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MONTERREY - CONFERENCE 12/02 MEDICAL HYPNOSIS

Materials gathered and taken from taped lectures of Milton H. EricksonM.D.

The clinical situation is not a situation for scientific truth. The clinical situation is for the accomplishment of the patient's goals and not to establish scientific truths. So in our workshop here this morning, I am not trying to establish scientific truths. I'm trying to encourage you to think about how to use your patients' own experiences to bring about accomplishments for your patients: for their medical and psychological goals.

What you can count on your patients knowing: The teacher may teach the class but it's the students that do all the learning.

Everyone has heard of soldiers that were seriously wounded in combat but didn't realize it until after they were safely away from the battle.
You can expect any patient that walks into your office to do extremely involved thinking. In fact, you should expect any person who walks into your office to do many complicated things. Many more than you expected and their capable of doing so many things that you'll never dream. So I think the right attitude is for the doctor or the therapist to be prepared to be amazed and impressed by what our patients will do and can do. I think we need to start with that kind of attitude and be prepared to be impressed.

Let's consider **dreaming** for the moment just to begin understanding what humans are capable of doing hypnotically.

We all have had a rather comprehensive set of learning experiences in dreaming throughout our lives. And while we're dreaming, we use concepts and ideas, memories, understandings and memories of emotions. All while we're lying perfectly still in bed, we can have any number of intense emotional experiences. We can do any number of complicated physical activities and yet lie perfectly still in bed with all our muscles atonic. In order for us to dream we must use our memories of all kinds and learnings and ideas. And you can expect every one of your hypnotic patients to have had a lifetime of experiences in dreaming. And so you need to realize that your patient has had a tremendous amount of experience in **dissociative physical activity, dissociative mental and emotional activity.**

In other words, dissociated from the quiet, sleeping body in the bedroom. In our dreams **we learn how to dissociate and separate psychological behavior from physical behavior.**

So therefore, when you ask your hypnotic subject to do things you ought to recognize that **they already**

know how to do all the things your asking and you ought to be completely confident in their abilities to carry out your ideas.

They *don't know that they know* how to do all those things, but **you need to be completely confident** in their abilities.

If you doubt your patient's ability to carry something out that you've suggested, they will hear it in your voice. You shouldn't have any doubt or fear or anxiety in your voice when you ask him to develop an anethesia or remember some long lost memory.

You recognize that your subject has accumulated a lifetime of body learnings you can have them call upon and what you really want them to do is to reestablish previous patterns of behavior. So you offer them ideas, **knowing that your ideas are not particularly important**, but as they initiate their own past learnings, as they evoke past memories, they will carry out certain processes that lead to a repetition of previous behavior. **Give example of the Raynauds's patient**:

Now it's important here to emphasize the role of **expectations and failure in the use of hypnosis.** Too many operators of hypnosis try to be perfectionists. They try to accomplish too much and fail as a result. Just ask any high school student or a college student about their orientation to perfection. They'll probably tell you that they don't expect to perform perfectly on every test or in every subject, just as the athlete doesn't expect to have a perfect performance every time. So, in life, the average patient doesn't expect to be perfect. So your patient's general orientation, gained from a lifetime of living, is to expect a certain amount of failure. You as the operator ought to go along with that expectation and be the one **who puts out the area of failure**. You should be careful to insure a certain percentage of failure.

Erickson's case of the terminal breast cancer patient:

So for the breast cancer patient who's death is certain, their first failure started in the breast. There's no way of getting around that fact. So in a case of terminal breast cancer, you express regret that you weren't able to take away the pain in that area, or where ever the site of the cancer began even though it might be a minor pain or minor distress. You express your regret at your failure to remove entirely the distress or pain from that one area. And your patient who doesn't expect perfection can agree with you that it would be nice to have the same numbness at that site of the cancer as in the rest of their body. You're making use of the double bind. As long as your patient has distress at the breast area or where ever the cancer started, they have to have numbness in the rest of their body and they can continue to wish you could have been as successful there as in the rest of the body. Thus, you have the patient's general experience substantiating the numbness of their bodies. You're using your patient's thinking and understandings and expectations who grew up in such and such a culture and who has certain learnings just from being alive and living, let's say, in Mexico City.

When you leave that minor pain or distress it proves that you're not God, it leaves your patient with another goal to strive for with a feeling that they're going to fail as far as that minor pain or distress is concerned but would succeed as far as the rest of their pain is concerned.

They won't hold your failure against you. You see that by you **putting out the area of failure** and taking responsibility for the failure and letting them keep that "minor failure" you have insured the success of the rest.

If your subject says: but I **can't remember** that long lost memory. Think to yourself, I'm not asking you to do anything different than you did last night or last week in your dreams. Do the same thing you did last night. That's all I'm asking of you. That should be the idea in your mind and so it comes out as confidence in your own voice**. It's your expectation that is communicated in your voice.** So the subject **rejects** things when there is a **note of doubt or disbelief in your voice.** So you tell your subject, I'd like you to take all the time you think is necessary to go into a trance, but you will probably think much more time is necessary than it really is necessary. So you can develop a trance in 30 seconds or 60 seconds but if you really think that you need to take 3 minuets or 5 minuets, take all the time you think you need. You need to think in terms of them developing it in 30 seconds with a willingness to let them take 2 minuets or even 5. **It's the way you present the ideas that determines the speed in which the subject responds.**

Is it the right hand or the left hand that's got the anethesia? It's there. Is it in the left hand or the right hand or both? Why not use your legs. That individual approach you make to your patients and the utter certainty that you express to the patient.

