. | The problem definition was limited to what the client was consciously aware of. |

**Elicited and built confidence in the client's own intuitive ideas for how to solve the presenting problem**

| Evidence of Competency | Failure to Demonstrate Competency |
|---|---|
| Had the client elaborate on his/her goals and then honored those goals (i.e., future focus). | The focus of therapy centered on the past and why there is a problem. |
| Helped identify and incorporate goals that were implicit in the client's actions or communication (i.e., unconscious goals). | The discussion of goals was limited to what the client was consciously aware of. |
| Elicited client ideas for how to frame therapeutic tasks both inside and outside of the office and cooperated with those ideas (i.e., collaborative engagement). | Failed to elicit creative problem solving from the client. |
| Helped the client develop strategies for implementing his/her solutions. | Focused on emotional process work or insisted on a purely indirect approach. |
| Used the client's individuality as a source of inspiration for a solution for the client's unique problem. | Relied mostly on research or case work to find possible solutions. |
| Invited the client to specify in concrete detail what he or she wants from the therapist or from therapy (i.e., specific thoughts, behaviors, or emotional states to be targeted for change) | Told the client what he/she needs to accomplish, the client was not given time to elaborate on his/her own desires, needs and intentions/goals. |
| Encouraged the client to outline the therapy which he/she thinks will work best and demonstrated clear compliance with the client's suggestion(s) for how therapy might proceed | Failed to solicit ideas or feedback from the client regarding how the therapy is to be conducted. |

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| Recognized indirect instructions for how the therapy should proceed and made obvious effort to comply (e.g., Client, "I wish my mother would listen to me without giving advice." Therapist listens, without giving advice.) | Failed to use feedback offered by the client. |
| Encouraged the client to trust his/her own abilities. | Assured the client that the therapist is capable of helping him/her. |
| Used the client's unique life experiences, resources, or education during the process of problem solving, transferring skill sets from one domain to another (e.g., work/home). | Focused on teaching the client new skills. |

| **Enhanced the client's readiness to act as the primary agent of change** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Directed attention toward client accomplishments, skill sets and character assets. | Focused attention toward client trauma, failure, or weaknesses. |
| Divided the problem into smaller chunks so that it seemed less overwhelming (i.e., partitioning). | Tried to solve too many problems all at once or too quickly. |
| Used existing emotional focal points as a source of motivation (e.g., a mother who hates herself but loves her child is encouraged to work on self-concept for the sake of her child). | Failed to recognize that the client is already highly motivated in one regard or another. |
| Using a rating scale to bring conscious attention to the changes of the symptom over time, or after a single exercise (i.e., symptom scaling). | Had difficulty helping the client recognize small, isolated instances of change. |
| Asked questions that implied success (e.g., "Did you know that you would be able to do that?" or "Do you realize that you have good instincts and that you can trust those instincts?") | Asked questions that implied concern, doubt, or mistrust of what the client is trying to accomplish. |
| Did something to arouse the type of strong emotion needed to catalyze action toward therapeutic goals. | The session seemed bland or emotionally flat. |
| Intentionally "under-stated" the client's readiness for change in order to elicit a strong response (e.g., arguing over when the client will start work or how much change he will allow). | Tried to motivate the client into action but clearly "over-stated" the client's readiness for change, resulting in contrary behavior. |

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| Expressed excitement or joy with the client as progress is achieved (i.e., affect attunement). | Failed to resonant with the client's joy. |
| Described a more difficult or painful process that the client would need to endure if he/she did not wish to cooperate with the immediate therapy. | Failed to negotiate with the client over how the therapy will be implemented. |
| Used contrary behavior from the client as a source of motivation in a positive direction (e.g., argued that the client should keep some percentage of the problem behavior). | Rejected behavior that was not in compliance with the prescribed therapy process. |

## IV. DESTABILIZATION: A readiness to disrupt stable psychological patterns to encourage flexibility and learning

In ET numerous systems are targeted for change. These include cognitive systems, behavioral systems, social systems, and even biological systems. As stated earlier, people are believed to be self-organizing, which means that growth and adaptation are innate processes, if there is sufficient flexibility. Any system that is too rigid (whether it be cognitive, behavioral, or social) is characterized by patterns that perseverate and repeat over time and are insensitive to shifts in contextual demands, all of which inhibit adaptation. In such instances, Erickson believed that learning new patterns of thought and behavior required a temporary period of destabilization during which conditioned responses are denied full expression.

Sometimes referred to as the "confusion technique," destabilization temporarily destabilizes conscious tracking by disrupting orientation to time, place, person, movement, or the meaning of events. As an example of the latter, with someone who insists that therapy cannot help, destabilization is achieved by asking the question, "Are you certain you have not already made progress without knowing it?" For additional effect, the therapist might add, "You wanted to become more assertive and you are now confidently insisting that you have not become more assertive." These questions disrupt the normal train of thought, thereby creating a period of fluctuation.

During this period, the established system of thought is destabilized and therefore more flexible and open to new information and exploration of potentially more adaptive configurations. When destabilization occurs within the context of a therapeutic relationship, new more adaptive patterns of thought and behavior, or social engagement, come about as unconscious processes reorganize with new associations and perspectives.

As stated elsewhere, while the use of hypnosis is not synonymous with Ericksonian approaches, there is a close association. Ericksonian practitioners often use formal and informal hypnosis to precipitate a fluctuation in conscious and unconscious systems. This is in keeping with Erickson's belief that hypnosis offers a unique opportunity to communicate new ideas and new perspectives. At times, the trance induction itself may be used to catapult a client into a state of destabilization and provoke internal reorientation.

With or without the use of hypnosis, destabilization is meant to evoke curiosity and openness to a world full of surprises and new possibilities. It is not meant to overwhelm the client or create excessive dependency on the therapist's ideas. While flexibility in behavioral and cognitive systems is generally promoted by Ericksonians, *the importance of individual integrity is also recognized*. In other words, system flexibility is conceptualized as curvilinear in that too much (e.g., "I don't trust any of my thoughts") or too little (e.g., "I refuse to change my beliefs") is associated with poor functioning. So when destabilization is employed it is used only to the point that an optimal degree of flexibility is achieved in which the client is able to maintain individual integrity while experiencing openness to change.

## Central Assumptions of Destabilization

There are a number of central assumptions that undergird the process of destabilization and govern a therapist's clinical decision making and behavior towards the client. Knowledge of these assumptions enables the practitioner to operate in accord with the spirit of the intervention rather than mechanically reproducing established techniques –

- Rigidity inhibits healthy adaptation and growth
- Humor and surprises are important for therapy
- People are not open to new information unless they experience some doubt
- When established patterns are denied full expression, unconscious processes seek to reorganize with new associations and perspectives
- New frames of reference should be elaborated by the client (not the therapist)
- Changing people's minds is not as helpful as achieving a broadening of perspective (with expanded perspectives comes more options and choices)

## Operational Examples of Destabilization

What does Destabilization look like?

| **Destabilized the client's immediate reality orientation** | |
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| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used words or ideas that exceeded the client's capacity to consciously track and/or make meaning of and followed this period of doubt with helpful information or a suggestion that was obviously helpful (i.e., confusion induction). | Might have confused the client but failed to follow up with helpful information. |
| Asked questions designed to momentarily increase self-doubt and provided motivation for continued reflection and self-discovery (e.g., "Are you certain that is the best you can do?"). | Hesitated to ask questions that might be awkward or embarrassing to the client. |
| Used interrupted movement during a highly practiced behavior, such as a hand shake, to create confusion (i.e., handshake induction). | Helped the client remain oriented to a process of normal social discourse. |
| Responded in a largely unpredictable manner, making careful use of unanticipated statements or actions, especially when established mental sets blocked progress (e.g., such as tossing a fake rock at the client) | The therapist's actions and comments were easily anticipated by the client. |

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| Juxtaposed and linked opposite concepts in the same set of directives (e.g., take a "vicious pleasure"), (i.e., apposition of opposites). | Tried to keep all of the communication straight forward and easy to understand. |

| **Destabilized an existing perspective on a set of events by changing the contextual background against which they are interpreted** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Redefined symptomatic behavior in a way that lessened its power (perhaps using less emotionally laden labels) and did this in such a way that the client appeared to feel empowered (e.g., use of humor and acceptance). | Continued to work primarily from the perspective that the client brought to the office. |
| Reoriented the client to a symptom such that it no longer seems pathological or abnormal (i.e., normalizing). | Tried to convince the client that he/she does not have a problem or that it is not so bad. (the difference is subtle but very important) |
| Experimented with new attributional sets while trying to make sense of other's behavior (e.g., "what if it was not intentional?" or "what if he was fearful but hiding it?" or "what if he was trying to help?"). | The therapist's view of others in the client's world remained under the control of the client's original perspective. |
| Directed the client's attention to additional outcomes that he/she had not considered or anticipated (which are associated with different more positive attitudes). | The therapist's view of situational factors remained under the control of the client's original perspective |
| Changed the emotional meaning given to a particular event (i.e., reframing) | Tried to get the client to think more positively about the events that have occurred. |

| **Destabilized a fixed emotional state by means of shock or humor** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used a shocking word or action to stimulate an emotional response. | Used language that was offensive or abusive resulting in a ruptured relationship. |
| Used a shocking word or action to defuse a problematic emotional state. | Tried to make the client change emotional states. The therapist became threatening or angry. |
| Used therapeutic humor to defuse a problematic emotional state. | Joked about the client's troubles in such a way that the client felt made fun of or that |

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| | the felt suffering was being minimized. |
| Made an unexpected comment for which the client was entirely unprepared. | Made too many unexpected or nonsensical comments, causing the client to doubt the intelligence of the therapist. |

| **Destabilized the experience of corporal reality by creating a sense of feeling apart from one aspect of the self** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used hypnotic dissociation to focus attention and catalyze the "automaticity" of new and helpful perspectives and experiences (whether emotional, behavioral or physical). | Engaged in normal social discourse that followed ordinary rules of conduct. |
| Split awareness into separate fields of experience (e.g., "First you can relive the event but only seeing it, with no emotion. Then you can re-experience all of the emotion but without seeing the events."). | Asked the client to experience too much emotional detail, all at once. |
| Suggested a dissociation from the symptom or problem behavior by engaging it as an entity separate from the self (i.e., externalizing). | Identified the client as being the problem, either directly, or through implication. |
| Experimented with different person-perspectives (e.g., role-reversal exercises, hypnotically altered identity, or simple questions, "What if this had been done to you? How would you have felt?") | Failed to show enough interest in the client's perspective, resulting in the client feeling misunderstood or that is his/her reality is inconsequential. |
| Had the client examine his/her experiences from an outside perspective (e.g., as a movie seen by someone in the audience, or from a "bird's eye perspective" as if flying overhead). | Failed to give permission for the client to examine those experiences which are most meaningful, most relevant to the immediate problem solving task. |
| Asked the client to personify some aspect of self and then dialogue with it is as if it were another person (i.e., Empty Chair) | Talked the client into doing an exercise which the client did not wish to do. |
| Processed events from the past, without conscious involvement, emotional involvement, or physical involvement (i.e., splitting experience). | Attempted to do all process work at the level of conscious awareness. |

## V. EXPERIENTIAL: A readiness to prioritize open-ended experiential learning

Experiential learning is the process of learning through experience, and is more specifically defined as learning through reflection on doing. For experiential therapies in general, the therapist is viewed as a facilitator of particular kinds of exploration of experience but not as an expert on the content of the client's experience. Rather, clients are viewed as experts on their own experience and therapy is meant to be a discovery-oriented process.

Similarly, the Ericksonian practitioner seeks to create experiential environments that will result in clients discovering their own solutions and insights to matters which they had previously considered problematic or impossible. What makes the experiential component of ET unique is the multi-layered manner in which the "calling forth of solutions" is achieved. Experiential events range from the use of metaphors, indirect suggestion, healing rituals, and ambiguous tasks, to the formal use of hypnosis. Another quality that distinguishes Ericksonian experiential work from other therapies is its near limitless field of application, which ranges from the consultation room, to the home, to work, school, or even the top of a mountain.

Most famously, Erickson invited his patients and students alike to climb to the top of a nearby mountain to gain a broader perspective on life events. This experiential event often produced important insights or shifts in awareness that were difficult to define with words. Whether the task involves visiting a garden, buying a new wardrobe, helping at a charity, or going on an unplanned adventure, Ericksonians recognize that experiences *can* promote change in state, perspective, mood, physiology, biology, and identity. These experiential events are often conducted outside of the therapy office, in the client's natural world, in order to communicate the idea that the process of growth, learning, and adaptation occurs in the individual's life and is not limited to a consultation room.

As stated earlier, while it is not necessary that a therapist use hypnosis or seek to induce trance states in order to be considered Ericksonian, one of the core competencies of this approach includes the ability to recognize changes in states of consciousness, as well as the implications of suggestion, and to utilize these for the sake of therapy. At all times, the practitioner seeks to notice those "existential moments" of opportunity to embed the therapeutic suggestions.

While almost every mental health therapist has been trained to observe changes in emotional states (e.g., as a person moves from sadness to anger, etc.), few have been trained to recognize changes in conscious awareness as a person moves from effortful conscious thought (i.e., vigilance) to inwardly absorbed reflective concentration (i.e., reverie), to highly responsive attentiveness (i.e., a loosening of ego control over reality orientation). Ericksonians recognize the benefit of altered states of consciousness and know how to evoke this naturally occurring process of learning and self-organization using a process known as *conversational induction*. This naturalistic trance induction stands in stark contrast to the notion of "making" a person go into trance or somehow controlling the client's mind. When a formal hypnotic induction is used, it is seen as more than a procedure to induce a trance state. Rather it is an experiential event that can be used to facilitate new possibilities. Thus the value of an

induction is commensurate with its ability to create a new experience in the mind and the heart of the subject.

Accordingly, the therapy sessions themselves are often designed as a symbolic drama of change, the imperative of which is: “By virtue of living this experience, you can be different.” During therapy experiential events are employed to help solidify the reorganization of experience deep within. As explained by Erickson, "Such reorganization takes place according to the patient's life experiences, their understandings, memories, attitudes and ideas, and cannot be realized in terms of those of the therapist.”[3]

Thus ET is an effort to create learning experiences rather than intellectual understandings. As with other experiential therapies, Ericksonians also use guided imagery, roleplay, physical movement, and physical props, but more uniquely they include the use of altered states and hypnosis. Whatever the method may be, the Ericksonian approach seeks to elicit an experiential sense of self-determination and adaptation. This is done through the integration of conscious and unconscious resources, leading to a building of new associations, acceptance of what cannot be altered, and empowerment to make meaningful choices in daily life.

## Central Assumptions of an Experiential Approach

There are a number of central assumptions that undergird the process of experiential therapy and govern a therapist’s clinical decision making and behavior towards the client. Knowledge of these assumptions enables the practitioner to operate in accord with the spirit of the intervention rather than mechanically reproducing established techniques –

- People are made to learn from experience, rather than didactic instruction alone
- Adult and/or current experience is as significant as childhood experience
- People are more powerfully influenced by their feelings than their beliefs and it is through experience that we acquire new feelings
- Strong feelings, such as those created by an experience that is fascinating, awesome, mysterious, beautiful, or dangerous, tend to produce lasting change
- Learning occurs on different levels, many of which exist outside of conscious awareness; therefore therapeutic communication should extend beyond the limits of language and conscious processing
- Hypnotic trance is one end of a continuum of experiential involvement, through which an unlimited array of experiential events can be produced

[3] This quote is taken from the book, *Hypnotherapy,* by Milton H. Erickson & Ernest Rossi, 1980.

## Operational Examples of an Experiential Approach

What does Experiential look like?

| **Created an event with physical involvement that contains elements of mystery, novelty, intrigue, or deep reflection** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Altered the experience of one's needs/intentions by having the client speak more slowly, with eyes closed, and the mind focused on a single idea (i.e., absorption, deepening). | The therapist spoke too fast, or frequently shifted around, or kept the conversation moving. |
| Created a moment of reverie in which the client could privately consider the nature of the problem, with or without conscious recollection after the exercise was complete. | Attempted to force an altered state by making the client go into a trance. |
| Used real sense memories from the client's experiential past, rather than imagined behaviors, to seed change (e.g., having an angry couple revivify a moment of mutual compassion) (i.e., revivification). | Failed to make mention of the client's experiential past. |
| Asked the client to visualize the future as it will be once the problem solved (i.e., visualization, hypnotic imagery). | Focused the conversation on negative possibilities, undesirable outcomes that the client should try to avoid. |

| **Engaged in some hypnotic procedure (extra-ordinary event) designed to elicit unconscious knowledge or ability** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Suggested the sensation of automatic or effortless movement in some part of the body as evidence of responsiveness (e.g., ratification by arm levitation). | Offered suggestions without determining the client's readiness to receive the suggestion. |
| Suggested a temporary suspension of motion in certain parts of the body or the entire body as evidence of hypnotic responsiveness (e.g., ratification by means of catalepsy). | Became overly focused on one type of responsiveness and thus failed to recognize other important behaviors (e.g., catalepsy in a different limb). |
| Taught the client to communicate with the unconscious mind by means of automatic movement (i.e., ideomotor signaling). | Failed to use more straight forward communication, such as speaking, when the client was ready to do so. |

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| Had the client write script or draw images while conscious attention is distracted (i.e., automatic writing). | Moved too quickly to an emotional issue without give the client some time to practice the new skill. |
| Changed orientation in time to an earlier date and used spontaneous memories of past problem solving, whether successful or unsuccessful, to better inform immediate problem solving (i.e., time regression). | The discussion of ideas and learning from the past was conducted at an intellectual level, without experiential involvement. |
| Changed orientation in time to a future date (e.g., "Go into the future 10 years from now and look back and reflect on these events. What message would you have for the you of today?") (i.e., time progression). | Allowed the discussion to become overly focused on future outcomes rather than teaching the client how to enjoy the process of trusting one's self. |
| Created some novel option for responding that evoked decision making and the realization of personal choice (i.e., ritual). | Failed to make use of rituals that would have had great cultural or religious significance to the client, instead using a therapy ritual that is familiar to the therapist. |
| Connected psychological change with nonvolitional body movement or sensation (e.g., reduce emotional involvement using hand levitation by linking disengagement to the experience of the hand that leaves the leg) (i.e., linking). | Failed to qualify the changes that have occurred, either implying that they are permanent, with no flexibility, or the changes are perfect and absolute. |
| Created a psychological link between one experience and another (i.e., anchoring). | Failed to perform a test and make certain the link has been established. |

| **Experimented with new behavior or thoughts that fit within the client's self-imposed limitations while progressively changing the established pattern** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Suggested the client experience the symptom in a new spatial location (e.g., moving an arm paralysis into a pinky finger or moving a phobia into a chair) (i.e., symptom displacement). | Failed to develop the expectation that a change in symptom location is both possible and probable. |
| Suggested the client continue to experience a symptom but with changes in the frequency, duration, spatial location, or time of day (i.e., symptom scheduling) or increased complexity (i.e., symptom embellishment). | Failed to include the client in the planning, did not ask the client to consider which type of modification is most likely to work. |
| Suggested the client replace a highly debilitating symptom with a new, less debilitating symptom (i.e., substitution). | *(Note: This term has a different meaning in analytic circles)* |

| Directed the client to do a therapeutic exercise between sessions | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Structured activities were provided for outside the consulting room to promote further learning (i.e., homework, therapeutic tasks) | Tried to make the client do things which he/she did not wish to do, resulting in a power struggle. |
| Interfered with the spontaneous experience of relapse by making it mandatory (i.e., prescribing relapse). | Failed to recognize a certain change in behavior, speaking to the client as if there was a partial desire to return to the old behavior when there is none. |
| Instructed the client to think about the problem or it's solution in a location that inspires awe (e.g., while hiking up a hill or sitting in a garden). | Recommended an event that would be enjoyable to the therapist but failed to identify an even that would be meaningful to the client. |
| Encouraged the client to experiment with new social contexts (e.g., joining a new organization, forming new friendships, dating a different type of person, reaching out to different members of the extended family). | Pushed the client to do something, such as dating, before the client was ready or without the client being interested in that possibility. |
| Helped the client construct a ritual that is designed to make the problem behavior more arduous or inconvenient (i.e., ordeals). | **WARNING:** Some therapists have had to surrender their license after attempting an "ordeal" in an incompetent manner.<br>Tried to punish the client with undesirable actions, or recommended the client pursue a course of action that resulted in emotional injury or harm to others. |

## VI. NATURALISTIC: A readiness create the expectation that change will occur naturally and automatically

Erickson taught that each human being is part of nature and therefore endowed with certain universal powers of nature. For those who view growth, learning, and freedom as inherent in all living things, then it logically follows that during therapy people should be given the freedom to respond in a way that corresponds with natural growth and learning or healing.

Erickson called his approach to hypnosis the "naturalistic induction" because rather than attempting to force an altered state of consciousness, Erickson would enter into his own state of heightened expectancy and focused attention. In response, his patients would naturally alter their state of consciousness and in that freely-chosen state become more open to new ideas and suggestions. If we look at this method of induction as analogous to what can be achieved with therapy as a whole, then the therapy itself becomes a naturalistic induction for change. This begins with a state of heightened expectancy within the therapist and ends with the client freely choosing how he or she will make that change manifest as he or she exercises natural powers of growth and learning.

