An Hypnotic Technique for Resistant Patients:
the Patient, the Technique and Its Rationale
and Field Experiments*

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

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

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

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

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

reason to seek therapy from me.” (This was a definition of his visit unrecognized by him.)

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

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

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

THE TECHNIQUE AND ITS RATIONALE

The technique, to be given in detail shortly, which is used sometimes almost verbatim, can be shortened or made longer by repetitions and elaborations all in accord with the patient’s capacities to understand and to respond. It is advantageous to modify it to include the patient’s own style of speech, whether abrupt, impolite or even outrageously profane. However, the author, in his use of it, usually discontinues very rapidly the discourtesies of the patient’s own type of language, but he is likely to continue any ungrammatical constructions that may be characteristic of the patient’s speech. Thus the patient’s violence (linguistically expressed) is unnoticeably discarded and the patient and the therapist arrive at a safe, pleasant linguistic level familiar in form to the patient. The patient does not know how this happened nor does he often sense that it is happening because of its indirectness; nor is there any reason for the patient to be led to understand the techniques and levels of communication, any more than does the surgical patient need to have a full comprehension of the surgical techniques to be employed.
When sufficient material has been obtained from the aggressive, hostile, antagonistic, defensive, uncooperative patient to appraise his unfortunate behavior and attitude and to judge his type of personality, he is interrupted by an introductory paragraph of mixed positive and negative seemingly appropriate and relevant remarks addressed to him in the form of language he can best understand at that moment. However, concealed and disguised in these remarks are various direct, indirect and permissive suggestions intended to channel his reactions into receptive and responsive behavior.

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

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

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

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

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

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

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

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

"Before I ask that question, I would like to suggest two possibilities. (1) Your conscious mind might want to know the answer. (2) You unconscious mind might not want you to know the answer. My feeling, and I think you will agree, is that you came here for therapy for reasons out of the reach of your conscious mind. Therefore, I think that we should approach this matter of the question I am going to put to your unconscious mind for its own answer in such a way that your own deep unconscious wishes to withhold the answer with your conscious mind are adequately protected and respected. This, to me, is a fair and equitable way in dealing with one's self and one's problems." (This is what he knows he wants from others, but has not quite recognized that he wants fair and equitable treatment from himself.)

"Now, to meet your needs, I am going to ask that yes or no question and be prepared to be pleased to let your unconscious mind answer, (this is an unrecognized authoritative suggestion with a foregone conclusion permissively stated) and in doing so, either to share the answer with your conscious mind or to withhold it, whatever your unconscious mind thinks to be the better course. The essential thing, of course, is the answer, not the sharing nor the withholding. This is because any withholding will actually be only for the immediate present, since the therapeutic gains you will make (also an unrecognized authoritative statement given in the guise of an explanation) will eventually disclose the answer to you at the time your unconscious mind regards as most suitable and helpful to you. Thus, you can look forward to knowing the answer sooner or later, and your conscious desires, as well as your unconscious desires, are the seeking of
therapy and the meeting of your needs in the right way at the right time."
(This is a definitive suggestion given as an explanation and a most emphatic posi-
tive suggestion.)