When the patient says, "but I'm too afraid or panicky to quite down", you know that they have had a life time of experience of "quieting down" and you can expect them to quiet down by telling them, with complete confidence: "You can now quiet down". You approach it with a confidence based upon your knowledge of their learnings achieved over their lifetime.

In the same way, you can expect your patients to be too busy attending to other things than to notice a little dental pain or surgical pain, etc. because they have had a life time of experience of not noticing. So we should expect that our patients can endure a certain amount of pain or distress. **But when too much is just too much,** we should help them get rid of the "too much" part of their pain. ***If we can help get rid of the "too much"***, then they can learn to endure a certain number of ills with out particularly noticing them.

For example, you can teach your arthritis patient how to deal with certain of his pain or discomfort problems so that he can see how he can put up with that amount of pain and then that allows them to put that pain in the category of "what I can put up with pain" and then they don't have to notice it.

Before we continue, let's talk a little about trance induction and what constitutes trance induction:

What constitutes the induction of a hypnotic trance:

All of you have learned certain techniques involving certain verbalizations. And you think that's the way of inducing a trance. Yet a trance can develop without any known reason at all. What are the requisites for the induction of a trance?

Think of your suggestions that you give to the patient. They are not the thing that the patient should do. "Now I want you to be very relaxed and rest comfortably". What are these ideas? They are merely a stimulus to elicit

patterns of behavior within the patient that are in accord with their own body learnings and their own psychological experiences. Your task is to say something that will get your patient's attention and allow your patient to make their own personal responses. **The importance of what you say lies in it's being a stimulus for the elicitation of responses unique to the patient**. It's a mistake for the operator to think he must outline in detail the personal orientation that the patient should have.

For example, if you were to tell someone to go home and rest and fall asleep by laying down flat on their backs with their arms to the sides of the body with the back of the head on the pillow and really enjoy that position. But what if you said that to someone who was in the habit of sleeping with their knees bent lying on their right side or a belly sleeper, your suggestion, regarding relaxing and enjoying that position and falling asleep, would be rather ridicules.

All you really need to say is to go to bed and assume a most restful and comfortable position. In other words, you want to give your suggestions in such a way that allows your patient to restructure those suggestions so that they fit the patient's own behavior. You don't know what your patient's body thinks is right. Because the body is governed by learnings that occur first in the brain and then become apart of body responses.

So I think that the hypnotic induction should be about getting the patient interested in a **goal achievement** that is meaningful to the patient. And the trance that develops, as a result, is the trance that's effective for them and not necessarily something that can be measured by a hypnotic scale. You don't need a somnambulistic trance for the dental patient who needs only an anethesia for the lower right jaw and so you don't need to include their feet or legs or even an arm in the trance. And for the dental patient you center your suggestions around ideas and understands and their memories of dental work. That's the part of your patient that you want involved in the situation.

So! With hypnosis, what do you need to suggest to a patient? You recognize that hypnosis takes place within the patient. The patient does all the work and uses the instructions of the operator merely as a point of departure in developing a trance state…a special **state of awareness**…a **peculiar state of awareness**.

With that understanding you can better direct the subject in becoming especially aware of, let's say, capillary bleeding. We want to use hypnosis, **not as a general phenomenon**, but a phenomenon that governs **specific types of physiological behavior, specific types of psychological behavior.** Understanding that means you can direct the subject's awareness towards special processes or behavior. (Raynaud's case)

Next, it is important to understand the totally different kind of awareness the hypnotized subject has of **reality in general.**

All of you are aware of being in this room and the others present. You can see the lights in the ceiling. And no matter how long we are here, you are going to have a continuous awareness of your reality surroundings. **That is a fundamental, biological part of survival…your existence**…your constant orientation to your surrounding reality. But in the hypnotic subject you get a totally different kind of utilization of surrounding reality.

The hypnotic subject comes into your office, or this room and looks around and makes a comprehensive, natural survey of the existing, surrounding reality. That's something that we do automatically. We've learned to do it since the beginning of our existence. Once that survey of the surrounding reality has been made, the hypnotic subject is

then in a position to keep that existing reality in mind. He or she doesn't have to check it again…to see if the lights are on, if you're sitting in your chair, and so on.
The subject doesn't feel a need to recheck surroundings until some major change effecting the subject develops. The subject **withdraws** from the surrounding reality **with a map of that reality** and doesn't update the map until or unless some change that might effect them develops.
You drive a car in the same way. You sit down behind the wheel, start driving and begin a conversation with your passenger, in which you discuss some new idea or some news event, or sports event or family event. And as you engage in this dialogue, you automatically obey the rules of the road. You stop at stop signs, you watch out at intersections..obey all the rules of driving and all the time you're still discussing some philosophical subject with your passenger. Not until there's a wreck in the road ahead of you or some one veers into your lane, do you suddenly shift from your orientation to your passenger to your driving orientation. It's an automatic orientation.