It has been said that to be Ericksonian is to embody expectancy. *Within the context of Ericksonian therapy, the naturalistic approach is an unstated expectation that the most ideal change comes from within*. It is a type of change that is facilitated by natural processes of growth and learning rather than being artificially induced through external agents. In order for the naturalistic approach to make sense, one must believe that all people possess an innate tendency to learn and grow and that when given the opportunity, most individuals strive for greater health and well-being. To this effect, throughout therapy a mood of expectancy is actively created so that possibilities can appear and be lived into.

As stated earlier, this begins with the therapist's own attitude, which is a profound trust that clients have within them the answers needed to resolve their problems. It is also assumed that answers produced from within have greater therapeutic value than answers that have been manufactured by others. In the same way that today's health conscious consumers are most interested in non-GMO produce, Ericksonian practitioners use techniques designed to stimulate organic growth. Thus methodologies such as conversational induction, permissive suggestion, ambiguity, or the snowball effect are all aimed at stimulating the natural powers of change that exist within the unconscious portion of every human mind. When this occurs, achievement in therapy seems to come automatically and without conscious effort. A client who has experienced this might comment, "I don't know how it happened, but I am different. I do not have the same problems as before."

Another important expectancy is that all people can reorganize their experience of themselves from within, without the mediation of consciously directed thinking. According to Erickson, the naturalistic approach is advanced by developing an increased dichotomy (in the client's awareness) between conscious and unconscious functioning. While working with a single individual, Erickson would address two psychological systems, "You are sitting here in front of me with your conscious mind and your unconscious mind." Of these two, the unconscious processes are assumed by practitioners of ET to have greater access to memory, automatic functions, and greater capacity for processing internal and external stimuli.

The unconscious is considered to be an immense reservoir of all of life's experiences, encoded deep within and yet accessible to help guide the individual unconsciously. Thus the unconscious has awareness of needs and experiences that are unknown to the conscious mind. In ET, addressing needs on an unconscious level is paramount, while problem resolution may or may not be needed on a conscious level. This is because unconscious processes are viewed as an important locus of change, and at times, the most powerful locus.

Another one of Erickson's most important contributions to psychotherapy is permissive suggestion, which is a form of hypnotic suggestion designed to stimulate naturalistic processes of growth and learning. Permissive suggestion is defined as *a suggestion with intentional flexibility so the client may utilize unconscious resources to find the most appropriate response*. It is this permissive approach to therapy in general that acts as a foundation for the flexibility that ET is characterized by as it creates space for maximum autonomy of the client and practitioner.

While the therapist seeks to act as a catalyst for change, he or she does not attempt to control client outcomes. This subtle yet highly important difference is what separates the use of suggestion in Ericksonian hypnosis from more coercive attempts at suggestion or persuasion. The innate need to experience freedom and an increasing sense of wellbeing are absolutely essential to the use of any technique in ET. Accordingly, contemporary Ericksonian practitioners communicate, from beginning to end, therapeutic suggestions aimed at expectancy rather than control. For example, open-ended suggestions, such as: help is available (i.e., you are not alone), change is imminent, the resources you need are inside you, you can do more than you realize, change can be automatic, progress is evident, and reality, as you know it, has altered; all provide space for individual discernment and self-organization (i.e., autonomy).

In ET, practitioners focus on what the client recognizes he or she is able to do and suggests a natural process of growth, which is directed by the client. This approach makes sense from a utilization perspective (i.e., use existing resources) and from a strategic perspective (i.e., it is the client who owns the process of growth and future achievements). Now we can add a third perspective, the naturalistic approach, by suggesting that this progress will occur naturally and automatically.

In ET, clients are asked only to make those changes that they are capable of at the moment. The unstated implication is that the client will naturally be ready for more difficult challenges in the near future. Casual conversation is used to introduce ideas that summon natural processes. For instance, asking a client what she will do when she is healed, interjects an implicit presupposition that healing will occur. The purpose of using a form of communication that points to a meaning beyond the stated words is to stimulate unconscious reasoning and/or mediate implicit emotions and attitudes. It is expected that this will occur in accord with the limits of the client's cognitive ability and range of life experience.

In closing, it is important to recognize that for Ericksonian practitioners interventions are not considered to be intrinsically therapeutic or beneficial. These are not exogenous agents that are assumed to be curative irrespective of context. Rather, there is an interpersonal relationship that must be formed. It is the skillfulness of the way in which the relationship is conducted that gives a special meaning to these techniques. Any naturalistic technique or strategy must be undergirded by a relational foundation of validation and cultivation. Without these, the technique is unlikely to yield positive results. *First and*

*foremost, the practitioner seeks to validate the goodness of the client's mind and of his or her innate capacity for healing, learning, growth, and for seeking out new challenges*. Secondly, the practitioner seeks to cultivate a mutual process of discovery. While the client explores previously unrecognized dimensions of his or her subjective reality, the practitioner engages in an exploration of what is possible within a therapeutic context.

## Central Assumptions of a Naturalistic Approach

There are a number of central assumptions that undergird the process of naturalistic therapy and govern a therapist's clinical decision making and behavior towards the client. Knowledge of these assumptions enables the practitioner to operate in accord with the spirit of the intervention rather than mechanically reproducing established techniques –

- The most ideal change is produced from within
- People can reorganize their experience of themselves (from within) without the mediation of consciously directed thinking
- Clients have within them the answers they need to resolve their problems
- Therapeutic change evokes natural tendencies toward growth, learning, and the pursuit of greater health and wellbeing
- Therapy should be flexible and allow for maximum autonomy of the client by including opportunities for creativity, discernment, and self-determination
- States of consciousness characterized by absorption or focused attention are especially conducive to new learning and shifts in frame of reference and thus important to the process of change
- Therapeutic suggestion is more effective when it communicates a general positive expectancy rather than prescribing a single concrete outcome
- The most effective suggestions give clients permission to do what they long to do but cannot on their own
- People are most healthy when they learn and grow in accord with self-organizing principles of change
- A strong sense of self-determination decreases the probability of relapse and leads to ongoing personal development

## Operational Examples of a Naturalistic Approach

What does Naturalistic look like?

| **Drew attention to internal capabilities for learning, creativity, insight, and performance** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Suggested that all the insight and discernment needed by the client will be discovered from within (i.e., suggesting self-efficacy). | The therapist was either too quick to offer advice or failed to recognize a genuine need for information. |
| Directed the client to answer some of his/her own questions (i.e., suggesting self-efficacy). | The therapist was too quick to provide answers to all the client's questions. |
| Suggested altered states of consciousness to evoke a "regressed state" to enhance the recall of information learned at an earlier period of life. | Went to painful experiences in the past but failed to translate it into a positive, meaningful experience. |
| Suggested altered states of consciousness to evoke a "learning state" to enhance the client's ability to benefit from experience. | The therapist seeks to induce an altered state of consciousness in order to "control" the client. |
| Suggested altered states of consciousness to evoke a "performance state" to enhance the client's ability to overcome difficult challenges. | The therapist is mostly focused on his/her performance and thus failed to allow the client to add value or demonstrate ability. |
| Suggested altered states of consciousness to evoke a "creative state" to enhance the client's ability to transform a problem into a solution or resource. | The therapist depends almost exclusively on his or her own creativity rather than seeking to generate it from within the client. |
| Used metaphor or anecdotes from the client's developmental history to suggestion the natural capacity of the mind and body for learning, growth, healing, etc. | Remained exclusively focused on the present moment or the future, failing to incorporate all dimensions of time therapeutically. |
| Taught the client how to take the initiative in inducing a hypnotic trance for the sake of suggesting automatic changes (i.e., self-hypnosis). | Isolated hypnosis to the therapy office and made it the exclusive property of the therapist. |

| **Created options for responding that evoke creative and self-delineating process within the client** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used a detailed and precise manner of speech to convey vague ideas, unclear meanings, or incomplete explanations or thoughts (i.e., partial communication). | Spoke in a way that was condescending or that left the client feeling unintelligent or that he/she lacks insight. |

| | |
|---|---|
| Used figures of speech to make a comparison or to communicate multi-level meanings (i.e., metaphor). | Tried to control the client's understanding or insights. |
| Took two apparently dissimilar things and using one to better explain the other but without providing detailed explanation (i.e., analogies). | Failed to check the client's understandings by seeking feedback, instead assuming the communication is clear. |
| Directing the client to complete a symbolic exercise without providing details about why or what it should mean (i.e., symbolic task or ambiguous task). | Tried to "make" the client understand the point the therapist wished to communicate. |
| Used a broadly permissive suggestion for change (e.g., "You can enjoy the process of discovering how you will become most comfortable with the changes that are occurring deep within."). | Made use of permissive suggestion but failed to assess or develop a readiness for change (i.e., put the cart in front of the horse). |
| Used a suggestion that covers all possibilities, soliciting a response but without dictating what that response must be (e.g., "You can tell me only what you are ready to reveal, and you can keep secret the things that are not important to your therapy.") (i.e., permissive suggestion). | Made use of permissive suggestion with overt language, but then tried to control the client's response, thus sending a contradictory implicit message. |
| Provided direction for general responding, while leaving the specifics of the response open-ended (e.g., encouraged the client to trust their "unconscious" or "universal wisdom") (i.e., open suggestion). | Expressed doubt or worry about some small part of the client's thoughts or actions. |
| Suggested that an unspecified change is imminent and that it will be realized as the client becomes ready (i.e., ambiguous prediction). | Used ambiguous prediction but did not allow enough time for it to develop (i.e., became discouraged too quickly). |

| **Elicited responses through insinuation or implication rather than making explicit declarations** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Used matter of fact statements or asked questions that presupposed imminent progress, healing, or problem resolution (i.e., presupposition or implication). | The therapist either oversold the idea of future progress or seemed doubtful that progress would occur. |
| Created a symbolic drama of change that seemed compelling to the client and communicated the idea that, "By virtue of living this experience, you will be different." (i.e., indirection suggestion). | Offered tasks in and outside of therapy but the client felt unable to succeed at these tasks or homework assignments. |
| Used narrative to develop a general line of thought but | Told stories that were upsetting or offensive to the client or that failed to address the |

| | |
|---|---|
| without providing detailed interpretation (i.e., storytelling). | immediate emotional needs of the client. |
| Told anecdotes of other clients who were at the beginning stages of making impressive gains and the details of their case seem parallel to the client's situation (i.e., case examples). | Described poor outcomes with clients who had the same type of problem or gave the idea that the client's problem was troubling. |
| Used seemingly causal conversation or storytelling to suggest an implied directive (i.e., embedded suggestion or interspersal). | Made jokes or shared ideas casually but without consideration of the client's clinical needs (i.e., careless banter). |
| Used overt intervention with one individual to indirectly treat others who are observing the intervention (i.e., parallel treatment). | Attempted to use parallel treatment but on an issue had some fundamental differences between clients. |
| Used a signal or stimulus to elicit an automatic response (i.e., minimal cues). | Put too much effort into soliciting a response that the client would have supplied without thought. |
| Omitted some element of conversation or action, which is expected to be present (i.e., conspicuous absence). | Accidently insulted the client by explaining things that should be obvious. |
| Established a cause and effect relationship without arousing conscious scrutiny (i.e., implicit causality). | Failed to pursue meaningful associations in therapy that have practical value for problem solving (e.g., identifying a food that is causing symptoms). |

| **Delivered suggestions outside the margins of conscious awareness** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Repeated the same therapeutic idea throughout a natural conversation, using indirect means (i.e., interspersal). | Made a useful suggestion but did not follow up to see if it got processed at deep levels. |
| Conveyed ideas by means of unconscious associations that have formed around certain objects or linguistic tools (i.e., symbolic communication). | Failed to have the client identify which symbols or objects have emotional significance to him or her. |
| Gradually exposed the client to new ideas or behavior with subsequent elaboration in advance of utilizing it for therapeutic purposes (i.e., seeding). | Tried to tell the client everything he or she "needed" to hear without assessing the emotional readiness. |
| Communicated a message or idea below the level of sensory perception or otherwise outside of conscious awareness (i.e., subliminal suggestion). | Used subliminal suggestion for an idea that needed to be understood at the conscious level and used for immediate decision making. |

| **Suggested an effortless and automatic action, thought, or perception to occur at a later point in time, away from the office** | |
|---|---|
| **Evidence of Competency** | **Failure to Demonstrate Competency** |
| Suggested imminent change at a location away from the office (e.g., "Because you went into trance so well, more positive results will occur later.") (i.e., post hypnotic suggestion). | Did quality hypnotic work in the office but then failed to suggest that the benefits would carry over into life outside of the office. |
| Suggested the smallest degree of change to establish the possibility of change, and then suggested that this is a natural process of learning. | Tried to move too quickly with change, causing the client to feel incompetent or to withdraw from therapy. |
| Directed attention to small gains made during the course of therapy, whether at home or in the office, and suggested that these will lead to other more important changes (i.e., snowball effect). | Directed attention to small problems or mistakes that the client had overlooked, resulting in the client feeling that his/her actions are not good enough. |
| Suggested that the smallest accomplishments, whether intentional or unintentional, are evidence of natural growth and continued progress (i.e., snowball effect). | Misled the client by suggesting that change can occur as if by magic, without having to invest any time or effort. |
| Credited the unconscious with initiating changes that the client assumed were random or accidental behavior and suggested that more automatic changes will follow. | Became caught up in the client's perception of failure (or someone else's criticisms of the client) and failed to recognize small progress. |
| Broke the therapeutic agenda down into small steps or minimal changes and suggested that these will naturally progress across time (i.e., partitioning or fragmentation). | In an attempt to make the problem more manageable, the therapist inadvertently suggested poor coping ability or more fragility than is true of this client. |
| Responded to presumed failure by suggesting future progress (e.g., "The change you are seeking may come after therapy seems to have ended.") (i.e., ambiguous prediction). | Used overly perfectionistic standards, insisting on a "total cure" otherwise dismissing the progress that was achieved. |

# IV. Measurement Devices

## Overview of Measurement Devices

Section IV of the treatment manual on Ericksonian therapy (ET) provides readers with practical tools of measurement that are easy to use, quick to interpret, and psychometrically sound. To date, there are two devices that have been created, each with its own unique strengths and each in the format of a summary scale (i.e., multiple items that measure the same factor).

The first device is the *Relational Foundations Scale* (RFS-SC), which provides meaningful feedback on the degree of skill exercised by the therapist during any given session. The form is designed to collect qualitative data from client (i.e., their subjective experience during therapy). This device can be analyzed immediately, without any numerical scoring. The open-ended information collected with this form informs researchers on the nature of the interpersonal dynamics and their relationship to overall progress. It also informs practitioners on the immediate status of the therapeutic relationship and which areas need attention or improvement. Thus the RFS-SC is both a tool to inform clinical practice, as well as an instrument of training, supervision and ongoing research. Some initial findings are included in this manual.

The second device is the *Core Competencies Scale* (CCS-6), which provides meaningful feedback on the nature of the therapeutic approach employed during any given session and the extent to which it reflected fluency in established Ericksonian methodology. This informs researchers on the type of therapy that is being employed. It also informs practitioners on areas of strength or weakness in regard to the ET skill set. Norms have been created that make it possible to interpret scores and assess one's relative level of skill as judged by third-party raters. Once again, the CCS-6 is both a tool to inform clinical practice, as well as an instrument of training, supervision and ongoing research.

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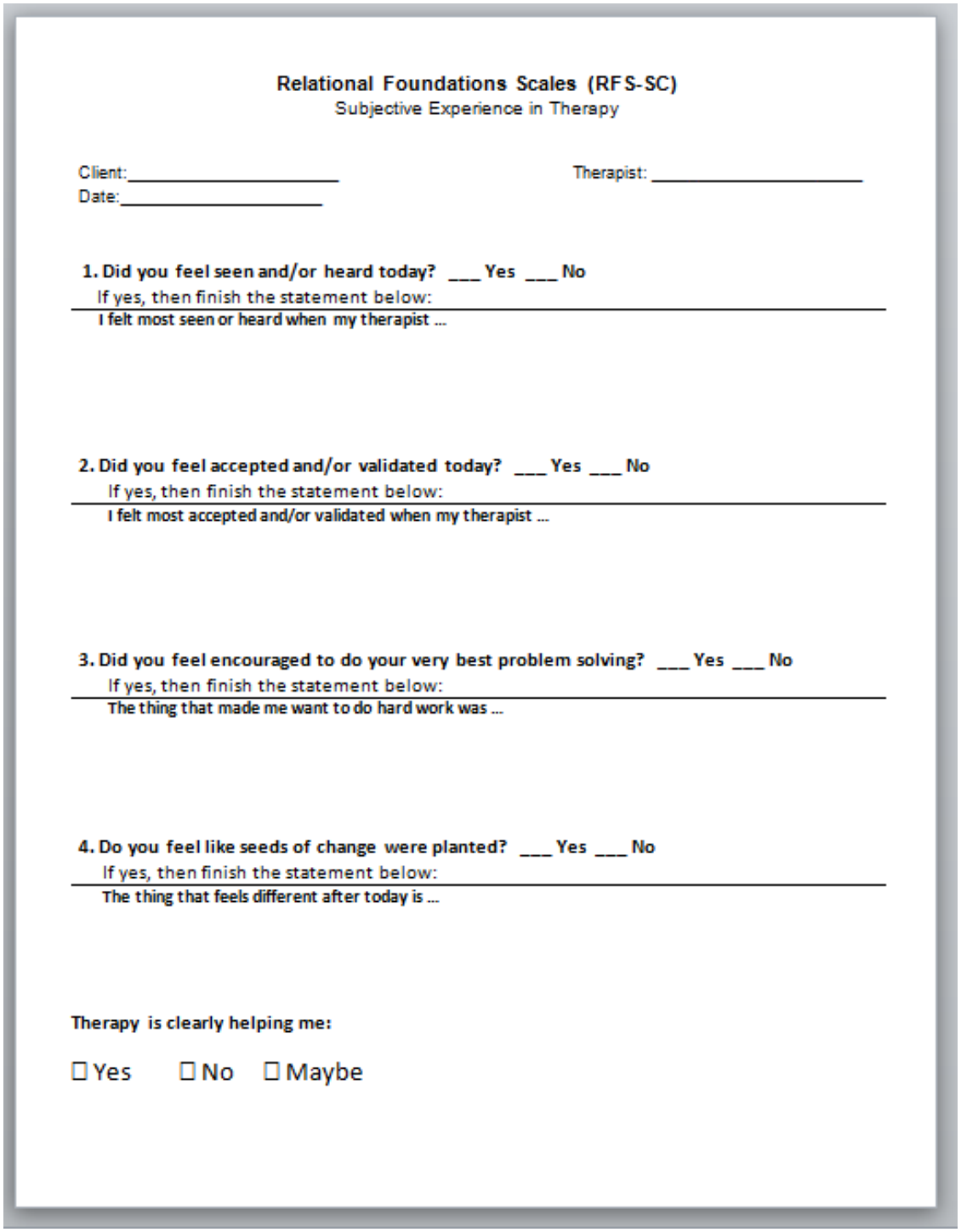
## RELATIONAL FOUNDATIONS SCALES (RFS-SC)



**Relational Foundations Scales (RFS-SC)**
Subjective Experience in Therapy

Client:_____ Therapist: _____
Date:_____

**1. Did you feel seen and/or heard today? ___ Yes ___ No**
If yes, then finish the statement below:
**I felt most seen or heard when my therapist ...**

**2. Did you feel accepted and/or validated today? ___ Yes ___ No**
If yes, then finish the statement below:
**I felt most accepted and/or validated when my therapist ...**

**3. Did you feel encouraged to do your very best problem solving? ___ Yes ___ No**
If yes, then finish the statement below:
**The thing that made me want to do hard work was ...**

**4. Do you feel like seeds of change were planted? ___ Yes ___ No**
If yes, then finish the statement below:
**The thing that feels different after today is ...**

**Therapy is clearly helping me:**

☐ Yes ☐ No ☐ Maybe

**RFS-SC**

## Instructions for administering the RFS-SC

These are the instructions for use of the RFS-SC scoring sheet, which is intended to be given to the client at the end of the therapy session.

1. **Introducing the score sheet**: The Relational Foundations Scales (RFS-SC) has four Likert scales numbered from 0 to 10. Under each item are prompts for both high end and low end ratings. Read the instructions at the top of the answer sheet to the client, encouraging him or her to simply mark the first number that automatically comes to mind.

2. **Qualifying the score**: After having the client complete the form and return it to you, ask the client to think about the four scales and determine which area of relating is most important to him or her. After receiving the answer, place a mark on the small line to the right of the domain name. Notice if this is the area in which you scored highest. If not, or if the score is any number below 10, then ask the client, *"What is something I could have done that would have helped increase this score?"* Make certain to validate any feedback offered by the client. Do not become defensive or disagree with the client's assessment. **The response provided by the client will be the most important piece of interpretative data produced by this device**.