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

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

"An unconscious mind response is different, because you do not know what it
is to be. You have to wait for it to happen and consciously you cannot know
whether it will be ‘yes’ or ‘no’." (How can a muscle movement be a ‘yes’ or a
‘no’? The patient has to listen intently for some reasonable explanation.) "It
does not need to be in accord with the conscious answer that can be present
simultaneously in accord with your conscious mind’s thinking. You will have to
wait, and perhaps wait and wait, to let it happen. And it will happen in its own
time and at its own speed." (This is an authoritative command but sounds like an
explanation, and it provides time for behavior other than conscious, in itself a
compelling force. Additionally one never tells the patient that an unconscious reply
is almost always characterized by a strong element of perseveration. Appar-
tently an altered time sense in hypnotic subjects, possibly derivitig from their
altered reality relationships, prevents even experienced subjects from appreciating
this point, and it constitutes an excellent criterion of the character of the response.
This perseveration of ideomotor activity, however, is much briefer in duration
if the unconscious mind wishes the conscious mind to know; the titlhe-lag and the
dissociated character are greatly reduced, although the unconscious answer may
be considerably delayed as the unconscious mind goes through the process of
formulating its reply and the decision to share or not to share. If the patient
closes his eyes spontaneously, one can be almost certain that the reply given will
be spontaneously withheld from the patient’s conscious awareness. When the
answer is “shared,” especially if the conscious opinion is opposite in character,
the patient shows amazement, and sometimes unwillingly admits to the self an
awareness of strong feeling that the unconscious answer is unquestionably correct,
thereby intensifying his hypnotic response. A repetition for comparison by asking
another simple question can be elicited by the operator by careful wording of a question such as, "But you can withhold an answer, can you not?", doing this so casually that the patient does not realize that the second question has been asked. Thus there can be secured a second ideomotor response that is withheld from or not noticed by the conscious awareness. Insuring that the patient learns both to share unconscious activity and to withhold it from conscious awareness greatly speeds psychotherapy. Thus, I have had a resistant patient, in reply to my question, consciously and promptly shake his head in a negative, briefly and emphatically, and then sit wonderingly at my apparent tardiness of response to his reply, not knowing that I was waiting silently to see if there would occur a slow head turning in a perseverative way from left to right, or an up and down nodding. Experimenting with such patients has disclosed such perseverative movements, particularly of the head, that may last as long as 5 minutes without the patient becoming aware of what was occurring. Once the patient is in a trance, the ideomotor response can then be as rapid as movement in the ordinary state of awareness, although in general there is a cataleptic character that is most informative of the patient's hypnotic state. This is another criterion for the operator's guidance, unrecognized by the subject.)

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

"I do not know if your unconscious mind wants your conscious mind to look at some object, or to pay attention to your head or fingers or hands. Perhaps you might like to watch your hands, and if your eyes blur as you watch them fixedly while you wait to see which one will move when I ask my simple question, such blurring is comprehensible. It only means that your hands are close to you and that you are looking at them intently." (Even if the patient's eyes are closed this paragraph can be used unconcernedly. In its essence, it is highly suggestive of a number of things, but unobtrusively so. Actually, the sole purpose of these purported and repetitious explanations is merely to offer or to repeat various suggestions and instructions without seemingly doing so. Also a variety of possibilities is offered, essentially as an indirect double-bind, which renders a refusal to make a response most difficult. All of the items of behavior are being suggested in such fashion that seemingly all the patient does is to manifest his choice, but he has actually not been asked to make a choice of the possibilities merely mentioned to him. He is not aware of what else is being said or implied. The author's
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personal preference is an ideomotor head movement, which can easily be achieved without conscious awareness, but regardless of the type of movement employed by the patient, the author immediately shifts to a second type of ideomotor response and perhaps to a third to intensify the patient’s total responsiveness. The hand movement offers certain distinct advantages in that it lends itself readily to the elicitation of other phenomena, as will be described later.)

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

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

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

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

Fortunately for both the operator and the patient, the elicitation of a single hypnotic phenomenon is often an excellent technique of trance induction, and should, for the patient’s benefit, be used more often. The realization of this was first reached in the summer of 1923 while attempting to experiment with automatic writing. To the author’s astonishment, the subject, his sister Bertha, who had never before been hypnotized nor seen hypnosis induced, developed a profound somnambulistic trance while suggestions were being made only to the effect that slowly, gradually, her right hand, holding a pencil on a pad of paper, would begin to quiver, to move, to make scrawling marks until her hand wrote letters, then words forming a sentence while she stared fixedly at the door just to enable her body to sit still. The sentence, “Grandma’s dog likes eating those bones,” was written, and the author inquired what she meant and received reply, while she pointed cataleptically toward the door, “See! He is eating that dishful of bones and he likes them.” Only then did the author realize that a trance had been unintentionally induced and that she was hallucinating visually what she had written since Grandma’s dog was miles away. Many times thereafter automatic writing was used as an indirect technique of trance induction, but was discarded because writing is a systematic ordering of a special skill and hence is too time-consuming. A ouija board was next utilized, but this, while somewhat effective in inducing a trance indirectly, was discarded because of its connotations of the supernatural. Resort was then more reasonably made to the simple movements of the type made automatically, promptly, requiring no particular skill. At first a modification of automatic writing was employed, a modification spontaneously and independently developed by a number of different subjects, namely, the use of a vertical line to signify “yes,” a horizontal line to signify “no,” and an oblique line to signify “I don’t know.” This has been described elsewhere by Erickson and Kubie (Psychoanalytic Quarterly Oct. 1939, Vol 8, No. 4 pp 471-509). It has often proved a rapid indirect technique to trance induction.