Now as the hypnotic subject goes into a trance, that subject **isn't going to use your words or ideas. R**ather they're going to use their own past learnings, past experiences and understandings. Your words and suggestions should be thought of as only a **way of arousing** within the subject the type of behavior that fits the situation the subject is currently needing help with.

Pain and Hypnosis:
Pain is a very subjective experience but not solely a conscious experience. It has certain temporal, emotional, psychological and somatic significances. It is a complex, a ***construct,*** *composed of past remembered pain, of present pain experience and of anticipated pain in the future. So the immediate stimuli are only one third of the entire experience. It's the anticipation of pain…the fear of it…that* ***intensifies*** *it. Thus, if you think of pain as a construct of past, present and future, then you can see that pain, as a construct, is highly vulnerable to hypnosis as a successful treatment approach. If, on the other hand, pain were only a phenomenon of the present, hypnosis would have little value in altering it.*

Pain also varies in its nature and intensity and because it's also apart of our life experience, we tend to give it various meanings…meanings that are unique to each individual. That's why it's so very important to listen to how the patient describes his pain: Dull, heavy, dragging, sharp, cutting, twisting, burning, nagging, stabbing, biting, cold hard, grinding, throbbing, gnawing, It's also important to understand it's time frame? Reoccurrence? Acute or chronic? If it's been experienced in one part of the body for a long time, it's very possible for pain become a "habit". Pain also has emotional attributes. It can be threatening or dangerous because it means the cancer has spread. It can be experienced as incapacitating, irritating, or demanding.
Each of these "qualities" of pain provides you and your hypnotic subject a great number of ways to alter the experience of pain and thus diminish or even abolish pain.
Erickson emphasized that the therapist should understand that pain, in and of itself, is a protective somatic mechanism. That's its function-purpose. It compels us to protect the painful area. It motivates us to seek help. It tells us in what part of our body we need help. All of this lends itself to hypnotic modification.

Erickson recommended that you first start small in relation to the entire pain complex. You first get some small success in relation in some "minor" aspect of the whole complex and thereby you lay down a foundation which allows you to eventually go after the most severe and distressing qualities of the pain. More important, as they make small successes, your patient is building up confidence in their own abilities to alter their body experience.
Erickson developed eleven (11) different hypnotic procedures for handling pain:

1. **Direct Hpynotic suggestion for pain abolition**: This is the approach most commonly used by hypnotherapist is the more likely to fail thus causing the patient to become unnecessarily discouraged and preventing further use of hypnosis. If is does work, it's effects are often too limited and short in duration.

2.Erickson taught that the more permissive and **indirect** the suggestion for complete **abolition of pain**, the more receptive some patients are and the more responsive they can be.

Thus, Erickson might say: ***Your pain has alerted you to a problem. You have sought the help you need and the problem has been identified and is now being treated. You can now turn off the alarm.***

3. **Utilization of Amnesia**: The forgetting of past pain and the forgetting of pain due to becoming more absorbed in something else. Amnesia can be applied partially, selectively or completely to selected subjective qualities and attributes of sensation in the pain complex.
4. **Hypnotic analgesia**: partial, complete or selective, i.e. a certain feeling of numbness without tactile loss or pressure. This approach allows for the introduction of sensory modifications such as altering a "dragging, dull pain" into a warmth and a numbness.
5. **Hypnotic anesthesia**: difficult to accomplish directly but can be built up indirectly and carried out post=hypnotically.
6. **Hypnotic replacement or substitutions of sensations**.

For example: **Jose's cancer pain:**

Let's take a hypothetical case: The high school graduate, let's call him Jose, who's suffering from intractable cancer pain that morphine can't touch, that nothing could touch and he's so frightened and in so much pain, and how do you approach him?

All that pain and all that fear gives you a very small window into that situation. In order to bring about relief for Jose, you need to somehow use Jose's own learnings and your thinking. And your thinking would not be necessarily compatible with a high school graduate who might only have a couple of months to life and will be leaving behind his wife and children and his mother and father.

And your job here is to bring about a hypnotic state in which you could evoke in Jose his own past learnings. He knows that no drugs can touch his pain. So you don't want to get involved with some futile effort. So you start with

something that you know he understands in his own reality orientations and can do immediately. You ask him to stay wide-awake from the neck up and let his body go to sleep. In Jose's past understandings, from as far back as early childhood, Jose knew what it felt like to have his leg fall sleep or his arm fall asleep. We all have that half awake/ half asleep body experience just before we get out of bed in the morning. And so you proceed being fully confident that Jose has some kind of experience of his body being asleep. All you're asking of him is to remain wide awake from the neck up.

So you're telling him to **let his body**…not make his body… let his body go to sleep while he **makes himself** stay awake from the neck up only. And you really don't know exactly what that means to Jose. All you want to do here is to start a train of thinking and understanding that would allow Jose to call upon his past body learnings. You're not asking him to go into a trance and cooperate with you. Let's say he didn't even know what a trance was. The window is too small for that. He knows what being wide-awake is and what a body being asleep is.
Next you tell Jose: After your body is asleep, develop a tingle, let's say, on the side of your foot or the back of your calf. You know he's experienced that many times in his life. It's well within his physiological, psychological, neurological experiences…in other words, his total body learnings.