3. **Interpreting the score**: While the body of research on this device is relatively small (i.e., still at the stage of pilot testing), these are some of the initial results and what they mean for clinical outcomes:
    a. Sessions that have a score of 6 or greater on each of the scales tend to be associated with hopeful client attitudes.
    b. Sessions that have a score of no greater than 5 on any of the scales tend to be associated with uncertainty about the value of therapy or ruptured/failing relations.
    c. Clients differ in need and relational preference. During pilot testing, there was a flat distribution in regard to preference, such that no one relational dimension was more frequently endorsed than others.

The completed survey should be kept as part of the clinical record. This measure can be completed on a session by session basis. It is most appropriate for use with adolescents or adults.

## Relational Foundations Scales (RFS-SC)

Subjective Experience in Therapy

Client:_____ Therapist: _____

Date:_____

**1. Did you feel seen and/or heard today? ___ Yes ___ No**

If yes, then finish the statement below:

**I felt most seen or heard when my therapist …**

**2. Did you feel accepted and/or validated today? ___ Yes ___ No**

If yes, then finish the statement below:

**I felt most accepted and/or validated when my therapist …**

**3. Did you feel encouraged to do your very best problem solving? ___ Yes ___ No**

If yes, then finish the statement below:

**The thing that made me want to do hard work was …**

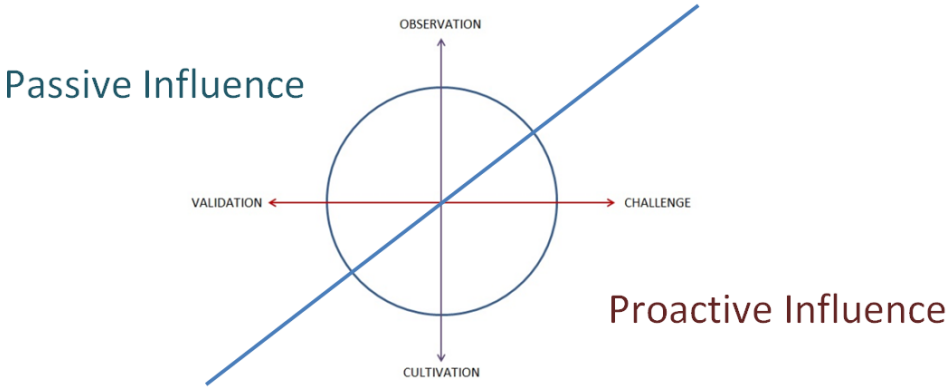
**4. Do you feel like seeds of change were planted? ___ Yes ___ No**

If yes, then finish the statement below:

**The thing that feels different after today is …**

**Therapy is clearly helping me:** □ Yes □ No □ Maybe

**Initial Results**

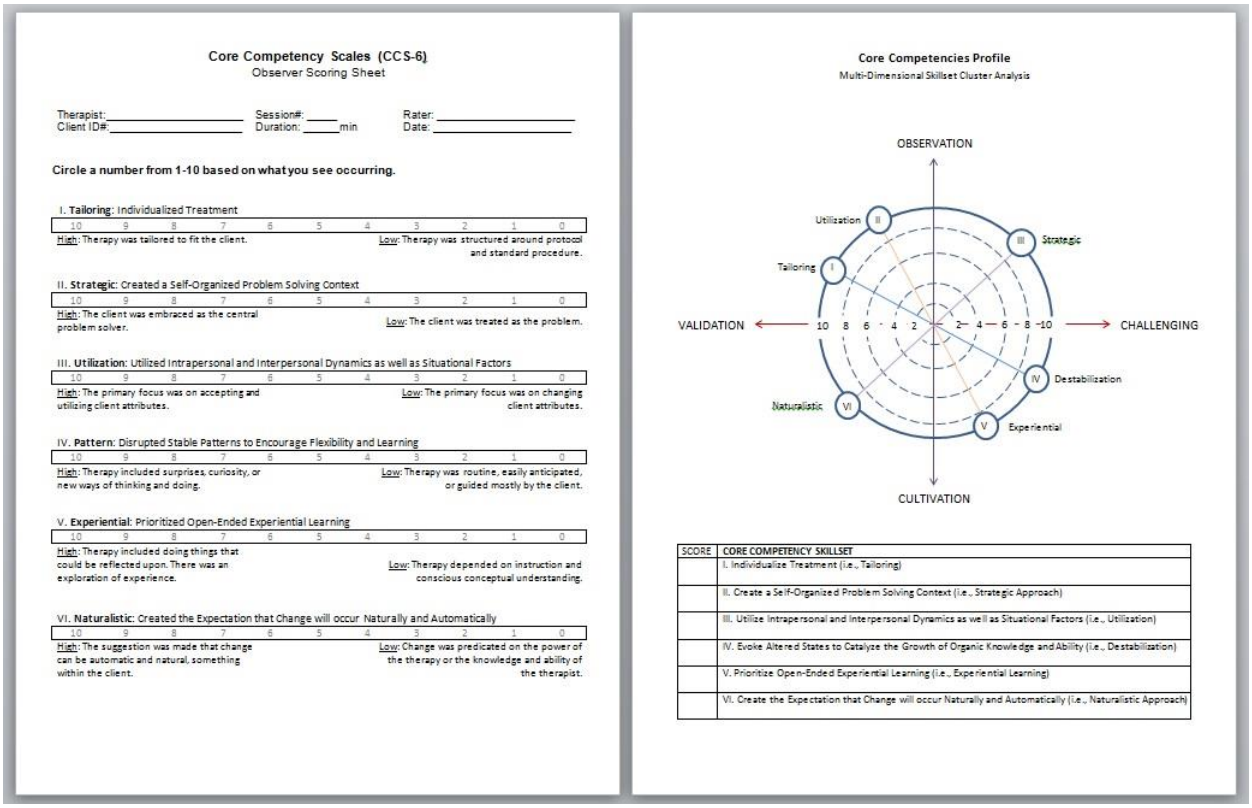



The RFS-SC has been used in a private practice setting* to collect information, which was analyzed at a qualitative level. A majority of the responses by clients (97%, n=38) where accounted for, or summarized, using the following descriptors.

| Passive Influence | | Proactive Influence | |
|---|---|---|---|
| **OBSERVATION** These are behaviors reported by clients, which helped them feel seen and heard | • Non-verbal feedback: eye contact, head nod, posture<br>• Asking questions: thorough investigation, seeking elaboration<br>• Responsiveness: focused on deepest concerns, answered all of the client's questions | **CULTIVATION** Circumstances reported by clients, which lead them to expect change to occur | • Tools: the client is educated on what to do differently at home or work<br>• Emotional arousal: strong emotions were experienced during therapy<br>• Shift in mood: client feels better at the end of the meeting than at the start |
| **VALIDATION** These are behaviors reported by clients, which helped them feel accepted and validated | • Verbal support: producing evidence to support the client's position<br>• Relating: identifying with the client's experiences<br>• Nonjudgment: a positive response to things the client fears being judged on | **CHALLENGE** These are behaviors reported by clients, which motivated them to put effort into therapy | • Alignment: the focus of conversation is aligned with the client's deepest concerns<br>• Therapeutic directives: the client is given challenging tasks to complete<br>• Hope: there is something positive to work toward |

** This data is taken from clientele who met with either Dan Short or Aimee Short. Each of the 38 surveys represents the opinions of a single client, taken randomly, at different points in the overall therapy process. Each of the itemized descriptors, seen in the chart, generally describes the response of one or more clients.*

# CORE COMPETENCIES SCALES (CCS-6)



Core Competency Scales (CCS-6)
Observer Scoring Sheet

Therapist:_____ Session#: ____ Rater: _____
Client ID#:_____ Duration: _____min Date: _____

**Circle a number from 1-10 based on what you see occurring.**

I. **Tailoring**: Individualized Treatment
10 9 8 7 6 5 4 3 2 1 0
High: Therapy was tailored to fit the client. Low: Therapy was structured around protocol and standard procedure.

II. **Strategic**: Created a Self-Organized Problem Solving Context
10 9 8 7 6 5 4 3 2 1 0
High: The client was embraced as the central problem solver. Low: The client was treated as the problem.

III. **Utilization**: Utilized Intrapersonal and Interpersonal Dynamics as well as Situational Factors
10 9 8 7 6 5 4 3 2 1 0
High: The primary focus was on accepting and utilizing client attributes. Low: The primary focus was on changing client attributes.

IV. **Pattern**: Disrupted Stable Patterns to Encourage Flexibility and Learning
10 9 8 7 6 5 4 3 2 1 0
High: Therapy included surprises, curiosity, or new ways of thinking and doing. Low: Therapy was routine, easily anticipated, or guided mostly by the client.

V. **Experiential**: Prioritized Open-Ended Experiential Learning
10 9 8 7 6 5 4 3 2 1 0
High: Therapy included doing things that could be reflected upon. There was an exploration of experience. Low: Therapy depended on instruction and conscious conceptual understanding.

VI. **Naturalistic**: Created the Expectation that Change will occur Naturally and Automatically
10 9 8 7 6 5 4 3 2 1 0
High: The suggestion was made that change can be automatic and natural, something within the client. Low: Change was predicated on the power of the therapy or the knowledge and ability of the therapist.

Core Competencies Profile
Multi-Dimensional Skillset Cluster Analysis



| SCORE | CORE COMPETENCY SKILLSET |
|---|---|
| | I. Individualize Treatment (i.e., Tailoring) |
| | II. Create a Self-Organized Problem Solving Context (i.e., Strategic Approach) |
| | III. Utilize Intrapersonal and Interpersonal Dynamics as well as Situational Factors (i.e., Utilization) |
| | IV. Evoke Altered States to Catalyze the Growth of Organic Knowledge and Ability (i.e., Destabilization) |
| | V. Prioritize Open-Ended Experiential Learning (i.e., Experiential Learning) |
| | VI. Create the Expectation that Change will occur Naturally and Automatically (i.e., Naturalistic Approach) |

**CCS-6**

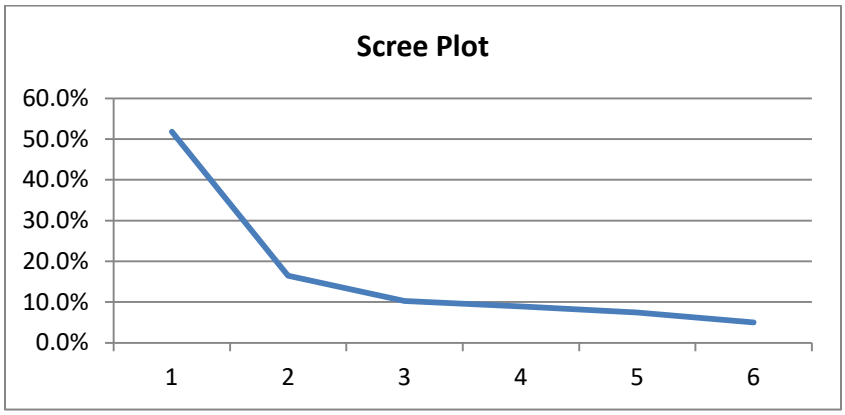
The Core Competencies Scales (CCS-6) has been constructed to produce reliable (consistent) and efficient measures of observable behavior *common among expert practitioners of Ericksonian Therapy*. The CCS-6 is *not* an authoritative list of all that can or should occur in Ericksonian therapy but rather an attempt to objectively define the types of behavior most commonly associated with this particular clinical skill set (i.e., ET). In order to achieve this, data was collected and studied by a team of experts in the field of Ericksonian therapy who are collectively responsible for a large portion of the literature on this topic and for providing teaching and training across a world-wide network of Ericksonian institutes and congresses.

## Psychometric Properties and Interpretation of Scores

The Core Competencies Scale (CCS-6) is a sum scales measurement device (i.e., one score derived from multiple independent items), which was designed and evaluated following the *classical testing theory* model (Nunally, 1970), which assumes that the observed score is composed of the true score and the measurement error (Y = T + E). A solid understanding of a scale's dimensionality, reliability, and validity is required for researchers to conduct research that provides clear information.

### Dimensionality

A scale's dimensionality, or factor structure, refers to the number and nature of the variables reflected in its items. Because the CCS-6 is intended to measure a single variable, the scale's items should be unidimensional, which means it produces a single score representing the lone dimension reflected in its items (i.e., Ericksonian practice). Exploratory Factor Analysis (EFA) is the most common method of evaluating the dimensionality of psychological scales. The extraction method used for the EFA was Principal Axis Factoring (PAF), which is more robust that other methods. The following scree plot was used for interpretation, which is the best widely-available option for evaluating the number of factors underlying a set of items.




When interpreting a scree plot, one hopes to find a clear "leveling-off point." When determining the number of factors, there are one less than the factor number of the flattened point. In this case, the first factor accounted for 51.8% of the variance, after which it dropped to 16.5% and leveled off. This suggests the presence of a single factor, as measured by six items.

### Reliability

Reliability is concerned with the ability of an instrument to measure something consistently. This is important because an instrument cannot be valid unless it is reliable. Internal consistency is one means of analyzing reliability, which is the extent to which all the items in a test measure the same concept or construct. Homogeneity is prerequisite for a meaningful analysis of inter-relatedness (i.e., internal consistency), which in this case has been satisfied by the unidimensionality of items.

A description of internal consistency was produced by analyzing the correlations between the six independent scaled items making up the CCS-6, relative to the variances of those items. The reliability index used for this estimate was *Cronbach's coefficient alpha* $\alpha = (k/(k-1)) * [1- {}^{\Sigma}(s^2_i)/s^2_{sum}]$, which is the most widely used objective measure of reliability. Relatively high covariance between subjects ($\alpha = .76$) suggests that the sum scale items measure the *same* variability between items and thus true score.

**Statistical Summary of Reliability Analysis**

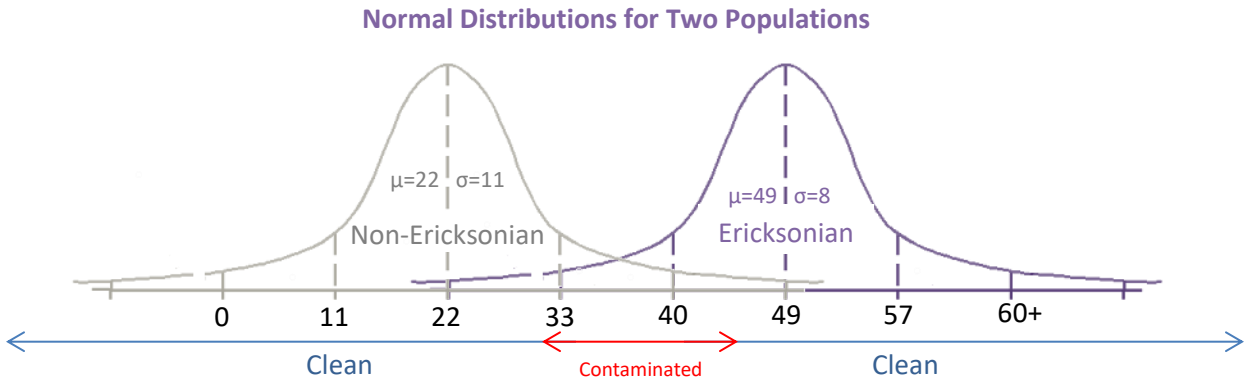
| | | | | |
|---|---|---|---|---|
| | | | Cumulative Mean= | 48.6 |
| | | | Standard Deviation.= | 8.3 |
| | | | Cronbach alpha= | 0.76 |
| | | | Average inter-item correlation.= | 0.7 |
| | Mean if deleted | StDv. if deleted | PM Itm-Tot Correl. (r) | Alpha if deleted |
| **I** | 40 | 7.4 | .66 | .73 |
| **II** | 40.4 | 7.2 | .71 | .71 |
| **III** | 40.7 | 6.81 | .76 | .70 |
| **IV** | 41.6 | 7.0 | .58 | .83 |
| **V** | 40.3 | 6.9 | .76 | .70 |
| **VI** | 39.9 | 7.2 | .74 | .71 |

As a second means of describing internal consistency, a split-half test of reliability was also performed with results indicating that the two halves are highly correlated ( *r = .61*).

## Validity

Validity is concerned with the extent to which an instrument measures what it is intended to measure. Any study that uses a measure as an index of a variable that is not itself directly observable (in this case competency in Ericksonian therapy) must establish *construct validity* in order for the results of the study to be meaningful. Researchers generally establish the construct validity of a measure by correlating it with a number of other measures that should, theoretically, be associated with it (i.e., convergent validity) or vary independently of it (i.e., discriminant validity). Unfortunately, in the case of Ericksonian core competencies, other universally agreed upon measures have not yet been established.

Without this type of nomological network and quantitative data, the most practical means of examining construct validity is to compare scale scores obtained from ratings of known experts in Ericksonian therapy versus scale scores obtained from ratings of known experts in other fields of therapy. Rather than using an index of positive and negative correlates, a frequency distribution has been constructed to assess both convergent and discriminant validity. This method can be used to demonstrate both the relative magnitude of population differences and to and provide confidence intervals for decision making.




Cut-off Score of 33=68% Confidence no False Positive

Cut-off Score of 44=95% Confidence no False Positive

As can be seen in the frequency distribution graphs, there are two distinct populations that can be identified by the CCS-6. A test of statistical significance was conducted using a *t*-test. This was chosen because for moderately large samples the *t*-statistic is relatively robust to moderate violations of the normality assumption (i.e., unequal variances). For these samples, there was a significant effect for therapy approach, $t(65)=5.01$, $p<.0001$, with Ericksonians receiving significantly higher scores than Non-Ericksonians.

While scores for Ericksonians range from 32 to 65, in 95% of cases (M=49, SD=8); scores for Non-Ericksonians can range from a low of 0 to as high as 44, in 95% of cases (M=22, SD=11). In order to obtain clean scores, it is necessary to go no further than 1 standard deviation from the mean for either population (68% CI). Ultimately, the problem of contamination (i.e., scores that do not clearly belong to one group or the other) must be dealt with by determining the level of confidence required for the question that is being asked, as well as which is worse: a false positive or a false negative.

The variable manipulated for discriminant validity (Ericksonian versus Non-Ericksonian) was a composite of recordings from multiple therapists. An effort was made to control for differences in overall skill and years of experience by matching level of expertise, age, and gender across groups. For both groups, three therapists were selected, each having two male therapists and one female therapist. The six therapists used to establish norms for these skills are all considered experts in their respective fields and physically mature (i.e., 50-70 years of age). Whether or not this level of expertise has inflated the CCS-6 scores is not known at this time. The three therapists used for the Ericksonian condition have all taught ET in various cities around the world. For the Non-Ericksonian condition, three therapy styles were selected: Cognitive Behavior (CBT), Traditional Hypnotherapy, and Rogerian therapy. These are the therapies that are considered closest to the Ericksonian approach and therefore the most rigorous test of discriminant ability. It is assumed that the problem of contamination will decrease when ET is compared to less philosophically similar approaches; however, this idea has not yet been tested.

## Quick Reference Scoring Key

**I. Tailoring:** Was therapy tailored to fit the client?

- **Tailored the language of therapy to fit the client**
- **Tailored the style of communication to fit the client**
- **Tailored the pace of therapy to fit the client**
- **Tailored the logic of change to fit the client's values, belief system and personal experience**

**II. Utilization:** Was the primary focus on utilizing client attributes?

- **Used the client's need to exercise choice and discernment**
- **Used the underlying energy/direction of the presenting problem to achieve some desirable end**
- **Used unexpected behavior or unplanned events to further some therapeutic objective**
- **Used the environmental context to support and enrich therapeutic processes**

**III. Strategic:** Was the client embraced as an important problem solver?

- **Made the client's role as the primary agent of change explicit**
- **Directed problem solving energy toward the most central problem or most urgent need, as defined by the client**
- **Elicited and built confidence in the client's own intuitive ideas for how to solve the presenting problem**
- **Enhanced the client's readiness to act as the primary agent of change**

**IV. Destabilization:** Was an attempt made to disrupt maladaptive patterns to attract new learning?

- **Destabilized the client's immediate reality orientation**
- **Destabilized an existing perspective on a set of events by changing the contextual background against which they are interpreted**
- **Destabilized a fixed emotional state by means of shock or humor**
- **Destabilized the experience of corporal reality by creating a sense of feeling apart from one aspect of the self**

**V. Experiential:** Was experiential learning given priority over didactic instruction?

- **Created an event with physical involvement that contains elements of mystery, novelty, intrigue, or deep reflection**
- **Engaged in some hypnotic procedure (extra-ordinary event) designed to elicit unconscious knowledge or ability**
- **Experimented with new behavior or thoughts that fit within the client's self-imposed limitations while progressively changing the established pattern**
- **Directed the client to do a therapeutic exercise between sessions**

**VI. Naturalistic:** Did the client receive suggestions for change that directed him/her to natural processes of unconscious growth, learning, and/or healing?

- **Drew attention to internal capabilities for learning, creativity, insight, and performance**
- **Created options for responding that evoke creative and self-delineating process within the client**
- **Elicited responses through insinuation or implication rather than making explicit declarations**
- **Delivered suggestions outside the margins of conscious awareness**
- **Suggested an effortless and automatic action, thought, or perception to occur at a later point in time, away from the office**

# Core Competency Scales (CCS-6)

Observer Scoring Sheet

Therapist:_____ Session#: _____ Rater: _____

Client ID#:_____ Duration: _____min Date: _____

**Circle a number from 1-10 based on what you see occurring.**

I. **Tailoring**: Individualized Treatment

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

High: The therapy was entirely unique to this client.

Low: Therapy was structured around protocol and standard procedure.

II. **Strategic**: Created a Self-Organized Problem Solving Context

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

High: The client was embraced as the central problem solver.

Low: The client was treated as the problem.

III. **Utilization**: Utilized Intrapersonal and Interpersonal Dynamics as well as Situational Factors

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

High: The primary focus was on accepting and utilizing client attributes.

Low: The primary focus was on changing client attributes.

IV. **Destabilization**: Disrupted Stable Patterns to Encourage Flexibility and Learning

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

High: Therapy included surprises, curiosity, or unexpected ways of thinking and doing.

Low: Therapy was routine, easily anticipated, or guided mostly by the client.

V. **Experiential**: Prioritized Open-Ended Experiential Learning

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

High: Therapy included doing things that could be reflected upon. There was an exploration of experience.

Low: Therapy depended on instruction and conscious conceptual understanding.

VI. **Naturalistic**: Created the Expectation that Change will occur Naturally and Automatically

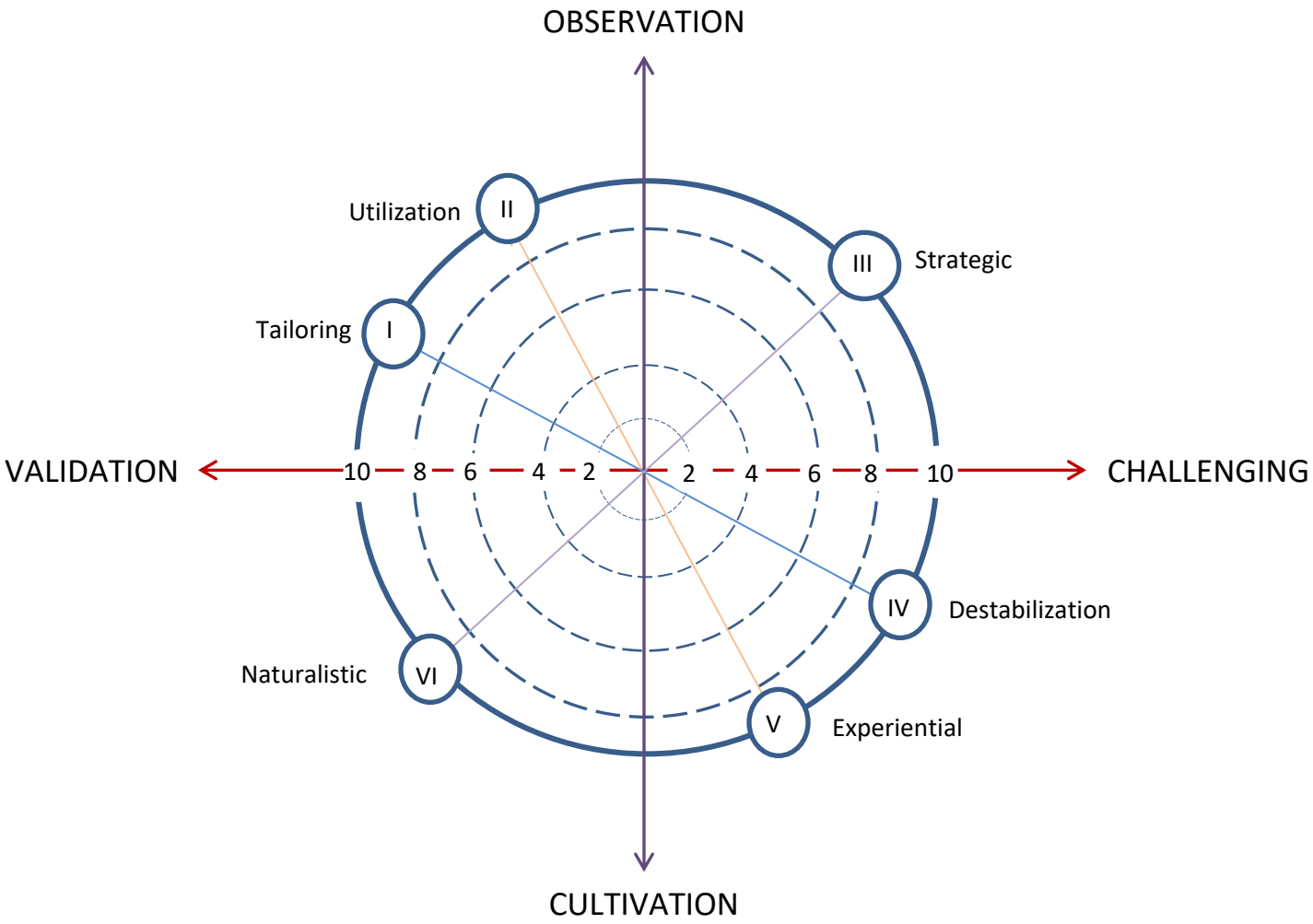
| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|---|

High: The suggestion was made that change can be automatic and natural, something within the client.

Low: Change was predicated on the power of the therapy or the knowledge and ability of the therapist.

## Core Competencies Profile

Multi-Dimensional Skillset Cluster Analysis




| SCORE | **CORE COMPETENCY SKILLSET** |
|---|---|
| | I. Individualize Treatment (i.e., Tailoring) |
| | II. Create a Self-Organized Problem Solving Context (i.e., Strategic Approach) |
| | III. Utilize Intrapersonal and Interpersonal Dynamics as well as Situational Factors (i.e., Utilization) |
| | IV. Evoke Altered States to Catalyze the Growth of Organic Knowledge and Ability (i.e., Destabilization) |
| | V. Prioritize Open-Ended Experiential Learning (i.e., Experiential Learning) |
| | VI. Create the Expectation that Change will occur Naturally and Automatically (i.e., Naturalistic Approach) |

## Instructions for administering the CCS-6

These are the instructions for use of the CCS-6 scoring sheet.

1. **Getting started**: Before using the score sheet to code therapy demonstration(s), you should familiarize yourself with each of the six scales listed on the CCS-6 and the associated explanations listed in the Scoring Key. This will help you know what behaviors to watch for as you observe the video and help you develop a comprehensive understanding of each skillset. After having done this, you will be ready to watch the video slated for coding.

2. **Marking the score sheet**: The core competencies scales (CCS-6), has six sections preceded by roman numerals and a brief description of the scale. Beneath the numbered portion of the Likert scale (0-10) are prompts for both high end and low end ratings. Answers are to be marked inside the box by circling ONLY one of the 11 integers. Each section (I-VI) requires a single score. Qualitative information can be listed in the space between sections (i.e., what you saw that caused you to choose a certain score). The qualitative information is optional.

3. **Selecting the score**: If after watching the demonstration you can recall a clear example that matches the high prompt, then choose a *high score* (10-8). If the standard seems to have been partially achieved, or some behavior matches prompts from both ends, then choose a *medium score* (7-4). If you can think of a clear example of the low prompt, then choose a *low score* (3-0).

   Some interventions are multi-faceted and can therefore satisfy criteria in multiple areas of competency. If a single statement or action from the therapist meets criteria across multiple scaled categories, then score accordingly in each area that it satisfies.

4. **Using the graph**: Once you have scored all six domains, transfer these scores to the table at the bottom of the summary page. If you wish to use the graph for a visual aid, then place an "x" on the axis of each domain on one of four concentric circles, depending on the score value listed in the table. Finally, a line can be drawn from one "x" to another resulting in a shape that depicts the size of each skill set.

## Training and Supervision

As a point of value for teaching and training, while studying practitioner effectiveness, Scott Miller and colleagues discovered that time and experience does not automatically improve practitioner effectiveness. Rather, on average, clinical outcomes slowly worsen. Similar results have been found in other fields (e.g., political forecasting) where the status of expert leads to overconfidence in ideology, guesswork (i.e., availability bias) and less attention to collaborative insight and critical feedback.

In response to this problem, Miller has recommended an education process which he calls deliberate practice (DP). This process involves a conscious and purposeful effort aimed at improving specific aspects of an individual's performance. As described by Miller, DP contains four essential ingredients: (1) identify performance objectives just beyond one's current ability, (2) together with a coach or consultation group, develop and execute a plan with steps and strategies for reaching those performance objectives; (3) use some means of reliable observation and measurement so that small errors and mistakes can be identified and corrective feedback provided; finally, (4) monitor progress on a scale sensitive enough to detect slow but steady improvement (ideally this should be displayed in graph form so that the trend line can be studied).

While the instrumentation of the CCS-6 is designed to meet rigorous standards as a research instrument, it is simple enough to administer and score that it can serve the dual purpose as a practical measure in graduate level training or ongoing professional development. For those who wish to excel at the practice of ET it is recommended that a video sample of one's work be rated by 3 to 4 others within the context of a consultation group or training program. The practitioner who was the subject of the clinical demonstration should also rate the session as well. This will provide interesting information on the professional's self-conceptualization and whether there is an under-inflation or over-inflation of perceived ability. The group should offer feedback on the points of strength. For any lower scores it is helpful to ask the group for concrete suggestions for how this skill could have been improved in this specific situation.

# V. ADDITIONAL RESOUCES

## Overview of Additional Resources

Section V of this manual, on Ericksonian therapy (ET), contains reference material that will be of interest to those who wish to learn more about this unique approach to therapy. As stated elsewhere in this manual, if you know of resources that have been accidently omitted, or details that need to be corrected, please contact the series editor so that the information may be considered for future editions: dan@iamdrshort.com.

### List of Ericksonian Institutes throughout the World

- *At this time, there are over 100 active institutes around the world*

### History of the Milton H. Erickson Foundation

- *The Erickson Foundation has been a focal point of leadership and training since 1980, as well as caretaker of the Erickson Audio Achieves and the Erickson Museum*

### Glossary of Ericksonian Terminology

- *An effort has been made to provide precise definitions for any term that appears in this manual*

### References for Primary Source Material

- *There are many things that have been written about Milton Erickson and Ericksonian hypnosis, some of it good and some not so good. The materials in this list are from credible sources and thus useful for better understanding this approach*

# List of Ericksonian Institutes throughout the World

Erickson Institutes are professional groups that have obtained permission from the Foundation to use Milton H. Erickson's name in the title of their organizations. They are directed by professionals that have met the Foundation's eligibility requirements, received high recommendation from affiliated professionals, and demonstrated knowledge of Ericksonian methods. The Foundation Board of Directors reviews each Institute application to ensure that they uphold the required standards.

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### Milton H. Erickson Institute of the Calfornia Central Coast

School: 125 Howard Avenue, Los Osos CA 93402, United States/ Phone: 805-528-0200 Website: https://ernestrossi.com/mhe-ccc/index.html

### Southern California Society for Ericksonian Psychotherapy and Hypnosis

School: 1440 East Chapman, Orange CA 92866/ Phone: 949-495-1164Personal Email: info@scseph.org
Website: https://www.SCSEPH.org

### The Milton H. Erickson Institute of San Diego

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### The Milton H. Erickson Institute of the Bay Area

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## *Canada*

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## *Germany*

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## History of the Milton H. Erickson Foundation: A Story of Cooperative Effort

This historical account is composed of contributions from Linda Carr-McThrall, Roxanna Erickson Klein, Marnie McGann, and Dan Short

"*A goal without a date is just a dream*." Milton H. Erickson, M.D.

**The Dream:** Perhaps it was foreshadowing that Dr. Erickson once made that pronouncement. The Milton H. Erickson Foundation came to life based on the dream of one man: Jeffrey Zeig, PhD. And, more than three decades after its inception, bolstered by a small hardworking staff, the generosity of donors, and extensive dedication of volunteer supporters, the Foundation has reached beyond humble beginnings to become one of the most globally recognized and influential organizations in the field of psychotherapy.

Early in his career as a clinical psychologist, Zeig aspired to repay the generosity that Milton Erickson had bestowed upon him. Remembering his own days as a medical student without monetary resources, Dr. Erickson mentored several promising students, including Zeig, without charging them a fee. Zeig's studies under Dr. Erickson were more intense than many of Dr. Erickson's other protégés. Over the six-year interval, from 1974-1980, Zeig was invited many times to stay as a guest at the Erickson home. As friendship and mutual appreciation grew, Dr. Erickson had a deep impact on Zeig's view of psychotherapy…and his view of the world.

Milton H. Erickson, MD, was already recognized by many as the world's foremost authority on hypnosis and brief strategic psychotherapy. His approaches had attracted worldwide attention and serious studies from research hubs. Many notables in the field, including Jay Haley and Ernest Rossi, recognized the pivotal importance of Dr. Erickson's contributions and called attention to the paradigm shifts that brought new understandings to psychotherapy.

Zeig wanted to thank Dr. Erickson for his mentorship by orchestrating an event in honor of Dr. Erickson. He also wanted to offer Dr. Erickson an opportunity to witness the tremendous impact his ideas had made. Zeig dreamed of holding a conference focused on Dr. Erickson's approaches to hypnosis and psychotherapy, featuring speakers who could attest to the impact and paramount influence Dr. Erickson had on their work. Zeig envisioned it as an international event, held in the convention center in Phoenix, Arizona, coinciding with Dr. Erickson's 78th birthday -- December 5, 1980.

**Humble Beginnings:** Several months passed before Dr. Erickson gave consent to the event, possibly evaluating Zeig's resolve. Once agreed upon, Zeig rallied the support of other students who had benefited from Dr. Erickson's generosity. Working out of Zeig's home, volunteers sent out 70,000 brochures. Faculty invitations were individually composed by Sherron Peters, then Zeig's fiancé, on a typewriter loaned by the Arizona State Hospital where Zeig worked. The response to the Congress was phenomenal. As registrations poured in, the need to establish a more formal non-profit educational foundation was recognized.

Dr. Erickson and his wife Elizabeth, along with Zeig and Sherron Peters, founded The Milton H. Erickson Foundation. All four principals served as the first Board of Directors, and Peters held the first paid position as executive director. Even then, the Foundation was envisioned as a vehicle to put together the Congress for the following year, an event that already had tremendous promise and momentum.

To obtain funds for the first Congress, Zeig decided to use a transcription of an exceptional Erickson seminar as the basis for a book: *A Teaching Seminar with Milton H. Erickson,* which was published by Brunner/Mazel. The publisher also contracted for the proceedings of the Congress and gave an advance that allowed for the legal filing of corporate papers. With formalized appointment of a Board of Directors, The Milton H. Erickson Foundation was officially incorporated in 1979. An educational mission was written and a non-profit commitment made.

In accordance with Dr. Erickson's wishes, emphasis was placed on integrating Ericksonian methods into the mainstream of psychotherapy, not on establishing a separate school. It was agreed that the presentations and training be restricted to professionals rather than include a broader audience. Also, the decision was made that the Foundation not be a membership organization. All of these policies remain in force today.

**Dr. Erickson's Death:** In March of 1980, seven months prior to the Congress, Dr. Erickson passed away suddenly following a brief illness. The family decided to hold a small private memorial service and to scatter his cremated ashes on Squaw Peak Mountain, overlooking the family home. Sorrow from the loss rippled throughout the professional community, and echoed the magnitude of Dr. Erickson's contribution. Dr. Erickson, however, was able to recognize and appreciate part of Zeig's gift, as 750 professionals had already registered for the Congress -- a number greater than had ever previously assembled for a conference focused solely on the topic of hypnosis.

**First Congress:** Despite their loss, the Erickson family encouraged Zeig to move forward with his plans for Congress. They felt it would serve to bring together those who wished to honor Dr. Erickson, and to unite professionals who shared similar beliefs in approaches to treatment. A few months after Dr. Erickson died there was another unexpected turn of events. Gregory Bateson, who was scheduled to be a keynote speaker at Congress, also died. "Nearly every available authority on Ericksonian hypnosis and psychotherapy was already on the faculty," Zeig explained, "so a decision was made to go outside the field and invite Carl Whitaker, MD, to be a keynote speaker." He accepted, and the first Congress took place in December 1980, attracting more than 2,000 attendees making it the largest conference ever held on the topic of hypnosis for decades to come.

**Board of Directors:** The Foundation's five Board of Directors members are dedicated volunteers who are instrumental in reviewing the mission statement and overseeing the performance of the Foundation. These unpaid appointed positions do not have a term of office.

After Dr. Erickson died, Kristina Erickson, MD, stepped in to fill her father's position on the Board. In 1988, Peters resigned her position and was replaced by J. Charles Theisen, JD, who had a law degree from Stanford, expertise in business, and a strong dedication to the Foundation's mission. In 1994, Kristina Erickson retired from her role and was replaced by another family member, Roxanna Erickson Klein, RN, PhD. In 1998, the Board reached out to the international audience by electing Camillo Loriedo, MD, as one of its members. Loriedo had successfully established the Erickson Institute in Rome and served as President for both the Italian Society of Hypnosis and the Italian Family Therapy organization. A year later, Bernhard Trenkle, Dip, Psy, Director of the Erickson Institute in Rottweil and then president of the German Erickson Society, also joined the Board. Renowned international figures and two of Europe's most imminent therapists, Loriedo and Trenkle have served as faculty at many Foundation conferences. In 2008, Elizabeth Erickson, one of the original Board members, passed away. In 2015, this position was filled by Elizabeth Erickson's daughter-in-law, Helen Erickson, PhD, MSN, BSN. What follows is a detailed description of each of the current board members.

> Jeffrey K. Zeig, PhD, is the Founder and Director of The Milton H. Erickson Foundation. Zeig also is the architect of the Evolution of Psychotherapy Conference, Brief Therapy Conference, Couples Conference, and the International Congresses on Ericksonian Approaches to Psychotherapy. He is on the editorial board of numerous journals; Fellow of the American Psychological Association; and Fellow of the American Society of Clinical Hypnosis. A clinical psychologist, Zeig has a private practice and conducts workshops internationally in 40 countries. He has been an invited speaker at major universities and teaching hospitals, and has edited, co-edited, authored, or coauthored more than 20 books on psychotherapy that appear in 14 foreign languages.
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> Roxanna Erickson Klein, RN, PhD balances her times between clinical work, writing, and teaching. Erickson Klein is coauthor (with Betty Alice Erickson and Dan Short) of *Hope & Resiliency: Understanding the Psychotherapeutic Strategies of Milton H. Erickson,* and co-editor of *The Collected Works of Milton H. Erickson*. She has compiled an international glossary to bring more consistency to translations of professional Ericksonian literature. Recently, she coauthored a book (with Kay Colbert) that offers group exercises for treatment of substance abuse, entitled: *Engage the Group; Engage the Brain*.
>
> Camillo Loriedo, MD, PhD, is a professor of psychiatry and psychotherapy at the University of Rome, School of Medicine, and School of Specialization. He is President of the Italian Society of Psychotherapy, and has served as president of the International Society of Hypnosis. Loriedo has authored more than 350 scientific papers and 26 books.

J. Charles Theisen, MA, MBA, JD, PhD, is, or has been, an active member of CEO (Chief Executive Organization) and YPO/WPO, (Young Presidents Organization and World Presidents Organization). Theisen also has or currently serves on the boards of Childhelp, USA, Homeward Bound, Robbins-Madanes Center, and Yo San University.

Bernard Trenkle, Dipl. Psych., is Director of the Milton Erickson Institute, Rottweil, Germany, and served as president of the International Society of Hypnosis . He also served as past president of the Milton Erickson Society of Clinical Hypnosis in Germany. Along with co-organizing the European Evolution of Psychotherapy Conference in 1994 in Hamburg, Trenkle has organized six international child hypnosis conferences in Germany and the International Society of Hypnosis meeting in Bremen in 2012, which currently stands as the largest meeting ever held on hypnosis with more than 2,300 attendees.

Helen Erickson, PhD, MSN, BSN, is Professor Emeritus at the School of Nursing at The University of Texas, Austin and a Fellow of the American Academy of Nursing. Helen has more than five decades of experience in nursing, has published dozens of professional articles, authored and edited many books, presented at many professional meetings, and is the recipient of numerous distinguished awards. Currently, Helen is in independent practice in Texas offering Holistic Nursing to clients. She is presently on the Board of Directors of the American Holistic Nurses' Certification Corporation and has served as Chair from 2002-2014.

**Volunteers**: The spirit of volunteering has been central to the Foundation since its inception. Since 1979, when volunteers sorted enrollment for the first Congress on the floor of Zeig's living room, through the present as volunteers make substantial gifts of their time and talents to contribute to virtually every element of the Foundation, the spirit of selfless giving is key to both the success of the Foundation and to the underlying philosophy of the Ericksonian approach. While not all of the needs are met, and not all dreams are yet fulfilled, the contributions made by volunteers have substantially enhanced what the small paid staff has been able to accomplish. A debt of gratitude to the broad base of volunteers is felt every day.