Now Jose wants relief and Jose knows that his other doctors sent you in because they couldn't help anymore with relieve his pain. And Jose really wants you to help him. And so you become very urgent and insistent about Jose developing that tingle or that itch on the side of his foot and you hope that Jose can **not** develop that tingle or whatever you tell him to have because you want to use his failure to get an even greater response in him. And so instead of a tingle or an itch, he gives you a numbness on the bottom of his foot-a response that's opposite of your suggestion. That numbness is Jose 's response taken from his own body learnings. It's not your suggestion, it's his experience.

And so you think to yourself "great" and accept his response but you say to Jose : **I'm so sorry** I wasn't able to get you to develop that tingle or itch on the side of your foot. In other words, you show polite regret that he didn't bring about the itch or tingle you suggested. Because your goal is to elicit an even wider response in Jose . And so you use that polite regret to get Jose as a personality to give you an even wider response because he now feels obligated. And Jose, coming from a very polite culture, feels obligated now to give you an even better response. In other words, since he fails you in one regard he feels even more obligated to put forth a greater and greater effort to cooperate with you. Now you can suggest that the numbness extend to his own foot and then up to his ankle and then his leg. And what is numbness? Jose knows that numbness means a lack of awareness of his foot, ankle, leg and so on. And as Jose responds more and more he's withdrawing from the his contact with external reality which includes his bed sheets and the bed and the room. What happens to Jose's awareness of the walls and the floor and the bed? The **unimportance** of external reality. And the importance of Jose 's own internal reality and not in terms of cancer pain but in terms of body learning of numbness and increasing freedom from pain. And you want Jose to

take an increasing interest in developing more and more numbness as you encourage him to spread the numbness throughout any area of his body he thinks is necessary for his comfort.

7.**Hypnotic displacement of pain**: A suggested displacement of the pain from one area of the body to another. In the hypnotic trance the patient is told that the intractable pain from the cancer in his abdomen, could be felt in his left hand and therefore be entirely endurable, since in that location it would not have its threatening significances. If the patient can accept that idea, he might be free of abdominal pain and spend all his time protecting his left hand from being bumped or touched. Thus, as long as he had his hand protected, he could carry on his relationships with his family until he died. This procedure also allows for the displacement of various of the attributes of pain I referred to earlier.

8. **Hypnotic dissociation** can be used to alter time and body disorientation. By reorienting the patient to an earlier time in their illness, when the pain was a minor consideration, post hypnotic continuation of that "earlier experience" can be continued into the future. Thus the intractable nature of the present pain has been rendered into a minor consideration, as it was in the earlier stages of the illness. Erickson also suggested that with some patients he was able to reorient patients to a time predating the illness, and by post hypnotic suggestion, effect a restoration of the normal sensations existing before the illness.

Erickson often used this body dissociation and brought about the experience that the patient would leave their sick and suffering bodies in the hospital bed while they took their heads out to the solarium to watch their favorite T.V. shows, etc.

9. **Hyponotic reinterpretation of pain experience.** For example, while in a trance the patient's description of his pain as a dragging, dull, heavy pain can be reinterpreted as a feeling of weakness, or profound inertia, followed by relaxation with warmth and comfort. Erickson has successfully reinterpreted throbbing, nagging, grinding pain as the unpleasant but not distressing experience of the rolling sensations of a boat during a storm. This requires a very accurate understanding of the patient's pain.

10.Hypnotic Time Distortion: Erickson's patient with intractable pain occurring every 20 to 30 minuets, night and day lasting from 5 to 10 minuets. Between attacks the patient would dread the next episode. Erickson taught him time distortion so that he could experience the 5 to 10 minuets in just ten to twenty seconds, and then to have an amnesia for past pain. He was given a post hypnotic suggestion to the effect that each pain episode would come as a complete surprise to him. (use pleasure instead of pain with volunteer subject)

Thus, the man in talking with his family, would suddenly scream in mid-sentence, go into a trance and ten seconds later come out of the trance state, look confused for a moment, and then continue his interrupted sentence.

11. **Diminution of pain via suggestion.** The approach begins with offering the idea that pain will diminish

imperceptively hour after hour until it is either completely gone or only some particular attribute of the pain will remain. This is a suggestion that can't be refused since the patient won't be aware of it until it's gone or changed. One percent can't be noticed. 5% a day might not be noticed for the first few days. How much would the pain have to diminish before you'd really noticed? 10%? Would you notice 25%? Probably 30-40% for sure. With this approach as well as others, the more indirect and permissive the suggestions are given, the better the patient can accept the ideas and thus, the better the results.

Damaged Body Image:

Whenever a patient comes into your office with a damaged body image which my be rather pronounced, they might tell you that their head feels like it's getting large, too large and they've been measuring their hat size or they may be concerned about he left arm getting longer or about their feet becoming to large for their shoes or they have a feeling that their leg is getting smaller even when it looks alright.