**Newsletter:** Shortly after the first Congress, Bill O'Hanlon, MS, volunteered to spearhead an Erickson Foundation newsletter as a way of networking with faculty, participants, and the wider audience of professionals interested in the work and directions of Milton Erickson. The first issue of *The Milton H. Erickson Foundation Newsletter* was published June 21, 1987. It facilitated the ongoing dialogue of Ericksonian approaches, and developed a forum for discussion and evaluation of effective therapeutic approaches. Following a six-year term as editor, O'Hanlon was succeeded by Michael Yapko, PhD, who served for the next six years. Subsequently, the position has been filled by long-term volunteers, including Roxanna Erickson Klein, PhD, Betty Alice Erickson, MS, Dan Short, PhD, and Sharon Mclaughlin, MS. Guest editors Carol Kershaw, PhD, and Bill Wade, MS, and feature and book review writers, contribute their talents in rounding out the publication, some for more than a decade.

The newsletter is published in newspaper format three times a year, and continues to increase in content, offering engaging interviews with professionals in the field, articles of interest, and book reviews. Currently, Richard Landis, PhD, serves as editor, Karen Haviley is production manager, and Alex Simpkins, PhD, and Annellen Simpkins, PhD, oversee the book reviews. The newsletter is mailed free-of-charge to 8,000 U.S. professionals per year. Worldwide, approximately 4,000 download it.

**Ericksonian Approaches:** The first mention in print of "*Ericksonian* Therapy," was in 1978 when Zeig published the brochure for the first Congress. As communication was enhanced among clinicians and educators, the term "Ericksonian approaches" began to gain attention and be more widely used. *Ericksonian* broadly refers to techniques of hypnosis and psychotherapy that were developed by Milton Erickson. However, it is important to recognize the distinction between Dr. Erickson's work, and Ericksonian work, which is generated by his followers. Zeig constructed a diagram that displays the genealogy of Dr. Erickson's influence in a way that is clear and meaningful to both students and professionals. (Available at www.erickson-foundation.org/genealogy) While Dr. Erickson's ideas were initially considered revolutionary, they have become more accepted and are the foundation for other schools of psychotherapy that are already considered mainstream.

Dr. Erickson eschewed the concept that any single approach can constitute a theory of psychotherapy. Rather, he believed the professional task is to adapt to changing needs and circumstances that evolve over time. Despite his position, efforts have been made by numerous Ericksonians to more clearly define Dr. Erickson's work, and the underlying constructs that identify the Ericksonian perspective.

**Lifetime Achievement:** At the 1980 Congress, Jay Haley was honored as the first recipient of the Foundation's Lifetime Achievement Award. The award is in recognition of professional contribution, not only to Ericksonian psychotherapy, but to the all-encompassing field of psychotherapy and the well-being of society. Subsequent winners have been Ernest Rossi (1986), Paul Watzlawick (1988), Elizabeth Erickson (1989), Kay Thompson (1992), Stephen Lankton (1994), Burkhard Peter (1999), Bernhard Trenkle (1999), Camillo Loriedo (2001), Stephen Gilligan (2004), Michael Yapko (2007), and Teresa Robles (2011).

**Archives:** The Foundation's Board of Directors has identified the development of the Erickson Archives as a primary role of the Foundation. This includes responsibility of making Dr. Erickson's work more accessible and familiar to the mental health community.

Lori Weirs, an early staff member, was the first to take responsibility for the Archives. She transcribed many workshops and interviews conducted by Zeig, and as myriad historical materials piled up -- letters, interviews, audiotapes, videotapes, books -- a professional archivist from Arizona State University was brought in to train Weirs. “The Archives were a big step forward,” Weirs reflected in an interview.

Today, the Archives serve as a repository for three distinct, but overlapping collections: The Milton H. Erickson works; the work of Erickson’s contemporaries and successors; and the expansive collection of materials pertaining to the conferences organized by the Foundation. The collection of articles and stories relating to Dr. Erickson’s influence continues to grow. The Archives also contain audios and videos from the Foundation’s Conferences, including Brief Therapy, Couples, Evolution, and the Erickson Congresses. The Foundation is moving forwarded in digitizing the Archives in several file formats, including Mp3s and Mp4s. Within three decades, the Foundation Archives have grown to become among the most extensive in the world.

The vision of making the Archives a destination for serious students has been limited in its success due to space and staff constraints. However, the Foundation’s move to new headquarters in 2012 has helped resolve the competition for space that stifled much of the Archive’s accessibility. A goal is to develop a process that will make the Archives more accessible – one that encourages students to visit and use the materials firsthand to fortify their education and enhance their skills.

**Headquarters:** With the success of the 1980 Congress, the Board began to envision future training events and educational opportunities. A modest white stucco cottage at 3606 North 24$^{th}$ Street in Phoenix was purchased for the Foundation’s operations, and a small staff was hired. With each training event, interest in Ericksonian approaches continued to grow, and the Foundation itself grew. Eventually, three more adjacent cottages were purchased and the four cottages became the Foundation’s headquarters for more than 30 years. In 2009, the Foundation purchased a building at 2632 East Thomas Road in Phoenix, and in 2011, construction began to remodel the upper level for new headquarters. In September 2012, the Foundation moved to the building. When a former long-term employee, Alice McAvoy, was asked to identify the most significant change in the Foundation over the years, she replied, “The new building -- it’s glorious!"

**Staff:** In the early days, Foundation employees wore many hats, and happily so. Lori Weirs, a retired schoolteacher, was no exception. In 1981, she accepted what she thought would be merely a part-time, temporary position and wound up staying at the Foundation for nearly two decades. She began by typing all conference registration names on 3 x 5 cards. “This was before we had computers,” she recalls, “and it was quite a test.” Weirs soon became volunteer coordinator before working in the Archives.

In 1986, Linda McThrall, an Arizona State University journalism graduate, joined the Foundation, becoming executive director a year later. “It was not easy for me,” she recalls, “because I don’t like being on the frontlines. I’m more comfortable in the background.” McThrall’s responsibilities included organizing the conferences, Congresses, seminars, and workshops. “Our staff accomplished some major things, often on a shoestring budget. There was always something interesting or challenging. You had the opportunity to be creative. At that time, the staff was almost all women. It was a place where you could be yourself.” To this day, McThrall and Weirs still meet for coffee. McThrall comments she will always be grateful for her years at the Foundation. “It was an opportunity to really stretch myself.”

The flexibility of the Foundation’s work environment allowed staff members to spearhead specific projects, some of which have continued to grow. Mary Helen Kelly brought years of experience in working with non-profits and helped to establish a systematic way of coordinating the Erickson Institutes and compiled the first Institute directory.

Unlike many of the staff whose introduction to Dr. Erickson’s work was in the context of employment, Alice McAvoy came to work at the Foundation *because* of Milton Erickson. She has visited him wanting to know more about hypnosis and how to deal with pain issues that plagued her throughout her life. “It was interesting meeting him.” she recalls. “He was in a wheelchair at that time, and he always wore purple ‘pajamas.’ He was very helpful, and although I did not get hypnosis from him, he gave me lots of tips on how to achieve self-hypnosis. One of the most exciting things about working at the Foundation was the big conferences and the opportunity to meet and interact with professionals from all over the world. We felt that we were doing something important by promoting and legitimizing the use the hypnosis. I felt what I was doing alone was not terribly significant, but I was doing something useful to serve humanity because I was supporting those who were significant.” At the time, McAvoy’s husband worked as a counselor, so she volunteered her services at the Foundation. “I did whatever was needed,” she says. Eventually, she was offered a paid position and stayed at the Foundation for approximately eight years. One of her achievements was to organize videos of Dr. Erickson.

Over the years there have been many outstanding Foundation employees. The Foundation seems to draw those who work best in a smaller organization and thrive in a world in which passion and purpose are the driving forces. Jeannine Elder is another employee who found a true sense of belonging at the Foundation. Her role as onsite faculty coordinator and liaison with the Institutes earned her the respect and allegiance of Institute leaders and faculty members from around the world. It was always interesting to see the bond of rapport she was able to establish in her long-distance communications. She remained with the Foundation until her death in 2010.

Another valued employee was Susan Velasco, who served the Foundation for 16 years (1995-2011) as administrative assistant and business manager. Susan was an exemplary meeting organizer and hands on with all significant Foundation functions and decisions. She helped refine the Foundation’s mission and managed her staff with efficiency and cheerfulness. And, despite learning she had cancer with a grim prognosis, Velasco persevered, and dedicated herself to work at the Foundation up until her death in April, 2011.

Current Foundation staff members include: Stacey Moore, finance manager; Chuck Lakin, marketing director; Chandra Lakin, events and education coordinator; Rachel Wu, faculty and institute coordinator; Marnie McGann, project specialist, Christina Khin, operations and IT manager; Matt Braman, multimedia specialist; Fred Huang, marketing assistant, and Kayleigh Vaccaro, sales and training specialist.

Board member Roxanna Erickson Klein notes that the staff at the Foundation has been impressively stable over time. "Employees are given the opportunity to grow into positions, and positions are flexible enough to capitalize on the talents individuals bring to the organization. It is pleasing to see how many staff members have made lasting friendships, and how much has been accomplished with a small staff. Over our history we have had many remarkable employees, and do today as well. Chandra Lakin and Rachel Wu are both prime examples of those who bring integrity and personal skills to their positions. But most importantly, they are able to adapt to the fluctuating demands the environment creates. It is not an easy place to work, and needs always exceed resources, but finding ways to make thing happen, and happen well takes a special kind of person."

**Institutes:** At the time the Erickson Foundation was formed, several smaller local Institutes had already approached Dr. Erickson for permission to use his name in the title of their professional businesses. The Foundation offers a vehicle for formalizing the process of using Dr. Erickson's name and of establishing a network of affiliation. There are guidelines of quality, and Institute applicants go through a rigorous process of evaluation. The network of independently established Institutes loosely affiliated with the Foundation, provides a referral network to which the Foundation can direct inquires. Each Institute represents an approach to running the practice or business that suits individual missions. The common element is the affiliation in the network, and in the commitment to use Dr. Erickson's name for the ethical delivery of services that promote societal health. The Institutes are identified on the Foundation's website, and today there are more than 140 in 32 different countries. The underlying philosophy of Ericksonian approaches has proved to be a good fit in a variety of cultures, and the ongoing recognition and growth of interest around the world has been rewarding to the Foundation and its supporters.

**Congresses:** The 1980 Congress on Ericksonian Approaches to Hypnosis and Psychotherapy turned out to be a success that exceeded expectations. So much so that the Foundation was able to purchase property for its operations, fund a small staff, publish a book on the proceeds, and most importantly, generate momentum in the interest of learning more about Dr. Erickson. In those years, it could not have been anticipated that interest in Dr. Erickson's work would continue to gain the momentum it has, which developed over the decades. Zeig and the Board remained committed to identifying and documenting the role of Dr. Erickson's influence in the field, and to organizing Ericksonian Congresses as part of the ongoing mission. The Congresses are held every four to five years, generally in Phoenix, and, to date, there have been 11.

After the first Congress, Zeig began to broaden his vision and developed the Brief Therapy Conference. He chose to create a cyclic pattern of having Brief Therapy Conferences rotate every few years with future Congresses. The Brief Therapy Conference has been held in Orlando, New York City, and numerous times in northern and southern California. It features experts in the field who teach effective brief therapy methods to professionals in medicine, dentistry, psychiatry, psychology, social work, and counseling. Thus far, there have been 10 Brief Therapy Conferences.

In the early years, Zeig also envisioned another conference. His intent was to make Ericksonian psychotherapy mainstream in the field, and give clinicians around the world the chance to meet and learn from luminaries. The first Evolution of Psychotherapy Conference was held in 1985 and attracted more than 7,000 registrants. It was hailed as a landmark event by the *Los Angeles Times* and *The New York Times*, and to this day remains as one of the Foundation's greatest achievements. The conference was so powerful and created such a cohesiveness never felt before in the field of psychotherapy, the Foundation continues to hold one every four years.

Working with the Foundation staff, Zeig displayed extraordinary talent for bringing together interests, so that like-minded or even disparate thinking psychotherapists can learn from one another. The first Evolution Conference was a remarkable feat, which drew high powered and dedicated professionals, and encouraged them to engage in dialogue and debate in a constructive way. Students of today are beneficiaries of the extraordinary prowess that Zeig demonstrated in bringing this group together.

The primary purpose of the Evolution Conference is to enhance the therapeutic skills of each attendee by learning principles and techniques of contemporary schools of psychotherapy; understanding the commonalities that underlie successful clinical work; and appreciating the historical development and future projections of psychotherapeutic disciplines.

Another conference Zeig developed is the Couples Conference, typically held in the spring in California. Organizational assistance for this popular conference is provided by Ellyn Bader, PhD, Co-Director of the Couples Institute in Menlo Park, California. A core group of trainers work together every year to produce a conference which is generative in energy and spirit. The Couples Conference focuses on two prominent aspects of couples' lives: intimacy and sexuality.

The Foundation also has jointly sponsored a number of international conferences, including the 1994 European Evolution of Psychotherapy Conference in Hamburg, Germany. Organized by Bernhard Trenkle, it was the largest gathering on the topic of psychotherapy ever held in Europe. More recently, the Foundation nominally cosponsored an international webinar with the Milton Erickson Institute of Tasmania.

**Instruction:** Brent Geary, PhD, developed the Foundation's Intensive Training Program in Ericksonian Approaches to Brief Hypnotic Therapy. The Intensives, held three times a year in Phoenix, offer a

dynamic learning experience that is focused, tailored, and goal-directed. Attendees learn principles, applications, and techniques of Ericksonian hypnosis and therapy. Smaller class sizes with limited enrollment afford students more individualized instruction. Workshops are organized into fundamental, intermediate, and advanced levels of training, held in several consecutive weeks, which is convenient for the 30% of attendees who live outside the U.S.

Zeig developed an annual series of Master Classes, also organized into beginning through advanced levels, in which therapists can actively participate in their own professional development. Held at Dr. Erickson's Hayward home in Phoenix, now the Erickson Museum, and only open to licensed, experienced mental health professionals, this experiential four-day workshop limited to 12 participants, is designed to greatly enhance skills.

**Clinic:** One of the early visions of the Board of Directors was for the Foundation to become a three-prong organization, with an equal balance of teaching, archives, and clinical work. In 1987, the Foundation established The Milton H. Erickson Center for Hypnosis and Psychotherapy. Michael Leibman, MC, was the director and Brent Geary, PhD, served as coordinator of training. The clinic offered a sliding scale fee to patients and gave professionals the opportunity to train in Ericksonian therapy and counseling. A one-way mirror viewing room and the opportunity for participatory classroom training showed promise for valuable learning. Unfortunately, the clinic did not evolve in a way to promote autonomy, and resources were not available to develop it further. The effort was abandoned and the clinic shut down; prospects for future clinical work remain uncertain.

**Publications:** Following several of the Congresses, the Foundation was able to secure contracts to publish proceeds. Royalties were then reinvested into the Foundation, and the works served to enhance the work of the Foundation in multiple ways.

**The Erickson Monographs:** In 1984, the Foundation Board decided to establish a scholarly publication to provide in-depth academic discussion of specific aspects of Ericksonian approaches. When *The Erickson Monographs* first hit the press, Stephen Lankton, MSW, served as volunteer editor. However, only 10 issues were ever released.

In 1997, a second series of annuals were released with volunteer co-editors William Mathews, PhD, and John Edgette. PsyD. Entitled *Current Research and Thinking in Brief Therapy,* the publication ran for only three years.

In 2002, the Foundation developed the Erickson Foundation Press to publish books that enhance Ericksonian directions.

The most important published work of the Erickson Foundation has been *The Collected Works of Milton H. Erickson*. Ernest and Kathryn Rossi, along with Roxanna Erickson Klein, volunteered their time and resources to secure the rights to publish many works which had previously been unavailable. Working with the Foundation they edited the collection of Dr. Erickson's works, updating with additional commentary pertaining to current knowledge and understanding that was unavailable during Dr. Erickson's lifetime. Each of *Collected Works* volumes has been a product of the Erickson Foundation Press. Envisioned as a collection of 18, the volumes are intermittently published and sold through the Foundation. All royalties are turned back to the Foundation.

**Museum:** The development of the Erickson Museum, Dr. Erickson's Hayward home, is one of the more recent undertakings of the Foundation.

After Dr. Erickson's death in 1980, his widow, Elizabeth, remained in the home they had shared together the previous decade. When Elizabeth died, Erickson family members agreed to sell the home to the Foundation and to loan possessions so that the experiential aspect of coming to study under Dr. Erickson could be preserved. Dr. Erickson's office has remained relatively intact since his death, as Elizabeth delighted in the ongoing flow of visitors, which has continued throughout today. Family members, as well as Zeig, have loaned precious items and memorabilia to the museum, which are on display for visitors who come from around the world.

When Milton and Elizabeth Erickson first moved to Arizona in 1948, Dr. Erickson had a position at the Arizona State Hospital. In 1949, he left this position and moved his family from the hospital grounds into a small house at 32 West Cypress Street in Phoenix. He then took up private practice and used one of the bedrooms as a home office. The Cypress Street house is no longer standing, although the Foundation purchased a load of bricks from the construction site when it was demolished in the '80s.

By 1970, the youngest of the Erickson children had gone off to college. Dr. Erickson, who had walked with a cane all of his adult life, was increasingly more dependent on a wheelchair. So he and Elizabeth sought to relocate in a central location – in a house that could accommodate a wheelchair; and one where he could establish a home office.

Among the numerous properties they visited, they fell in love with (as did the property's original owner) the giant palo verde tree nestled in the backyard of the house on Hayward Avenue. Various other features made the house desirable, including what came to be known as the "Little House," a separate building to the south of the main house where Dr. Erickson could see patients and hold his group seminars. There are two bedrooms in the main house, and the more independent quarters in the Little House has a small bedroom, bathroom, and kitchen. A few changes were necessary to make the house more wheelchair-friendly; ramps were added and rails placed in bathrooms. Milton and Elizabeth moved in 1970, and settled into the home alone as a couple for the first time in their long marriage.

The Hayward Avenue ranch-style home is located a few miles west of what was then known as Squaw Peak (now Piestewa Peak) Mountain. The residence and office of Milton Erickson was constructed in the early '60s. It originally was the personal family residence for the building contractor. He purchased two lots, and positioned the house in such a way that it incorporated the large native palo verde tree into the backyard design. The Erickson's new home proved to be much more accommodating. The Little House served as a place where students who came for longer visits could comfortably and privately stay.

Dr. Erickson had a passion for teaching, but his physical limitations related to post-polio syndrome made travel hard. Dr. Erickson's reputation of being able to work with the most difficult patients generated a flood of interest in learning his techniques. It was a time when experiential teaching was becoming increasingly popular, and a number of master therapists were beginning to open their doors to students for their learning -- something that had not been previously done. This trend coincided with the publication of Jay Hayley's 1973 book, *Uncommon Therapy*, in which the author attempts to describe Dr. Erickson's work.

Haley, Weakland, Watzlawick, and Fisch, all hailed from the Mental Research Institute in California. They were among the first groups to visit the Erickson home for experiential teaching. The colleagues could observe and record therapeutic techniques used by Dr. Erickson, then hold scholarly discussions on his methodology. Between the teaching sessions held in the home offices on Cypress Street and Hayward Avenue, literally hundreds, possibly thousands of students made pilgrimages to study under Dr. Erickson. His reputation was so widespread, that individuals came from far and near to see him.

What started out as an occasional group, advanced into a primarily clinical practice, and rapidly evolved into a series of week-long teaching seminars in which self-selected groups would come to study with Dr. Erickson. Eventually, this became his professional focus until the end of his life. He believed that by reaching out to students, he could benefit the therapeutic needs of far more patients than he could see individually; thus, he welcomed the opportunity to extend his reach.

Students were from all levels -- some established professionals seeking to enhance their own repertoire; others, undergraduates seeking to be grounded. Some harbored problems they hoped could be addressed by coaxing Dr. Erickson into a private session. Others sought only to hone their expertise. Some students and groups came repeatedly; some recorded sessions; and some wrote about what they learned. Many reported the week-long sessions to be life changing.

The Ericksons continued to manage the sessions as a "mom and pop" arrangement, with Elizabeth often bringing in a tray of lemonade during an afternoon break. Dr. Erickson's part time secretary, Maretta Ramirez, typed his correspondence at the kitchen table and answered the phone when she was in, but otherwise it was Elizabeth or Dr. Erickson himself who took the calls and kept the schedule. The Ericksons agreed not to book the training sessions too far in advance; six months were as long as they felt comfortable in projecting Dr. Erickson's physical capability to work.

Most of the groups had eight participants, and were self-arranged. Occasionally, a single participant would want to attend, so they were booked in with a smaller group. The sessions were generally held Monday, Tuesday, Thursday, and Friday. The one free weekday and weekend proved flexible enough so that Dr. Erickson could dedicate time to individuals who had special needs or abilities. The seminars became a self-sustaining flow of energy -- a grapevine reaching out to those who sought professional growth.