In psychology we would call this a distorted or disturbed body image. And you need to let the patient know that most likely he has misunderstood certain ordinary body sensations. Take for example the 14 or 15 y/o girl who complains of severe chest pain and you look at her and she has no noticeable breast development. What she's really describing may be a change in sensation in her chest wall and you explain to her in her own language. Erickson liked to use the analogy that veal comes from a young beef cow. And veal has a certain consistency and beef steak comes from an old beef and it has a consistency quite different from veal. "You're changing from veal to beef steak and there ought to be a different feeling, just as there ought to be a different taste." And they might walk out of your office feeling proud of that sensation. Or the girl that is just premenstrual and has misinterpreted sensations in her pelvic area as something wrong with her legs. She complains that she can't run like she used to. Then you find out that the mother hasn't talked to her daughter about menstruation and the girl doesn't have any language to talk about her pelvic region.

How about the 13 or 14 y/o boy whose face skin is thickening as his body prepares to grow a beard. But he interprets that sensation as something terribly wrong with his face and he's spending a lot of time in front of the mirror looking for something to attach those sensations to.

Emotional Behavior

It's the emotional attitudes and understandings that are really important. I think it's very important that you keep in mind the reality orientation and the difference in reality orientation in the hypnotized patient in mind so that you make your suggestions to the patient as an emotional being and not just an intellectual being. You can then better build up in them a rather complete response.

How would you feel if your brother were sitting right there, in that chair next to you? Your brother!!! Your

emphasis is about "Your Brother". He has to call upon all of his emotional memories regarding his brother. You're just incidentally using the chair. You see in that way the suggestion appeals to them as feeling and experiencing creatures.

We can take only so much but there's always **one last straw**. In hypnosis you ought to make use of that learning, that expectation, and get rid of everything except leave **that last straw** as a distraction because it is a minor thing and the patient can consider it unimportant. So, when you think of your suggestions that you give to the patient: They are not the thing that the patient should do. They are merely a stimulus to elicit patterns of behavior within the patient that are in accord with their own body learnings own psychological experiences.
Your task is to say something that will get your patient's attention and allow your patient to make their own personal responses. The importance of what you say lies in it's being a stimulus for the elicitation of responses peculiar to the patient.
It is a mistake for the operator to think he must outline in detail the personal orientation that the patient should have.

In your observations of your patient you need to consider the possibility that your suggestions for hand levitation or anethesia or whatever are being carried out, **not at the muscle movement level**, but are being **hallucinated** and that **hallucinated level** is just as effective in bringing about adequate responses as actual muscle movements. So you tell that patient: I want you to feel me opening your mouth and sticking a probe in your mouth and pushing very hard against your teeth or gums or tongue or whatever and notice the absolute numbness of your mouth. And the whole time you're standing there with your hands at your sides and the patient feels you doing all those things and then the patient can agree with you that they have an absolute numbness and then you tell the patient: now that you've got that numbness, we can proceed with the dental work or whatever. And then you start the dental work and the patient having gone through the hallucinatory experience of having it tested, can permit you do the actual work.
The hallucinatory anethesia and the hallucinatory testing of it becomes the actual means by which the anethesia is transferred to the mouth.

Glove anethesia can be transferred like this, from the hand to the mouth. But you ought to recognize that a psychological transfer can take place from the hallucinatory experience to an experiential thing for the subject because the hypnotized subject has a different appraisal of reality than the waking subject does. They withdraw from the external reality, they keep away from it. They orientate to the reality of their body and having once oriented to the reality of their body, in what further way do they need to orient to their body? Some of them need that rehearsal process of a hallucinated performance.
Your willingness to understand the kind of understandings that the patient has is very important.

Now how quickly should the hypnotic subject be able to produce an anethesia?(Person's brick)

I remember the anesthesiologist that told Erickson he'd become very discouraged by his early use of hypnosis and the development of hypnotic anethesia because it took so much time. Erickson suggested that he sit himself down one day and think over how long it should take. And later he reported back to Erickson that he sat down and looked himself over carefully and said to himself: Look here buddy. Hypnotic anethesia is a psychological phenomena. How long does it take for a psychological phenomena to occur? **In just a moment's time**, he concluded. And so he decided that he should expect that patient to develop the anethesia quickly and that he shouldn't have in his voice the words that said in an hour or two you should be able to develop an anethesia. Now he has that attitude in his voice, that sound in his voice that his patients should develop an anethesia quickly.

It's your expectation that is communicated in your voice. So the subject rejects things when there is a note of doubt or disbelief in your voice. So you tell your subject, I'd like you to take all the time you think is necessary, but you will probably think much more time is necessary than it really is necessary. So you can develop a trance in 30 seconds or 60 seconds but if you really think that you need to take 3 minuets or 5 minuets. You need to think in terms of them developing it in 30 seconds with a willingness to let them take 2 minuets or even 5. It's the way you present the ideas that determines the speed in which the subject responds.

Is it the right hand or the left hand. It's there. Is it in the left hand or the right hand or both? Why not use your legs. That individual approach you make to your patients and the utter certainty that you express to the patient.

Dentistry: Here's the syringe that's going to take away all the pain. One syringe with distilled water and one with nova cane. How often will you need to use the nova cane? What if you loaded a syringe with only 10% nova cane?

And remember, it's the syringe that fails and not you. **Your patient can have neurotic pain in spite of the best nova cane.** And if the syringe fails, then you've got the opportunity to remark upon how that patient is one of those exceptional patients who has to rely upon psychological anethesia or analgesia rather than chemoanathesia or chemoanalgesia-chemical means.

You should be **unafraid** of identifying things. Sometimes your patient will make a excellent response to chemoanalgesia and you should be free to comment on that: you can feel the **movement** of your tooth within your jaw without feeling pain. Now there's a nice accomplishment.

Allergies

First: One should take seriously this idiosyncratic reactions to drugs. You should always ask very seriously if the patient has any allergic reactions to drugs and carefully watch them when they tell you about those allergies and always take them seriously because they have been told by many people, including other doctors, that they are "crazy" and if you convey even the hint of disbelief regarding their reactions, you might become the **sorry owner** of their bad reaction to something that you might have prescribed to them. I even heard of patient who claimed

they were allergic to aspirin dieing after their doctor prescribed it because he didn't believe them. That doctor had a horrible time overcoming that patient's death.
Erickson's approach to allergies was that they are very often the physiological result of noxious stimuli. As doctors you should not forget that the body can react to various chemicals by edema, by asthmatic responses, by swellings, itching by dermatitis.
Erickson emphasized through out his career that patients can have a 5% asthma reaction and a 95% freight reaction response to that asthma. Because breathing is so critical and important to human beings. A 12 y/o child gets a little bit of asthma, and that child gets frightened. And everyone gets frightened and before you know it you have a wheezing, struggling child who's headed off to the hospital E.R. What does the child do?
The more frightened the child gets, the more tense he gets. The more tense he gets the more the veoli close up causing progressive and rather rapid difficulty in breathing. And the muscles in his neck are tensed. His thorax muscles tense. You listen to his voice and you realize how tense his diaphragm has become. All his fright is cutting down his ability to breath.
Your task is to let that patient know that in addition to his asthma he's got something else…fear. And you emphasize that until the child or the adult gets more and more frightened about the something else. Then you tell them that he's scared to death just as you would be if someone cut off your breath. In other words, you need to get the patient to realize that he is scared. And then you ask him: do you think being scared makes breathing any easier? You tell them you don't think it makes breathing easier to get scared because it makes your breathing muscles all tight. Your diaphragm, the muscles of your neck get all tight. And just as soon as someone who's gotten very scared starts loosening their muscles, they begin to breath easier. Letting your arms loose, your diaphragm loose. **Get them interested in loosening up their different muscle groups.** This approach also is appropriate with adults, even psychiatrists and other doctors can get just as frightened as that 12 y/o child.

It's the **role of fright** that you need to properly diagnosis. It should be considered with every asthmatic patient and every emphysema patient.
And also you need to be aware of how those patients will attach other problems that they have to their asthma or emphysema and you need to study the situation well enough to recognize that while there is some emphysema or asthma, there may also be a marital problem or a sexual problem.

In general, you should have your patient describe their reactions to drugs, even if it's distilled water. So you get an idea of just what their neurotic response is. And if you're not a therapist or a psychiatrist, you should avoid those patients and the trouble you're likely to run in to. Your patient might tell you that they have a terrible reaction to eating beefsteak but they can easily handle ground beef because that patient will tell you that when they ground up the beef they broke down the allergy. There's no sense of arguing or trying to convince them otherwise because a neurotic patient can do any amount of body injury…to themselves.

Obstetrics

The **obstetrical patient** really needs to have her ideas and understandings of that part of her body that she thinks is involved in the birth of her child. Some women want an anethesia of their feet when they give birth. And if she wants to think that way, that's her business and you meet her needs by wording your suggestions in a way that she can elaborate whatever you say to include her feet in the obstetrical situation.

You don't argue with her about her idea of the importance of involving her feet.

Should you suggest a perennial anethesia or analgesia or should they be suggestions that allow the woman to think in terms of her personal emotional and physical experience of childbirth. **To many hypnotic failure are the result of the operator's limitations. Their not recognizing the meaningfulness of the situation to the patient.**

In the **obstetrical case** that didn't go well. They may have needed a hallucinated experience to confirm the reality of their hypnotic learning and then transfer it to the **reality body** in the delivery room. The reality body of the patient in the doctor's office is one order of things. And the reality body in the delivery room is still another order of things. So while they may have learned obstetrical anethesia in the doctor's office for a body in the doctor's office (or wherever), they must also learn an obstetrical anethesia for the reality body in the delivery room. They need to go through that process. So you then tell the patient to hallucinated being in the delivery room. Your willingness to understand the kind of understandings that the patient has is very important.

Now I'd like to mention the importance in hypnotherapy of providing **adequate sensory intake** for medical patients who you are using hypnosis with hypnoanesthesia.

For example, the woman who says she wants a hypnoanesthesia from her shoulders down in order to have her baby. She says she wants a total anethesia. That woman needs a good amount of sensory intake from the neck up. And you need to remind her about those senses from the neck up. Remind her to visualize things, and feel things with her face like the pillow. Remind her she can hear things and smell things. Keep her well supplied with sensory input because she's going to have none from the neck down and that alone can be intolerable. And this meets a need she has had a psychological as well as a neurological level.