Milton and Elizabeth Erickson valued their long-term professional alliances, maintaining friendships for decades. As the teaching seminars grew in popularity, they "adopted" various professionals as special friends, opening their hearts and their home. Jeff Zeig, Ernest Rossi, John Beahrs, Marion Moore, and a plethora of others became regular visitors, staying in the Little House for days or even weeks. After Roxanna, the seventh child, moved back home while she attended nursing school at Arizona State University, she would free up the Little House where she stayed and move into the main house when there were guests. On a rare occasion, a visitor would be invited to stay in the second bedroom of the main house. Around this time, the youngest Erickson son, Robert, and his wife, Kathy, purchased a home just a few blocks away. Dr. Erickson loved hosting large family dinners that would include both family members and favorite students.

The Ericksons valued relationships, communication, exploration, and adaptation. They found beauty in everyday life, and in bringing the power of healing from within to those around them. Their modest quarters and family lifestyle conveyed a message of values that still speaks to visitors who come from around the world to explore. It never ceases to amaze visitors that such a great teacher enjoyed such a simple lifestyle. Dr. Erickson never apologized for his sparse or modest furnishings; rather he emphasized the experience of living life as it is. When he first opened his practice on Cypress Street with no desk and only couple of chairs and a folding table, he expressed: "I'm here, and so is the patient."

Today, the Hayward house/Erickson Museum is lovingly maintained by dedicated caretaker, Ceil Gratz, who is, and has been, a treasured family friend for many years. Gratz also serves as a tour guide for the museum. A quaint gift shop has been established on the grounds, and family members contribute their time and knowledge to support the museum.

**Wizard of the Desert:** In 2011, the Foundation became involved with a creative endeavor -- producing "Wizard of the Desert," an important film about the life and work of Dr. Erickson made by renowned filmmaker, Alex Vesley of Noetic Films. Vienna-born Vesley, a licensed psychotherapist and also the grandson of Viktor Frankl, won the California Films Award Diamond Award for his film, "Viktor and I." "Wizard of the Desert" is scheduled to be released at the Evolution of Psychotherapy Conference in Anaheim, December 2013.

**Future Directions:** The Foundation looks forward to many more years of offering outstanding educational opportunities to health and mental health professionals through conferences, workshops, seminars, training programs, and the Foundation's Archives and Press.

"When I started the Foundation," Zeig recalls, "I thought it would have impact for 10 years and then fade into obscurity. Yet today, I now see that my thinking was limited because the Foundation has turned out to be even more vibrant in the 21st century, and I'm sure will continue to have impact into the indeterminate future."

*https://store.erickson-foundation.org/foundation-press/*

*http://www.ericksoncongress.com/*

*http://brieftherapyconference.com/*

*http://www.couplesconference.com/*

*http://erickson-foundation.org/training/intensives/*

*http://erickson-foundation.org/training/master-class/*

*www.erickson-foundation.org/newsletter*

*http://erickson-foundation.org/erickson-museum/*

*http://erickson-foundation.org/wizard-desert/*

# *A*

**Absorption** – An internal or external focusing of attention in which psychological activities gain priority over external experiences. Creating an event with physical involvement that contains elements of mystery, novelty, intrigue, or deep reflection. *(See also: fixation of attention)*

**Alliance –** A collaborative relationship characterized by strong feelings of appreciation, trust, respect, and mutual interest. *(Also referred to as: Bonding or Rapport)*

**Altered States of Consciousness –** A shift in conscious awareness that impacts reality orientation as well as responsiveness to that reality.

**Arousal** – A state of heightened physiological activity, expectation or readiness to respond in which integration or resolution typically takes place. In hypnosis it often refers to a temporary state of reorientation following trance activity. In emotional process work it often refers to a change in state caused by the intensification of emotion (i.e., emotional arousal).

> **Creative State** – An altered state of consciousness associated with an increased capacity for creative insight. *(Also referred to as "Creative Mindset")*
>
> **Learning State** – An altered state of consciousness associated with an increased capacity for learning. *(Also referred to as "Learning Mindset" or "Growth Mindset")*
>
> **Performance State** – An altered state of consciousness associated with an increased capacity for the automatic and effortless execution of highly developed skill sets. Hypnotic phenomena such as time distortion have been associated with this state. *(Also referred to as "Flow" or "being in the zone")*
>
> **Relaxed State** – An altered state of consciousness commonly associated with hypnosis or hypnotic induction. The relaxed state is intended to create a sense of safety and physiological ease, such as experienced in natural sleep or parasympathetic activity.
>
> **Trance State** – An altered state of consciousness associated with an increased responsiveness to ideas and sensations. The trance state can be deep, such that the subject is minimally responsive to environmental stimuli and yet intensely focused on suggestions, or the trance state can be light, during which unconscious processes are attuned to suggestion while the conscious mind remains alert. In the case of waking trance, the subject is able to converse and perform daily functions while remaining absorbed in an internal event.

**Ambiguity** – The strategic use of non-specific information in communication, which is left open to multiple meanings and interpretations, leaving both the implementation and resolution open to the client's imagination and creativity. *(Also referred to as: Open-ended Suggestion)*

> **Ambiguous Task** – Directing the client to complete a symbolic exercise but without providing details about why the task is being performed or what it should mean to the client *(See also: Task Assignment)*
>
> **Ambiguous Prediction** – A suggestion that an unspecified change is imminent and that it will be realized as the client becomes ready. *(Also referred to as: Response Expectancy)*

**Analogy** – An implicit or explicit parallel that provides a different perspective and enhances understanding.

**Anchoring** – Creating a psychological link between one experience and another. For example, linking feelings of safety with an image, or confidence with a cue word, or linking relaxation with a physical touch, etc. (*Also referred to as: conditioned response).*

**Anecdote** – A narration of an interesting or amusing event for the purpose of communicating new ideas or evoking a particular subject matter from client's own experiential past.

**Apposition of Opposites** – The juxtaposition and linking of opposite concepts in the same sentence or set of directives, an oxymoron (e.g., "vicious pleasure"). This can be used in indirect therapeutic hypnosis where a problem is experienced in one part of the body, such as a hand, and the opposite in the other hand facilitating new creative outcomes.

**Attention** – The aspect of consciousness that relates to the focus on certain aspects of an experience, activity, or task. *(Also referred to as: Concentration or Focus)*

**Attitude** – A summary evaluation or view of an object, event, or set of ideas, that carries a positive or negative value.

**Automatic Writing** – Having the client write script or draw images while conscious attention is distracted. Of used during trance as a means of describing implicit experiences or find answers not available on a conscious level.

## *B*

**Behavior** – Identifiable activity that can be observed, measured, and potentially predicted or modified. Behavior can be experienced as voluntary or involuntary.

**Blocking** – An interruption of thought or expression initiated by unconscious factors, suggestions, or extraneous influence.

## *C*

**Catalyst –** A person, object or event that stimulates energy, activity and change.

**Catalepsy** – A temporary suspension of motion in certain parts of the body or the entire body. This can be caused by physiological factors, psychological dynamics, or as a result of suggestion. *(Also referred to as: Cataleptic immobility).*

**Client** – The individual seeking psychological or emotional care from a professional care provider, and thus the one to whom the therapist has a fiduciary responsibility, obligations of confidentiality, and the right to privileged communication (*Also referred to as: Patient).*

**Clinical Judgment –** The ability to evaluate a clinical situation using objective observations, professional experience and intuition. This stands in contrast to decisions based on algorithms, protocol, or authority external to the therapist (e.g., laws).

**Coercive Persuasion** – Any technique designed to manipulate human thought or action against the desire, will, or without knowing consent of the recipient *(Also referred to as:* **"***Brainwashing," "*Coercive Dominance," *"Manipulation," or "Indoctrination").*

**Collaboration –** A relationship established for problem-solving purposes in which all participants are actively engaged and treated as valuable contributors.

**Communication** – Any act or expression by which an idea, feeling, or understanding is transmitted from one individual to another.

**Core Competency –** A measurable ability to perform or accomplish an action or task required for effective performance. Core competencies include the knowledge, skills, and abilities that are required before the practitioner can say that he or she is using a particular model of practice.

**Conversational Induction** –Moments of spontaneous absorption that result in an altered state of consciousness (without the presence of hypnotic induction sequences). This naturalistic process is seen in all individuals. *(Also referred to as "Conversational Hypnosis" or "Common Everyday Trance")*

**Confusion –** A temporary destabilization of conscious tracking caused by disrupted orientation to time, place, person, or the meaning of events. *(See Destabilization)*

> **Confusion Induction** – A hypnotic induction technique developed by Milton H. Erickson in which the subject escapes from confusing verbal or physical stimuli by slipping into a trance state.
>
> **Confusion Technique** – A technique developed by Milton H. Erickson to surmount resistance and increase responsiveness to subsequent suggestion. It is sometimes used to deepen an existing trance state.

**Conscious Mind** – Experiential awareness that may be described by language, logic, sensation, or specific memories and ideas**.**

**Conspicuous Absence** – A missing element that one expects to be present. Often used as an indirect means of communicating ideas. *(See Also: Indirect Suggestion)*

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# *D*

**Deepening** – The process by which a hypnotic subject is guided to a stronger sense of altered states of consciousness.

**Defining Roles** – Making the client's role as the primary agent of change explicit (i.e., creating internal attribution for change).

**Depoteniation** – *See Destabilization.*

**Destabilization:** A temporary disruption of habitual frameworks, belief systems, or conscious tracking during which conditioned responses are denied expression. It is believed to be essential for the client to become more flexible and open to new means of experiencing, learning, and adapting. It was considered by Milton Erickson and Ernest Rossi to be one of the defining principles of Erickson's therapy and is a core competency for current Ericksonian practice. (*Also referred to as: "Depoteniation" and "Confusion Technique"* )

**Direct Suggestion** – *See Suggestion.*

**Disambiguation** – To remove uncertainty of meaning from an experience by addressing both sides of the client's ambivalence. For example, the client can simultaneously wish for therapy to succeed and for it to fail, which is addressed by having some aspects of the therapy fail (such as trance induction) with success still attained in other areas.

**Discovery –** The process of becoming aware of the existence of resources, information, or elements that are available for use.

**Dissociation** – A sense of feeling apart from one aspect of the self, yet still connected in to a distinct self-identity. (e.g.: One can dissociate from an experience that seems to just happen, or from pain in some part of the body.) *(See also: Externalization)*

**Distraction Technique** – A natural and automatic redirection of attention or perception away from areas of distress or anxiety to other more compelling ideas or experiences (e.g., telling a child a story of courage and adventure as he under goes a painful medical procedure). (*Also referred to as: Refocusing*)

**Double Bind:** The double bind technique employs a dichotomy in which either of two options represents progress. This technique obscures the possibility of negative outcomes by linking therapeutic progress to actions in either direction. For example, the statement, "You can understand this concept now or remain confused and achieve deeper insight later," both validates freedom of choice and creates an expectation of progress regardless of the response. When only one of the two options is explicitly stated, and the implicit alternative is subsequently chosen by the client, then a form of unconscious commitment is activated. For example, "I don't know when you will begin to notice that change is beginning to take place. You may have made a lot of progress and didn't even notice it yet."

The alternative option, that was not mentioned, is that the client can choose to have immediate conscious awareness of progress.

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# E

**Elicitation** – The reliable production of a response to a stimulus. In hypnosis, elicits trance though an invitation to a subject to respond.

**Ericksonian Practice –** The psychotherapeutic strategies and techniques developed, explored and taught by Milton H. Erickson and expanded by his students. (also known as Ericksonian practice or Ericksonian approaches)

**Evoke** – The use of a stimulus *(often referred to as a catalyst*) to draw forth an intended response.

**Exercises** – Structured activities practiced by students to strengthen specific skills. *(Also called Tasks).*

**Expectation** – The anticipated outcome of a situation, suggestion or plan of action.

**Experiential** – A process of learning through direct experience by personally observing, encountering or participating in an event. It is an active form of learning that is distinct from rote or didactic learning, in which the learner plays a comparatively passive role.

**Experiment** – In therapy, exposure to a novel condition that has been designed to provide impetus discovery and ongoing learning through continued exploration.

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# *E*

**Experiential** – Any attempt to facilitate learning through experience or adaptation following reflection on doing. Experiential exercises, such as hypnosis, are used to achieve altered states of consciousness, or higher states of consciousness, as subconscious realities are identified or adjusted. Other experiential exercises include role playing, guided imagery, the use of props such as empty chairs, and interpersonal experiments. Is considered an essential feature of Ericksonian therapy and is a core competency.

**Externalizing** – An experiential exercise during which the client dissociates from the symptom or problem behavior by engaging it as an entity separate from the self. This is often achieved by means of personification (e.g., naming the symptom) or use of props. *(This therapeutic technique is not to be confused with "Externalizing Disorder," which is a broad diagnostic category that encompasses a class of behavioral disorders associated with denial of accountability)*

**Evoking:** Helping people gain access to state dependent learning or forgotten abilities and resources.

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# *F*

**Fixation of attention** – Utilization of an interest, curiosity, or attraction to internal or external phenomena to create a state of absorption. Often used to facilitate a naturalistic trance state. *(See also: absorption)*

**Focus on Strengths** – Any attempt to direct attention toward the strengths and virtues that enable individuals, families, and communities to thrive. *(Also referred to as: "positive psychology", and "competency-based approach")*

**Frame of Reference –** The contextual information integral to evaluation.

**Future Focus –** Directing problem solving energy toward future goals (that are concrete and achievable) as well as long-term dreams (that inspire hope and a sense of purpose), in contrast to therapies that focus on resolving issues from childhood or past relationships.

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# *H*

**Hand Shake Induction –** A hypnotic induction technique developed by Milton H. Erickson which makes use of the traditional salutary greeting. The induction involves the use of touch, ambiguous movement, and sudden interruption of habitual behavior sequences to create confusion and response attentiveness.

**Hope –** The expectation that some good will occur despite unfavorable odds.

**Humor (therapeutic) –** Whimsical, comical or amusing input used to introduce an element of the unexpected or surprise into a therapeutic context.

**Hypnosis** – A term introduced by James Braid (1843), which is still used to describe a broad class of suggestive therapeutics. Milton H. Erickson introduced various context dependent definitions of hypnosis. A definition Erickson wrote for Collier's, Enclyclopedia Britanica was published from 1954-1973: "A term applied to a unique complex form of unusual but normal behavior which can probably be induced in all normal persons under suitable conditions but also in many persons suffering from various types of abnormality. It is primarily a special psychological state with certain physiological attributes resembling sleep only superficially and marked by a functioning of the individual at a level of awareness other than the ordinary conscious level. Functioning at this special level of awareness is characterized by a state of receptiveness and responsiveness in which inner experiential learnings and understandings can be accorded values comparable with or even the same of those ordinarily given only to external reality stimuli."

**Hypnotherapy** – Treatment for mental illness, somatic symptoms, and behavioral disturbances in which a licensed, trained health-professional incorporates the use of therapeutic hypnosis as part of the intervention process.

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# *I*

**Ideomotor Signaling** – A technique for communication with unconscious processes by means of gesture, usually a finger or hand signal. A pendulum can also be used for signaling yes/no responses.

**Implication** – The communication of a specific belief without explicitly stating it, often in the form of an implied assumption that certain actions will or have already taken place. (e.g., "Have you found a good time to exercise yet?" which assumes that the individual is willing to exercise and that a routine will be established). (also known as "presupposition")

**Implicit Causality** – The establishment of a cause and effect relationship without arousing conscious scrutiny.

**Incorporating –** The utilization of unexpected responses, unplanned events, or other possible distractions for some therapeutic purpose.

**Indirect Hypnosis** – A therapeutic approach in which the hypnotherapist uses an indirect focus of attention to offer hypnotic suggestions; the indirect focus may involve an identified subject and a setting that allows other participants to enter into the hypnotic experience, or it may involve attention focused on some other process. (*See also: Parallel Treatment)*

**Indirect Suggestion** – *See Suggestion*.

**Informed Consent** – The formal process, typically in writing, in which a voluntary understanding and agreement between two parties is reached prior to action.

**Interspersal** – The repetition of an idea within casual conversation, using indirect means such as the timing, tonality, or emphasis placed on certain words.

**Intervention** – Any action by the therapist which is intended to produce therapeutic benefit.

**Intuitive** – The use of insight, perception, or reason that is stored at an implicit level of awareness and therefore not entirely available to the scrutiny of conscious logic. (Also referred to as: Implicit Reasoning).

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# *L*

**Levitation** – Suggesting the sensation of automatic or effortless movement in some part of the body.

> **Arm Levitation** – A lifting of the arm, often used as a form of trance ratification, or a sign that some type of deep process work is taking place.
>
> **Hand Levitation** – A lifting of the hand but without arm movement.
>
> **Finger Levitation** – A lifting of one or more fingers, often used as a signaling technique, in a "yes" "no" format, with the answers attributed to unconscious process work.
>
> **Leg Levitation** – A lifting of one or both legs from the ground, typically by straightening the knee, often used to ratify some major shift in somatic experience (e.g., "Your legs are light, free of pain, and full of energy.")

**Linking:** Linking is a form of suggestion in which new ideas are tied to existing behaviors or internal associations. For example, the therapist might say, "Each time that you come to therapy, you will notice that the therapy gets easier and easier, and that you are gradually increasing the amount of progress that you make." The client has already established his ability to come to the office so the therapist simply links coming to therapy with making progress. *(See also: Anchoring)*

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# *M*

**Matching** – The indirect validation of a client's beliefs, personality, language, posture, or breathing as the therapist discreetly engages in the same behavior. *(Also referred to as: Motor mimicry. Distinct from Tracking)*

**Meta-message** – A large underlying idea communicated by way of a simpler and more readily grasped notion.

**Metaphor** – A symbolic reference or parallel in which one topic is used to illuminate another. This includes anecdotes, analogies, stories, puns, riddles, jokes, and idiomatic phrases.

**Motivational Enhancement:** A variety of methods used to enhance the client's readiness to act as the primary agent of change. These can be straightforward, such as offering encouragement; or paradoxical, such as restraining progress "not yet"; or emotional, such as the evocation of anger.

**Minimal Cues** – The smallest amount of stimulus needed to suggest action in a particular direction but without drawing conscious attention to the behavioral cue, allowing the response to be experienced as natural and automatic. The cue is either very subtle or subliminal. Typically it is meant to trigger a sequence of behavioral, cognitive, or emotional associations (e.g., smiling in order to elicit feelings of comfort and safety, or a change in voice tonality and rhythm to signal trance induction).

**Mirroring** – *See: Matching*.

**Multi-Level Communication** – A message which simultaneously address multiple concerns by using various techniques of expression, such as metaphors, inflections, locus of voice or other indirect techniques that communicate ideas at different levels of interpretation.

## *N*

**Naturalistic** – Any attempt to create the expectation that change will occur naturally and automatically, while eliciting natural processes of healing, growth, learning, and adaptation. Naturalistic is a close complement to utilization, and rest on an attitude of respect for the goodness of the client's mind and body (i.e., the most ideal change comes from within). It is considered one of the defining principles of Ericksonian therapy and is a core competency.

**Normalizing** – A framing technique which reorients the client to a symptom such that it no longer seems pathological or abnormal.

**Novelty** – Exposure to new or unfamiliar experiences.

**Nuclear Problem** – A term used by Erickson to describe a high yield point of focus for problem solving. Also known as the "keystone problem," it is the problem that once it is resolved will automatically eliminate many other problems.

## *O*

**Ordeal** – A therapeutic assignment in which an aversive task is paired with symptom occurrence in order to decrease the probability of reoccurrence. *Note: in order for an assignment to be therapeutic, versus abusive, it must always be safe, respectful of all involved, and freely chosen. First and foremost, the Ericksonian practitioner must always seek to do no harm.*

# *P*

**Pacing** – A naturalistic versus mechanical process in which demands of therapy are tailored to fit the client's needs. It requires the use of observational skills and clinical judgment to set the pace and duration of therapeutic activities.

**Paradoxical Intervention** – A directive that alters the experience of non-voluntary behavior by evoking intentional processes.

> **Prescribing Resistance** – When a resistant client is intentionally directed to resist the influence of the therapist or hypnotic operator. (e.g., "As I conduct the trance induction you can stay wider awake, and wider awake, and wider awake").
>
> **Prescribing Relapse** – The possibility of a brief re-emergence of symptomatic behavior is reframed as evidence of ongoing progress. (e.g., "You will learn self-control more thoroughly if you contrast it with a brief relapse").
>
> **Symptom Prescription** – A reorientation to the symptom as necessary behavior that has specific applications (e.g., "You need to keep some of your anxiety so that you are still capable of being careful when necessary"). *(See also: Pattern Interruption)*
>
> **Symptom Transformation** – *See: Utilization*.

**Parallel Treatment** – Use of the direct intervention with one individual to indirectly treat others who are observing the intervention. *(Also referred to as: Piggy Backing or Indirect Hypnosis.)*

**Partitioning** – Dividing a concept, experience, or action into smaller components. *(Also referred to as: Splitting or Fragmentation).*

**Pattern Interruption** – Experimenting with new behavior or thoughts that fit within the client's self-imposed limitations while progressively changing the established pattern (i.e., change the way that pattern is done).