Body Cast

The patient in a body cast needs the feel of a lot of things, the taste of water because that body cast creates a lot of sensory deprivation.

The person who's gone through having had a broken back. They'll tell you about that tremendous loss to the lower part of their body…bowel control, bladder control. I remember the case that Erickson talked about in which this psychologist with a broken back was paralyzed from the waist down. The revolt, the resentment and the hostility. How do you help such a patient plan for future living? Erickson taught the man something about body sensations

so that he could move his own bowels and empty his own bladder with regularity. The patient who loses his teeth who says he just can't wear dentures. You approach it as a sensory deprivation problem in which you recognize that he feels so utterly deprived and resentful. You teach him something about the replacement of sensations though the dentures.

As human creatures, we are so dependent upon sensory intake and it's a horrible experience to be deprived of it.

Just as your dental patient should become fascinated with control of capillary circulation and by the thought of dental anethesia and by the thought of learning how chew his food with a different kind of bite so he won't have temporal mandibular pain, you recognize that it is the thing that interests your patient that should be the point of departure for the therapy. And you as the professional should be thinking in terms of the kind of thinking and the kind of understandings that your patient is likely to be going through when you're dealing with him.

You should not be afraid to tell your patients that they have a need for dental care, or psychiatric care, or medical care. I remember a former colleague of mine who was afraid to tell the patient's family and the patient about the his concerns about colon cancer because the patient and his family would be angry at him and so he didn't tell him and his patient died six months later and he couldn't accept the death and had to be threatened to prescribe morphine. I asked him if he attended the funeral or sent flowers or something. He told me "no", he hadn't done either.

I asked him what kind of a doctor was he anyway being so afraid to tell his patient that he was concerned about telling his patient about colon caner. I told him that at least he could have sent the man to me for a consultation and I would have told him what my suspicions were. At least I could have used some kind of double bind to get the man into a specialist for a definitive diagnosis.

The fear that physicians show towards their patients. Your willingness to look at a patient and recognize any problem that your patient has instead of being so bloody polite about it all. They come to your office hoping that you won't notice that they have a peculiar dental formation that they've been adapting to all their lives by turning their heads away and covering their mouth with their hand while talking out of the corner of their mouths. And you know right away they've got these four crooked and unsightly lower teeth that they and their parents neglected all of their lives. And you can recognize that lifetime of neglect and the fear in them that you might mention it, much less, recommend that they see a dentist. And because they come to you for something else, you express your willingness to help them with their marital problem or child problem but you also mention that you also know something that could make them so very happy in just a short amount of time and you know just the right orthodontist that would do an absolutely beautiful job in correcting the lower teeth and then she would be able to show anyone that beautiful smile of hers without any more fear of shame or fear. That will bring about a lot of personal happiness in addition to working on your marital problem.

These patients with **psychosomatic manifestations** who have a target organ, don't dispute what they say. Take their words and elaborate on their words in such a fashion that there's a "back-lash" of some kind. For example Erickson's patient referred by his cardiologist who's had a Demerol addiction helped along by his cardiologist… Erickson asked the man how much more cardiac problems did he want to have? Erickson fit his suggestions in with the man's neurosis and got the man to convince Erickson that he didn't want any more heart damage.

Psychosomatic:
Telling the patient the **function** of their psychosomatic symptoms, when that function is apparent to you almost immediately. You don't want to tell that to them and yet you must tell it to them. The way you approach it is by walking around the issue in a fashion that leads you closer and closer to the target. As soon as you get close enough they begin to realize that they hope you don't recognize it and understand the meaning, then they're do anything to help you correct that. Lets take the university student with colitis who resents having to do everything her parents tell her to do because she needed money from them to finish her education. Her reaction was severe colitis. As she got closer and closer to understanding, she hoped that I didn't understand.

At this point we shift to a physiology lecture and she was just taking her first university level physiology class and you can then begin to lay out what a miracle the human body is with all it's functioning taking place automatically and how one ought to develop respect for their body and treat it respectfully and do whatever helps your body to work in it's wonderful God given manner like brushing your teeth, cleaning the body in general and not abusing any part of the body whether it be the feet by wearing the wrong kind of shoes or the stomach, by putting rotten or poison in it. And all along you are building up in your patient a good feeling towards their colon and treat it as well as they treat their feet and their hair and their skin and you get your patient agreeing with everything that you say and they are building up a good feeling towards their bodies. Then it's an easy next step then to talk about the colon and how it works and how often it should empty itself and you can ask your patient if once or twice a day would be enough or would twenty times a day be alright? Then you get back to the idea that maybe the girl's parents shouldn't have treated her in the manner they did but then how do you stop them. You wouldn't slap a cactus to get it out of your way because it would do damage to your nice hand. Nor should you use your colon to slap your parents around, to tell them that they're **full of crap. You** shouldn't use your colon to bring about the necessary changes in your family's treatment of you.