> **Symptom Displacement** – A directive to intentionally experience the symptom in a new spatial location (e.g., moving an arm paralysis into a pinky finger or moving a phobia into a chair).
>
> **Symptom Embellishment** – A directive to continue to experience a symptom but with greater frequency, intensity, longer duration, or increased complexity of the symptom pattern. *(A therapeutic suggestion to embellish symptoms is a paradoxical directive.)*
>
> **Symptom Scheduling** – A directive to perform a symptom but with changes in the frequency, duration, spatial location, or time of day in which it occurs.

**Symptom Substitution** – A directive to replace a highly debilitating symptom with a new symptom that is fairly innocuous. *(Note: This term has a different meaning in analytic circles).*

**Permissive Approach** – A therapeutic style that is flexible and allows for maximum autonomy of the subject.

**Phenomenology** – Phenomenology is the study of structures of consciousness as experienced from the first-person point of view (i.e., subjective reality). The central structure of an experience is its intentionality, its being directed toward something, as it is an experience of or about some object. It is an approach to psychological subject matter that has its roots in the philosophical work of Edmund Husserl (*Logical Investigations, 1901*).

**Piggy Back** – *See Parallel Treatment*.

**Prescribing Resistance** – *See Paradoxical Intervention*

**Presupposition** – *See Implication*

**Problem** – The discrepancy between what is occurring and the expected or desired outcome. Problem resolution is thus a change in behavior, a change in expectations, or both, such that the discrepancy no longer exists.

**Provocation** – Any attempt to stimulate greater activity by clients toward discovering their own solutions and insights. This "calling forth of solutions" is often done in a multi-layered manner using metaphors, voice tone, imagery and interpersonal dynamics (e.g., "playing the devil's advocate"). The use of provocation is based on the assumption that people change and grow in response to challenges.

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# *R*

**Ratification** – Reinforcement of an idea by means of experiential input.

**Trance Ratification** – The increase in response expectancy following evidence that one is responding to hypnotic suggestion (e.g., seeing one's hand lift into the air in response to suggestions for Hand Levitation, or by testing for the presence of hypnotic phenomenon such as

time distortion (by asking how long he thinks he has had his eyes closed). If the client's expectations for making progress in therapy rest upon the idea of going into a trance, then it becomes necessary to demonstrate that a meaningful psychological has indeed occurred.

**Reflecting** – An attempt to increase the experience of familiarity and acceptance by adopting the client's vocabulary and basic point of view (different from the Rogerian technique of "reflective listening").

**Refocusing** – *See Distraction Technique*.

**Reframing** – A sudden, often unexpected, reorientation to new meanings or new interpretation of a particular event. Most often, an attempt to change the way the problem is viewed, though solutions and non-progress can also be reframed. Reframing is not an experiential event, not in the typical sense. That is because rather than creating a new experience to reflect upon, the therapist identifies an existing experience that offers valuable opportunities for learning once it is reconsidered.

**Reorientation** – A significant change in perspective or frame of reference.

**Age Progression –** A reorientation in time during which the person participates in future events. (Also referred to as future progression)

**Age Regression –** A reorientation in time during which the person re-experiences events from the past.

**Resiliency –** The capacity to overcome adversity and the ability to recover quickly from illness, change, or misfortune.

**Resistance** – The failure of an individual to comply with the demands of a situation, such as subject's opposition to suggestion or a client's opposition to treatment.

**Response Expectancy** – People's beliefs about their own reactions to specific events, especially non-volitional or emotional. This can be a part of people's learned limitations.

**Responsive Attentiveness** – *See Suggestibility.*

**Revivification** – The experience of reliving emotionally significant events with full sensory involvement. It can be used for joyful positive memories as well as difficult or negative recollections.

**Rigidity** – A reduction in adaptive capacity due to inflexibility.

> **Physiological rigidity** – Reduction in the movement of the muscular/skeletal systems (e.g., catalepsy).
>
> **Psychological rigidity** – Resistance to new ideas, perceptions, or experiences (e.g., orthodoxy and fundamentalism).

**Rituals** – A prescribed set of behaviors that inspire some greater meaning than the practical outcome of the behavior itself (e.g., The ritual of climbing to the top of Squaw Peak was meant to achieve more than simply getting to the top of a hill).

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# *T*

**Tailoring** – The modification of treatment approach and relationship style to fit the unique needs and capacities of a particular client or subject. Is considered one of the defining principles of Ericksonian therapy and is a core competency. (*Also referred to as: Individualizing Treatment*)

**Task Assignment** – Directing the person to do a therapeutic exercise between sessions (behavioral), or to perform an ambiguous task that has symbolic importance (symbolic), or to think about something between sessions (deliberative), or to perceive something in a new way (perceptual).

**Tracking** – A form of verbal feedback that describes the client's behavior thus increasing self-awareness or self-consciousness *(Distinct: from Matching*).

**Trance** – *See Altered States of Consciousness*

**Translating –** Using the client's system of logic, personal belief system, or personal experience to explain important concepts and ideas.

**Therapeutic Milieu** – The utilization of a broad environmental context to support and enrich therapeutic processes (e.g., vacations with family members, trips to a park, or educational programs at a local community college).

# *S*

**Seeding** – Gradual exposure and subsequent elaboration of new ideas or new behaviors in advance of utilizing it for therapeutic purposes. *(Also referred to as Priming*)

**Self-Hypnosis** – When the subject takes the initiative in inducing a hypnotic trance for the sake of suggesting automatic changes. This can be done either in the presence of a hypnotist or in private. *(Also referred to as Auto-hypnosis)*

**Shock** – The sudden introduction of an unexpected stimulus that carries a strong emotional element and for which there is no prior psychological preparation. Used in therapy to facilitate the assimilation of new ideas and understandings or to focus attention (*Also referred to as: Surprise*). *Note: in order for therapist behavior to be therapeutic, versus abusive, it must always be safe, respectful of all involved, and freely chosen. First and foremost, the Ericksonian practitioner must always seek to do no harm both physical or emotional.*

**Snowball Effect –** A behavioral phenomenon in which one small change leads to a series of ongoing changes, thereby reducing the need for lengthy interventions. Erickson often constructed therapy in such a way that the modification of one small element could initiate a series of positive self-propelling changes. (It has been argued that this dynamic is essential to brief therapy.).

**State-Dependent** – An association between psychological functioning and conditions of awareness.

> **State-Dependent Behavior** – Actions associated with a particular level of awareness or experience (e.g. trance).
>
> **State-Dependent Learning** – The assimilation of information associated with particular conditions that accompany the learning process. This can be intentionally constructed, or may occur circumstantially.
>
> **State-Dependent Memory** – When recollections are triggered or improved by re-creating specific conditions present at the time of learning.

**Strategic** – A phenomenologically based problem solving context organized around the client's values, needs, and agenda for change. Therapy is strategic when the client is embraced as the central problem solver, rather than being treated as the problem. It was considered by Jay Haley to be one of the defining principles of Erickson's therapy and is a core competency for current Ericksonian practice.

**Subconscious** – The marginally noticeable component of the conscious mind in which information is noted by an individual, but not taken into full conscious consideration.

**Subliminal Suggestion** – Suggestions delivered to the outside margin of conscious awareness.

**Subject** – A term used in hypnosis to designate the intended recipient of hypnotic suggestion.

**Subjective Reality** – An individual's first-person perception of the environment and the meaning of events that occur within it. *(see also: Phenomenology)*

**Suggestibility** – The degree of psychological availability to outside influence. When used in the context of hypnosis, there is an implication that the subject is uncritically receptive to the communication of ideas. (*Erickson taught that subjects did not accept suggestions that were outside their own system of beliefs and values). (Also referred to as: Responsiveness or Response Attentiveness).*

**Suggestion** – The communication of an idea that contains an implied directive or possibility for responding.

> **Direct Suggestion** – An overt suggestion in which the subject is asked to respond in a specific way (e.g., "You will experience a decrease in pain.").
>
> **Embedded Suggestion** – An indirect or implied directive contained within another message.
>
> **Indirect Suggestion –** Suggestions that insinuate a response rather than making an explicit declaration. Includes the use of metaphor, implication, and nonverbal suggestions.
>
> **Open Suggestion** – Suggestions that cover all possible alternatives– such that any subsequent action is interpreted as useful responsiveness. The message is delivered in such a way to allow the subject to determine the extent and direction of the response. (e.g., "With your eyes opened or closed, you have the ability to see or imagine anything or absolutely nothing at all.")
>
> **Permissive Suggestion** – A suggestion with intentional flexibility so the subject may utilize unconscious resources to find the most appropriate response (e.g., "You can enjoy the process of discovering how you will become most comfortable.")
>
> **Post Hypnotic Suggestion** – A suggestion given during the trance state for some action, thought, or perception that will occur at a later point in time. (e.g., "After arriving home, you will find yourself ready to relax.").
>
> **Subliminal Suggestion** – A message or idea perceived below (sub) the threshold (limen) of conscious awareness, which is intended to influence thoughts, feelings, or actions. A stimulus is

perceived subliminally when it is processed at a sensory level without an accompanying conscious sensory experience. When environmental stimuli (words, symbols, sounds) are subliminally perceived and encoded, mental representations of these stimuli and associated mental constructs are activated. The internal activation of mental representations makes schematically related constructs, goals, and behavioral tendencies more accessible in memory. Consequently, subliminally perceived messages may be "suggestive" of those behaviors that are mentally activated, as their heightened accessibility increases the likelihood that they will be enacted.

**Taking Over** – A suggestion for action that is imminent or already occurring (e.g., "As you take in your next breath *(a truism)* you will realize that your eyes will eventually close*," It is impossible to never again close one's eyes).*

**Suggesting States** – Use of the hypnotic context and the agency of suggestion to draw attention to internal capabilities for learning, creativity, insight, and performance.

**Symbolic Communication** – A method of conveying ideas by means of unconscious associations that have formed around certain objects or linguistic tools.

**Symptom** – A concrete behavior or somatic event which is non-volitional in nature and has become associated with the experience of physical or mental distress. In Ericksonian therapy the term is not used for diagnostic purposes but rather to identify the target of utilization or other means of therapeutic intervention. *(See also: "Paradoxical Intervention" and "Pattern Interruption")*

**Symptom Scaling** – A rating scale used to communicate the intensity of symptoms (e.g., From 0 to 10, where is your [symptom] right now?). Symptom scaling is often used to bring conscious attention to the changes of the symptom over time.

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# *U*

**Unconscious Mind** – The traditional term used to describe the repository of life experiences and capacities, including the natural tendency for self-protection and preservation that are not recognized by on a conscious level of awareness. Current researchers are more likely to refer to unconscious processes. *(Note: this term has a different meaning in psychoanalysis).*

**Utilization** – Any attempt to engage established habits, beliefs, perceptions, symptoms, or resistances, as well as situational factors, in service of problem resolution or some other meaningful end (e.g., trance induction). Utilization is the natural complement to tailoring, which rest on an attitude of acceptance and optimism. It is considered one of the defining principles of Ericksonian therapy and is a core competency.

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# *V*

**Visualization** – The process of creating a visual image in one's mind.

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# *Y*

**Yes-Set** – A series of questions, typically three or more, designed to elicit as "yes" response so that an atmosphere of agreement and mutual understanding is created.

## References for Primary Source Material

The following list of books contains primary source material, meaning that they have statements coming from Erickson or those who knew him. This is the best place to start the study of Ericksonian therapy as it provides a solid grounding in the core principles.

*If you know of a book that should be added to this list, please contact the series editor so that it can be considered for the next edition: dan@iamdrshort.com*

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| Alman, B., & Lambrou, P. | *Self-hypnosis: The complete manual for health and self-change (2nd ed.)* | 1991 | Reviewed in the Foundation Newsletter: 12(2) |
| Baker, R. | *They Call it Hypnosis* | 1990 | |
| Bandler, R. & Grinder, J. | *Patterns of the hypnotic techniques of Milton H. Erickson, M.D.: Vol.1* | 1975 | Ideas for reproducing Erickson's use of language in trance inductions. The model is based on transformational grammar and split-brain research. The forward was written by Erickson. |
| Barber, J., & Adrian, C. | *Psychological Approaches to the Management of Pain* | 1982 | Five of eleven chapters focus on Ericksonian methods of pain management, one written by Erickson himself.<br><br>Reviewed in the Foundation Newsletter: 14 (1) p14 |
| Barber, J. | *Hypnosis and Suggestion in the Treatment of Pain. A Clinical Guide*. | 1996 | |
| Battino, R. | *That's Right, Is it Not? A Play About the Life of Milton H. Erickson, MD.* | 2008 | |
| Battino, R. | *Healing Language* | 2010 | |
| Battino, R., & South, T.L. | *Ericksonian Approaches: A Comprehensive Manual, 2nd Ed* | 2005 | |

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| Bauer, Sofia M. F | *Hipnoterapia Ericksoniana Paso a Paso* | 1998 | (In Portuguese) |
| Bell-Gadsby, Cheryl, & Siegenberg, Anne | *Reclaiming Her Story: Ericksonian solution focused therapy for sexual abuse* | 1996 | Reviewed in the Foundation Newsletter: 16(3) p4 |
| Betty Alice Erickson, B. A. & Keeney, B. | *Milton H. Erickson, M.D.: An American Healer* | 2006 | This is essentially a biography of Milton H. Erickson |
| Burns, G. W. | *Nature-guided Therapy: Brief Integrative Strategies for Health and Well-being* | 1998 | |
| Burns, G. W. | *101 Healing Stories: Using Metaphors in Therapy* | 2001 | |
| Burns, G. W. | *Healing with Stories: Your Casebook Collection for Using Therapeutic Metaphors* | 2007 | |
| Calof, D. | *Hypnotic Techniques* | | |
| Calof, D. & Simons, R. | *The Couple who Became Each Other* | 1996 | Reviewed in the Foundation Newsletter: 17 (1) p14 |
| Cheek, D. & Rossi, E. | *Mind-Body Therapy: Methods of Ideodynamic Healing in Hypnosis* | 1994 | |
| Colbert, K. & Erickson-Klein, R. | *Engage the Group, Engage the Brain: 100 Experiential Activities for Addiction Treatment* | 2015 | One hundred state-of-the-art experiential activities for use in addiction treatment to facilitate improved client cognitive and behavioral functioning. |
| Combs, G. & Freedman, J. | *Symbol, Story & Ceremony: Using metaphor in individual and family therapy* | 1990 | The authors illustrate the artistic and metaphorical side of Ericksonian psychotherapy.<br><br>Reviewed in the Foundation Newsletter: 13 (1) |

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|---|---|---|---|
| Cooper, L. & Erickson, M. | Time Distortion in Hypnosis: An Experimental and Clinical Investigation | 1954<br>1959<br>1982 | The results of Erickson and Cooper[1]s experimental and clinical work in this area. Much of this material is included in the *Collected Papers.* |
| Cooper, L.; Erickson, E.; Erickson, M.: Morgan, R. F.; Sacerdote, P.; & Zimbardo, P. G. | Training the Time Sense: Hypnotic and Conditioning Approaches | 1994 | |
| de Shazer, S. | *Keys to Solution in Brief Therapy* | 1985 | |
| Dolan, Y. | *A Path with a Heart: Ericksonian utilization with resistant and chronic patients.* | 1985 | This book presents an extension of Ericksonian principles and techniques into work with difficult, multi-problem, long-term patients. |
| Dolan, Y. | *Resolving Sexual Abuse: Solution focused therapy and Ericksonian hypnosis for adult survivors.* | 1991 | Reviewed in the Foundation Newsletter: 12 (3) |
| Edgette, J. & Edgette, J | *The Handbook of Hypnotic Phenomena in Psychotherapy* | 1995 | Reviewed in the Foundation Newsletter: 16 (1) p14 |
| Erickson, M. | Encyclopedia Britannica<br>*14th Edition, Vol. 12, "Hypnotism"* | 1954 | |
| Erickson, M. | *Special Collection: Papers by Milton H. Erickson* | July 1977 | A collection of papers published by Milton H. Erickson in the ASCH journal. |
| Erickson, M. | *The Seminars of Milton H. Erickson: Presentation to the San Diego Society of Clinical Hypnosis* | 2001 | This is an edited transcription of a seminar by Erickson in San Diego, April 29, 1962. |

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| Erickson, M. & Gilligan, S. | *The Legacy of Milton H. Erickson: Selected Papers of Stephen Gilligan* | 2002 | |
| Erickson, M., & Rossi, E. | Hypnotherapy: An Exploratory Casebook | 1979<br>1980 | The second book in the series. This volume deals extensively with hypnotic therapy, utilizing numerous case examples and transcripts. |
| Erickson, M., & Rossi, E. | Experiencing Hypnosis: Therapeutic Approaches to Altered States | 1981 | The third book in the series, containing a transcript of a lecture on hypnosis in psychiatry by Erickson and discussion of various therapeutic techniques and approaches. |
| Erickson, M., & Rossi, E. | The February Man: Evolving Consciousness and Identity in Hypnotherapy | 1989<br>1991 | Reviewed in the Foundation Newsletter: 10 (1) |
| Erickson, M., Hershman, S., & Secter, I. | *The Practical Application of Medical and Dental Hypnosis* | 1961<br>1991 | This book was compiled primarily from transcripts of workshops for medical, psychological and dental professionals given by the authors during the late 1950s. It was reissued in 1989 with a foreword by Jeffrey K. Zeig, Ph.D.<br>Reviewed in the Foundation Newsletter: 10 (2) p11 |
| Erickson, M., Rossi, E., & Rossi, S. | Hypnotic Realities: The Induction of Clinical Hypnosis and Forms of Indirect Suggestions | 1976 | The first book in a series of three co-authored by Erickson and Rossi. Gives an overall model for Erickson's hypnotic approaches. |
| Evans, B. & Burrows, G. | Hypnosis in Australia | 1998 | Provides an introduction to Ericksonian methods.<br>Reviewed in the Foundation |

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| | | | Newsletter: 19 (1) p19 |
| Fisch, R., Weakland, J., & Segal, L | *The Tactics of Change* | 1982 | This book was dedicated to Milton H. Erickson |
| Freytag, F. | *The Hypnoanalysis of an Anxiety Hysteria* | 1959 | This book was dedicated to Milton H. Erickson |
| García-Sánchez, T., Short, D., Erickson, B.A., & Erickson-Klein, R. | *La hipnosis de Milton Erickson* | 2015 | Written in Spanish |
| Gilligan, S. | *Therapeutic Trances: The Cooperation Principle in Ericksonian Hypnotherapy* | 1986 | This book is Gilligan's overview of Ericksonian hypnotherapy, including his model of symptom phenomena as self-devaluing trance phenomena and how to transform them into self-valuing assets. |
| Gilligan, S. | *Generative Trance: The experience of Creative Flow* | 2012 | |
| Gilligan, S. & Dilts, R. | *The Hero's Journey: A voyage of self-discovery* | 2009 | |
| Gordon, D. | *Therapeutic Metaphors: Helping others through the looking glass* | 1978 | |
| Gordon, D., & Myers-Anderson, M. | *Phoenix: Therapeutic patterns of Milton H. Erickson* | 1981 | An attempt at systematizing and making explicit Erickson's therapeutic (as opposed to strictly hypnotic) work. Uses material from Erickson's teaching seminars to illustrate the principles discussed. |
| Grinder, J., DeLozier, J., & Bandler, R | *Patterns of the Hypnotic Techniques of Milton H. Erickson M.D.: Vol. 2* | 1977 | Offers conceptions of sensory-based maps, different approaches for congruent and |

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| | | | incongruent clients and other ideas about Erickson's hypnotic work. A transcript of Erickson's work (taken from "The Artistry of Milton Erickson" videotape) is analyzed with reference to the formulations presented in both volumes. |
| Gurman & Kniskern | Ericksonian Family Therapy | 1991 | Reviewed in the Foundation Newsletter: 12 (2) |
| Haley, J | Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D. | 1973<br>1986 | Contains numerous case examples, discussions with Erickson, commentaries and specific techniques. The book is mainly about Erickson's therapeutic approaches. The material is organized and presented within the family life cycle framework. |
| Haley, J. | *Strategies of Psychotherapy* | 1963<br>1990 | |
| Haley, J. | *Problem Solving Therapy* | 1976 | |
| Haley, J. | *Ordeal therapy* | 1984 | This is an extension of the benevolent ordeal therapy Haley learned from Erickson. Some Erickson cases are used, but the majority comes from cases Haley supervised or treated himself.<br>Reviewed in the Foundation Newsletter: 4 (3) |
| Haley, J. | *Conversations With Milton H. Erickson: Changing children and families, Vol.3* | 1985 | This material was the source for much of the material in |

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| | | 1999 | *Uncommon Therapy.* |
| Haley, J. | *Conversations With Milton H. Erickson: Changing couples, Vol. 2* | 1985<br>1999 | Reading the books is like reading the transcripts of supervision sessions with some theoretical material and some case discussion. |
| Haley, J. | *Conversations With Milton H. Erickson: Changing individuals, Vol. 1* | 1985<br>1999 | These conversations took place mainly in the late 1950s between Erickson, Haley, John Weakland and occasionally Gregory Bateson. Haley and Weakland were trying to understand Erickson's brief therapy for their research with Bate son's project on communication and for their own clinical work with individuals, couples and families. |
| Haley, J. | *Jay Haley on Milton Erickson* | 1993<br>1994 | Reviewed in the Foundation Newsletter: 14 (2) p12 |
| Haley, J. (Ed.) | Advanced Techniques of Hypnosis & Therapy: Selected Papers of Milton H. Erickson | 1967 | This was the first effort to compile Erickson's major papers on hypnosis and therapy. It also contains a biographical introduction and discussion of Erickson's work by Haley, Erickson's longtime student and popularizer. All of this material, with the exception of Haley's writing, is included in the *Collected Papers* (edited by Rossi). |

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| Hammerschlag, C. | *Dancing Healers* | 1988 | |
| Hartland, J. | *Medical & Dental Hypnosis, 2nd Edition* | 1971 | Erickson wrote the forward. |
| Havens, R. | The Wisdom of Milton H. Erickson, Vol. I | 1985 | This book is a compilation of quotations from Erickson on various topics relating to therapy and hypnosis. The quotations are organized into sections, and what emerges constitutes a natural model for Erickson's therapeutic and hypnotic approaches |
| Havens, R. (Ed.) | The Wisdom of Milton H. Erickson: Human behavior and psychotherapy, Vol. II | 1989<br>1992 | Reviewed in the Foundation Newsletter: 5 (3) |
| Havens, R., & Walters, C. | *Hypnotherapy Scripts: A neo-Ericksonian approach to persuasive healing* | 1989 | Reviewed in the Foundation Newsletter: 9 (3) |
| Hughes & Rothovious | World's Greatest Hypnotists: (Chapters 22-24, pp. 223-248) | 1996 | Reviewed in the Foundation Newsletter: 17 (3) p17 |
| James, U. & Rossi, E. | *Clinical Hypnosis Textbook: A Guide for Practical Intervention* | 2015 | |
| Kershaw, C. | *The Couple's Hypnotic Dance: Creating Ericksonian strategies in marital therapy* | 1992 | Reviewed in the Foundation Newsletter: 11 (3) |
| Klippstein, H. (Ed.) | *Ericksonian Hypnotherapeutic Group Inductions* | 1991 | |
| Lankton, C., & Lankton, S. | *Tales of Enchantment: Goal-oriented metaphors for adults and children in therapy* | 1989 | |

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| Lankton, S. | *Practical Magic: A translation of basic neurolinguistic programming into clinical psychotherapy* | 1980 | |
| Lankton, S. | *Ericksonian Hypnosis: Application, Preparation and Research* | 1988 | |
| Lankton, S. | *Assembling Ericksonian Therapy* | 2003 | |
| Lankton, S. (Ed.) | *Ericksonian Monographs Number 1: Elements and dimensions of an Ericksonian approach* | 1985 | This first volume includes a new article, contributed by Elizabeth Erickson, that is an update of an unpublished Milton Erickson article on certain principles of medical hypnosis<br><br>Reviewed in the Foundation Newsletter: 8 (3) |
| Lankton, S. (Ed.) | *Central Themes and Principals of Ericksonian Therapy* | 1987 | |
| Lankton, S. (Ed.) | *Ericksonian Monographs Number 2: Central themes and principles of Ericksonian therapy* | 1987 | This is the second of the *Ericksonian Monographs series*<br><br>Reviewed in the Foundation Newsletter: 8(3) |
| Lankton, S. (Ed.) | *Ericksonian Monographs Number 5: Ericksonian Hypnosis: Application, Preparation and Research* | 1989 | Reviewed in the Foundation Newsletter: 14 (3) |
| Lankton, S., & Erickson, K. (Eds.) | *Ericksonian Monographs Number 9: The essence of a single session success* | 1993 | Reviewed in the Foundation Newsletter: 14 (1) p11 |
| Lankton, S., & Lankton, C. | *The Answer Within: A clinical framework of Ericksonian hypnotherapy* | 1983 | Contains case examples from Erickson's and Lankton's work embedded in a comprehensive framework to provide clinicians access to Ericksonian approaches to the use of |

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| | | | hypnosis in therapy |
| Lankton, S., & Lankton, C. | *Enchantment and Intervention in Family Therapy: Training in Ericksonian Approaches* | 1986 | This book takes the Lankton's elaboration of Erickson's work further than the first book and links the hypnotic approaches to family and couple therapy.<br><br>Reviewed in the Foundation Newsletter: 14 (2) p14 |
| Lankton, S., & Zeig, J. (Eds.) | *Ericksonian Monographs Number 3: Treatment for special populations with Ericksonian approaches* | 1988 | Reviewed in the Foundation Newsletter: 8 (3) |
| Lankton, S., & Zeig, J. (Eds.) | *Ericksonian Monographs Number 4: Research, comparisons and medical applications of Ericksonian techniques* | 1988 | Reviewed in the Foundation Newsletter: 14 (3) |
| Lankton, S., & Zeig, J. (Eds.) | *Ericksonian Monographs Number 6: Extrapolations: Demonstrations of Ericksonian Therapy.* | 1989 | Reviewed in the Foundation Newsletter: 14 (3) |
| Lankton, S., & Zeig, J. (Eds.) | *Ericksonian Monographs Number 7: The Broader Implications of Ericksonian Therapy* | 1990 | Reviewed in the Foundation Newsletter: 14 (3) |
| Lankton, S., & Zeig, J. (Eds.) | *Ericksonian Monographs Number 10: Difficult contexts for therapy* | 1995 | Reviewed in the Foundation Newsletter: 15 (3) p13 |
| Lankton, S., Gilligan, S., & Zeig, J. (Eds.) | *Ericksonian Monographs Number 8: Views on Ericksonian Brief Therapy, Process and Action* | 1991 | Reviewed in the Foundation Newsletter: 14 (3) |
| Lankton, S., Lankton, C., & Matthews, W. | *Ericksonian Family Therapy: In A. Gurman and D. Kniskern (Eds.) The handbook of family therapy, Vol. 2* | 1991 | |
| Lankton, S., Gilligan, S., Zeig, J. | *Views On Ericksonian Brief Therapy* | 1992 | |

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| Le Cron (Ed.) | *Experimental Hypnosis* | 1958 | |
| Leva, R. (Ed.) | *Psychotherapy: The Listening Voice: Rogers and Erickson* | 1987<br>1988 | Reviewed in the Foundation Newsletter: 8 (2) p14 |
| Loriedo, C, & Vella, G. | *Paradox and the Family System* | 1992 | |
| Loriedo, C,., Zeig, J. & Nardone, G. | *TranceForming Ericksonian Methods: 21st Century Visions* | 2011 | |
| Lovern, J. D. | *Pathways to Reality: Erickson-inspired treatment approaches to chemical dependency* | 1991 | Reviewed in the Foundation Newsletter: 14 (1) p11 |
| Lyons, L. & Yapko, M. | *Using Hypnosis with Children: Creating and Delivering Effective Interventions* | 2015 | |
| Matthews, W. J. & Edgette, John H. (Eds.) | *Current Thinking and Research in Brief Therapy: Solutions, strategies, narratives, Vol. I* | 1997 | Reviewed in the Foundation Newsletter: 17 (3) p14 |
| Matthews, W. J. & Edgette, John H. (Eds.) | *Current Thinking and Research in Brief Therapy: Solutions, strategies, narratives, Vol. II* | 1998 | Reviewed in the Foundation Newsletter: 17 (3) p14 |
| Matthews, W. J. & Edgette, John H. (Eds.) | *Current Thinking and Research in Brief Therapy: Solutions, strategies, narratives, Vol III* | 1999 | Reviewed in the Foundation Newsletter: 19 (3) p15 |
| McClintock, E. | *Room for Change: Empowering Possibilities for Therapists and Clients* | 1999 | Reviewed in the Foundation Newsletter: 20 (2) p13 |
| McNeilly, R. | *Healing the Whole Person: A Solution-Focused Approach to Using Empowering Language, Emotions, and Actions in Therapy* | 2000 | |
| McNeilly, R. | *The poetry of therapy Creating effectiveness after Erickson* | 2013 | |
| McNeilly, R. | *Utilizing Hypnosis with Children* | 2013 | |

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| McNeilly, R. | *Creating Connections: Selected Papers of Rob McNeilly* | 2014 | |
| McNeilly, R. | *Learning Hypnosis: A Common Everyday Approach After Erickson* | 2016 | |
| McNeilly, R., & Brown, J. | *Healing With Words* | 1994 | Reviewed in the Foundation Newsletter: 15 (2) p7 |
| Mehl, L., & Peterson, G. | *The Art of Healing* | 1989 | |
| Mills, J., Crowley, R., & Ryan, M. | *Therapeutic Metaphors for Children and the Child Within* | 1986 | |
| O'Hanlon, W. H. | *Taproots: Underlying principles of Milton Erickson's therapy and hypnosis* | 1987 | Reviewed in the Foundation Newsletter: 7 (2) |
| O'Hanlon, W. H. | *Do One Thing Different: Ten Simple Ways to Change Your Life* | 2000 | |
| O'Hanlon, W. H. | *A Guide to Trance Land: A Practical Handbook of Ericksonian and Solution-Oriented Hypnosis* | 2009 | Covers the key aspects of hypnosis, including: using possibility words and phrases; using passive language; and inducing trance. |
| O'Hanlon, W. H., & Hexum, A. L. | *Uncommon Casebook: The Complete Clinical Work of Milton H. Erickson* | 1990 | |
| O'Hanlon, W. H., & Martin, M. | *Solution-Oriented Hypnosis: An Ericksonian approach* | 1992 | |
| Overholser, L. | *Ericksonian Hypnosis: Handbook of clinical practice* | 1984 | This is a primer on the induction and therapeutic use of hypnosis using an Ericksonian approach. |
| Phillips, M. & Frederick, C. | *Healing the Divided Self : Clinical and Ericksonian Hypnotherapy for Post Traumatic and Dissociative Conditions* | 1995 | Reviewed in the Foundation Newsletter: 15 (3) p10 |
| Ray, W., & Keeney, B. | *Resource Focused Therapy* | 1993 | |
| Rhue, Lynn & Kirsch | *Handbook of Clinical Hypnosis: An* | 1993 | Reviewed in the Foundation |

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| | *Ericksonian Model of Hypnotherapy (Chapter 9, pp. 187-214)* | | Newsletter: 12 (2) |
| Ritterman, M. | *Using Hypnosis in Family Therapy* | 1983 | Reviewed in the Foundation Newsletter: 6 (2) |
| Robles, T. | *A Concert for Four Hemispheres in Psychotherapy* | 1990 | Reviewed in the Foundation Newsletter: 13 (2) p8; 16 (3) p11 |
| Robles, T. | *Terapia cortada a la medida: un seminario ericksoniano con Jeffrey K Zeig* | 1991 | *In Spanish*<br><br>Reviewed in the Foundation Newsletter: 13 (3) p13 |
| Rosen, S. | My Voice Will Go With You: The Teaching Tales of Milton H. Erickson | 1982 | Edited and with commentary boy Sidney Rosen. Foreword by Lynn Hoffman (translated to Japanese) |
| Rossi, E. | *The Psychobiology of Gene Expression: Neuroscience and Neurogenesis in Hypnosis and the Healing Arts* | 2002 | |
| Rossi, E. | *A Discourse with Our Genes: The Psychosocial and Cultural Genomics of Therapeutic Hypnosis and Psychotherapy* | 2005 | |
| Rossi, E. (Ed.) | *Innovative Hypnotherapy* | 1980 | |
| Rossi, E. (Ed.) | *The Collected Papers of Milton H. Erickson on Hypnosis: Hypnotic alteration of sensory, perceptual and psychophysiological processes, Vol.2* | 1980 | |
| Rossi, E. (Ed.) | *The Collected Papers of Milton H. Erickson on Hypnosis: Hypnotic investigation of psychodynamic processes, Vol.3* | 1980 | |
| Rossi, E. (Ed.) | *The Collected Papers of Milton H. Erickson on Hypnosis: Innovative* | 1980 | |

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| | *hypnotherapy, Vol.4* | | |
| Rossi, E. (Ed.) | *The Collected Papers of Milton H. Erickson on Hypnosis: The nature of hypnosis and suggestion, Vol.1* | 1980 | This four-volume work includes all of Erickson's published papers on hypnosis and therapy, some previously unpublished material, and a few papers by Erickson's collaborators (Rossi, Elizabeth Erickson, Jeffrey Zeig and others). |
| Rossi, E., & Ryan, M. | *Creative Choice in Hypnosis: The seminars, workshops and lectures of Milton H. Erickson, Vol. 4* | 1991 | A collection of some of Erickson's often-used teaching stories, some case examples, some personal and family anecdotes, with commentary and organization by Rosen |
| Rossi, E., & Ryan, M. (Eds.) | *Life Reframing in Hypnosis: The seminars, workshops and lectures of Milton H. Erickson, Vol. 2* | 1985 | This is a continuation of the volume above. A tape of Erickson doing hypnotic therapy with a photographer is included. |
| Rossi, E., & Ryan, M. (Eds.) | *Mind-body Communication in Hypnosis: The seminars, workshops and lectures of Milton H. Erickson, Vol. 3* | 1986 | The third volume of this edited series is mainly focused on Erickson's work with somatic problems and issues. |
| Rossi, E., Ryan, M., & Sharp, F. (Eds.) | *Healing in Hypnosis: The seminars, workshops and lectures of Milton H. Erickson, Vol.1* | 1983 | This is the first in a four-volume series of transcripts of Erickson's lectures and demonstrations from the 1 950s and '6 Os. |
| Rossi, K. & Rossi, E. | *Creating New Consciousness in Everyday Life: The Psycho-Social Genomics of Self Creation* | 2012 | |
| Short, D. | *Transformational Relationships: Deciphering the Social Matrix in Psychotherapy* | 2010 | |

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| Short, D. & Casula, C. | *Speranza e resilienza: cinque strategie psicoterapeutiche di Milton H. Erickson* | 2004 | Written in Italian. |
| Short, D. & Erickson-Klein, R. (Editor: Neukrug) | *The SAGE Encyclopedia of Theory in Counseling and Psychotherapy: Ericksonian Therapy* | 2015 | Provides a definition and description of Ericksonian Therapy. |
| Short, D. & Weinspach, C. | *Hoffnung und Resilienz: therapeutische Strategien von Milton H. Erickson* | 2007 | Written in German |
| Short, D., Erickson, B.A., & Erickson-Klein, R. | *Hope & Resiliency: Understanding the Psychotherapeutic Strategies of Milton H. Erickson* | 2005 | A book that compiles and analyzes a broad spectrum of Erickson's techniques and casework using ideas taught by Erickson. |
| Simpkins, C., & Simpkins, A | *Effective Self Hypnosis: Pathways to the Unconscious* | 2000 | |
| Simpkins, C., & Simpkins, A | *Timeless Teachings from the Therapy Masters* | 2001 | |
| Simpkins, C., & Simpkins, A | *Neuro-Hypnosis: Using Self-Hypnosis to Activate the Brain for Change* | 2010 | |
| Wallas, L. | *Stories for the Inner Ear* | 1985 | |
| Walters, C., & Havens, R.A. | *Hypnotherapy for Health, Harmony and Peak Performance: Expanding the goals of psychotherapy* | 1993 | |
| Waltzlawick, P. | *The Language of Change: Elements of Therapeutic Communication* | 1978 | This book was dedicated to Milton H Erickson |
| Waltzlawick, P., Weakland, J., & Fisch, R. | *Change : Principles of Problem Formulation and Problem Resolution* | 1974 | Milton H Erickson wrote the forward to this book. |
| Watkins, J. | *Hypnotherapeutic Techniques* | 1987 | |
| Wolinski, S. | *Trances People Live* | 1991 | This book was dedicated to Milton H. Erickson. |

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| Yapko, M. | *Trancework, 4th ed.* | 1990 | Reviewed in the Foundation Newsletter: 5 (3); 10 (3) |
| Yapko, M. | *Hypnosis and the Treatment of Depression: Strategies for change* | 1992 | Reviewed in the Foundation Newsletter: 13 (2) p8 |
| Yapko, M. | *Essentials of Hypnosis* | 1995 | Reviewed in the Foundation Newsletter: 15 (3) p10 |
| Yapko, M. | *Breaking the Patterns of Depression* | 1997 | Reviewed in the Foundation Newsletter: 17 (3) p15 |
| Yapko, M. | *Treating Depression with Hypnosis: Integrating Cognitive-Behavioral and Strategic Approaches* | 2001 | |
| Yapko, M. | *Mindfulness and Hypnosis: The Power of Suggestion to Transform Experience* | 2011 | |
| Yapko, M. | *Hypnosis and Treating Depression: Applications in Clinical Practice* | 2013 | |
| Yapko, M. | *Keys to Unlocking Depression: An Internationally Known Depression Expert Tells You What You Need to Know to Overcome Depression* | 2016 | |
| Yapko, M. | *The Discriminating Therapist: Asking "How" Questions, Making Distinctions, and Finding Direction in Therapy* | 2016 | |
| Yapko, M. (Ed) | *Hypnotic and Strategic Interventions: Principle and practice* | 1986<br>1987 | |
| Yapko, M. (Ed.) | *Brief Therapy Approaches to Treating Anxiety and Depression* | 1989 | |
| Zeig, J. | *A Teaching Seminar with Milton H. Erickson* | 1980 | Transcript of a five-day teaching seminar recorded August 1979. Introductory chapters by Zeig on Erickson's use of anecdotes. |

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| Zeig, J. | Experiencing Erickson: An Introduction to the Man and His Work | 1985 | This book contains an overview and introduction to Erickson as a person and as a therapist, as well as transcripts of Erickson's supervision and teaching with Zeig.<br><br>Reviewed in the Foundation Newsletter: 6 (4) |
| Zeig, J. | *Confluence: The Selected Papers of Jeffrey K. Zeig* | 2006 | |
| Zeig, J. | *The Induction of Hypnosis: An Ericksonian Elicitation Approach* | 2014 | |
| Zeig, J. (Ed.) | *Ericksonian Approaches to Hypnosis and Psychotherapy* | 1982 | Edited proceedings of the First International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, which was held in Phoenix, Arizona in 1980. |
| Zeig, J. (Ed.) | *Ericksonian Psychotherapy: Clinical Applications, Vol.2* | 1985 | These volumes are meant to show the development and furthering of Erickson's work in new directions or to show new applications for Erickson's techniques and approaches |
| Zeig, J. (Ed.) | *Ericksonian Psychotherapy: Structures, Vol.1* | 1985 | These are the edited proceedings of the Second International Erickson Congress, held in Phoenix in 1983. Keynote and plenary addresses are by Watzlawick, Rossi, Haley and Madanes. Includes a special section by Erickson's family on his child-rearing techniques. |
| Zeig, J. (Ed.) | *The Evolution of Psychotherapy* | 1987 | This book contains the edited proceedings of 27 presentations given at the first |

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| | | | Evolution of Psychotherapy Conference, a landmark meeting held in Phoenix, Arizona in *1985.* (translated into German & Japanese)<br><br>Reviewed in the Foundation Newsletter: 7 (3) |
| Zeig, J. (Ed.) | *The Evolution of Psychotherapy: The Second Conference* | 1992 | This book contains the edited proceedings of the second Evolution Conference, which was held in Anaheim, California. It includes the presentations and question/answer sessions of 23 distinguished faculty members.<br><br>Reviewed in the Foundation Newsletter: 13 (2) 7 |
| Zeig, J. (Ed.) | *Ericksonian Methods: The Essence of the story* | 1994 | Edited proceedings of the Fifth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy.<br><br>Reviewed in the Foundation Newsletter: 15 (2) p10 |
| Zeig, J. (Ed.) | *The Evolution of Psychotherapy:*<br><br>*The Third Conference* | 1996 | This book contains the edited proceedings of the second Evolution Conference, which was held in Las Vegas, 1995<br><br>Reviewed in the Foundation Newsletter: 17 (2) p13 |
| Zeig, J., & Geary, B. (Eds) | *The Letters of Milton H. Erickson* | 2000 | These letters are written by Erickson to various colleagues. The letters contain insights into his thinking and explanations of concepts.<br><br>Reviewed in the Foundation |

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| | | | Newsletter: 20 (3) p19 |
| Zeig, J., & Geary, B. (Eds) | *The Handbook of Ericksonian Hypnosis and Psychotherapy* | 2001 | This book contains the edited proceedings of the Seventh International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, held in Phoenix, 1999. |
| Zeig, J., & Gilligan, S. (Eds.) | *Brief Therapy: Myths, Methods and Metaphors* | 1990 | This book contains the edited proceedings of the Fourth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, held in San Francisco, California, in 1988.<br><br>Reviewed in the Foundation Newsletter: 15 (2) p18 |
| Zeig, J., & Lankton, S. (Eds.) | *Developing Ericksonian Therapy: State of the Art* | 1988 | This book contains the edited proceedings of the Third International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, held in Phoenix, Arizona, in 1986 |
| Zeig, J., & Munion, M. | *Milton H. Erickson* | 1999 | This primer provides an induction to the work of Milton H. Erickson.<br><br>Reviewed in the Foundation Newsletter: 20 (1) p20 |