That's certainly not what a colon was designed to do and you ought to have respect for what your colon does so well. I tell my patients about what a wonderful experience it was to see inside my colon the last time I got a colonostomy. How great it was to be looking into my live colon which had been all cleaned out for the examination. How I could see the muscle structure and all the blood vessels, the entire structure which had served me so well for 57 years. Then you can use that Erickson metaphor about how the colon is the only valve that can hold liquid, solid and gas and emit downward only the gas. No man has ever designed such a versatile valve..no one.

Bowl of Fruit exercise:
For example, I want all of you to sit quietly and comfortably now with your eyes closed. Think of a bowl of fruit. Bananas, peaches, etc. sitting on a small table beside the chair you're sitting in. How do you think about a bowl of fruit that isn't there and a small table that isn't there? How does it feel to pick up a banana? What shoulder sensations, what finger sensations, what chest sensations do you get when you pick it up? What does the smell remind you of? Thinking through of what your behavior would be if there were a bowl of fruit sitting there next to you and you reached over and picked one of those items up. Sensing the feel of the banana or peach. How the arm would feel as you extended it to pick up the banana? Visualizing the movement of the banana as it came towards your body. All that might be involved.
The task of mentally, introspectively working on an imaginary task. No mention of hypnosis need be made.
Once you really get involved in thinking through that bowl of fruit situation, you'd be dealing with memories and ideas and concepts of bananas and peaches. You'd use muscle memories, taste memories, olfactory memories. All would be involved and you would have to dissociate from your environment and in the process you would go into a trance.

So then what is a hypnotic technique: **it is any procedure by which you orient a person to his or her thinking within their own mental and physical environment and making their own memories the important thing.** *Not the doctor's office or even the doctor is important*. And what kind of thinking do you want your hypnotic patient to do? Any thinking that allows that patient to get within himself or herself, so that they're dealing with themselves.

Resistance:
There are those patients who really don't understand or comprehend what the total situation is and you need to present ideas to them in such a way that you satisfy their needs. You have the patient with the chronic, uncontrollable pain who comes to you needing certain understanding with which they could accept and thereby alter their pain experience and you don't dare to induce a trance state because that patient would interpret hypnosis as you forcing ideas on them.

Instead, you begin by accepting the patient's statements regarding their uncontrollable pain and everyone one of their patient's statements until they know that you really understood and believe what they are experiencing. Then you begin to explain to the patient in a way, **that you really mean,** about how their pain could come about. You might explain the structure of a nerve and how it's not really one nerve but a bundle of fibers each carrying different messages to the brain. For example, heat traveling on one, cold on another, and touch and pressure on others and you keep talking until the patient knows that you really understand about nerves. Then you begin to intersperse the idea that pain wears out and that eventually the body begins to adapt. You can talk about a doctor with tender hands who doesn't do a lot of physical labor and how they would develop blisters very quickly if and that if they tried to dig a hole or a trench with a spade or shovel or use a pick. But if they used that shovel or pick for a couple of minutes for one day and a couple more minuets the next day and so on that eventually they would

build up callus formations sufficient to dig all afternoon long.

You can expand that **callus idea** to the idea of becoming used to an emotional deprivation. One can form emotionally calluses, intellectually calluses, dermal calluses, nerve calluses. You continue until the patient begins to accept all those suggestions and begins to seek a way to lose their pain.

As you explain all this, the patient is thinking: I know what a callus is and I wish I could have a callus on the nerve where all my pain is. How nice that would be and how would my leg feel or my arm feel if I had a callus on that nerve. It would feel as comfortable as the other leg or arm does. **At no time are you asking the patient to accept the ideas.** You are merely explaining the possibilities and in such a manner that the **patient needs** to reach out and pull in whatever ideas they needed to get whatever effect they desired.

So I think that the hypnotic induction should be about getting the patient interested in a **goal achievement** that is meaningful to the patient. And the trance that develops is the trance that's effective for them and not necessarily something that can be measured by a hypnotic scale. Remember, you don't need a somnambulistic trance for the dental patient who needs only an anethesia for the lower right jaw and so you don't need to include their feet or legs or even an arm. And for the dental patient you center your suggestions around ideas and understands and their memories of dental work. That's the part of your patient that you want involved in the situation.

To many hypnotic failures are the result of the operator's limitations. They're not recognizing the meaningfulness of the situation to the patient.

I recall a case Erickson commented on regarding the illiterate man who was a good hypnotic subject who wanted hypnodentia. Erickson said that the dentist did a good job of inducing an oral anethesia and because the man could hallucinate well, the dentist asked the man to hallucinate a TV and watch his favorite program with his eyes wide open, but whenever the dentist touched the man's mouth dental anethesia evaporated. According to Erickson, the problem was rather simple. The dentist was working on the front teeth. And the man knew that two of his front teeth were called "eye teeth" and as long as he looked at TV he was using his eyes there could be no anethesia of those "eye teeth". And that was the failure of the dental anethesia. And that was the man's idea that interfered with the dental anethesia. Why argue with the man about the wrongness of his idea of "eye teeth"? Why not have him develop an anethesia for both eyes closed?

Erickson's theoretical orientation to hypnosis is that it is a special state of awareness and in a special kind of way.