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

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

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

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

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

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

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

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

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

**FIRST FIELD EXPERIMENT**

This paper had been typed in final form up to this point and it had been carefully reviewed that same evening. The next morning a most fortunate coincidence occurred.

A new patient, 52 years old, a successful upper social class business man entered the office. He was shame-faced, embarrassed and in apparently severe emotional distress. He pointedly looked at the state license to practice medicine in Arizona posted on the wall in accord with Arizona law, read the certificate from the American Board of Psychiatry and Neurology qualifying the author as a diplomat of
that Board, picked up the Directory of Medical Specialists from the dictionary stand, read the author's qualifications there, picked up the Psychological Directory and read the author's qualifications there, went to the book case and selected the books, *The Practical Applications of Medical and Dental Hypnosis* and *Time Distortion in Hypnosis*, pointed to the author's name on the dust jackets and remarked caustically, "So you fool around with that stuff!" The author agreed casually but (to add further fuel to the patient's fire) added, "And just last night I finished writing a paper on hypnosis, and I am also the Editor of The American Journal of Clinical Hypnosis." The reply was, "Yes, I've heard plenty about you being a crack-pot but I'm in trouble, (noting that the author was writing down each of his statements, the patient spontaneously slowed his speech to accommodate the author's writing speed, but otherwise continued uninterruptedly with his complaints) and I need help.

"And it's getting worse. It began about 8 years ago. I'd be driving to work and I would go into a panic and would have to park the car at the curb. Maybe a half-hour later I could drive the rest of the way to the office. Not constantly, but slowly it increased in frequency until one day it changed. I couldn't park by the curb. I had to drive home. Sometimes it happened on my way home from the office and I'd have to drive back there. Then maybe after an hour, sometimes only a half-hour later, I could go to the office or home with no difficulty. My wife tried to drive me there to save me from these panic states. That just made things worse. I'd be sure to get a panic and yell at her to speed up. I tried taxicabs. That didn't work. The taximen thought I was off my rocker because I would suddenly yell at them to turn around and try to make them break the speed laws getting back home or getting back to the office. I tried a bus once and I thought I'd go crazy. The bus driver wouldn't let me off until he reached the next bus stop. I nearly killed myself running back home. It didn't happen every day at first, but it kept getting more frequent until three years ago it was every day I was late to the office and late back home. I had to take a lunch with me. I would get a panic going to or coming back from lunch.

"Three years ago I went into intensive therapy with Dr. X. He was trained in psychoanalysis at the Y Clinic for three years and had two years of controlled psychoanalysis himself. I saw him 4 or 5 times a week, an hour each time, for 2½ years, but I always had to allow about two hours to get there on time and then two more to get home. I didn't always need the time. I sometimes arrived way ahead of time, and sometimes I could leave on time. But I just continued to get worse. Then about 6 months ago, the psychoanalyst put me on heavy dosages of tranquilizers because I had made no improvement; but he kept on analyzing me. The analysis didn't do any good. Some of the drugs would work for a week or even two, but then they would wear out. Most of them did nothing for it. Just name a tranquilizer; I've taken it. Pep pills! Sedatives! Extra analytic hours too. Then about a couple of months ago I tried whiskey. I never had done any drinking to speak of, but what a relief that whiskey was. I could take a drink in the morning, put in a day's work at the office, take a drink and go home feeling fine. With the tranquilizers that worked, I hadn't been able to do my office work, and even those that didn't work interfered with my office work terribly. I had had to take a simpler job. For one month I used two drinks of whiskey a day, one in the morning, one at quitting time, and everything was O.K. Then about a month ago I
had to double the morning dosage, then take some at noon, then a double dose to get home. Then I started on triple doses with extra single ones thrown in between times. My home is 20 minutes from here. It took three drinks to get me here, stiff ones. I came early so I would have to wait a couple of hours and sober up, and I sober up fast.

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

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

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

Slowly, carefully, the technique was read almost verbatim, sometimes rereading parts of it as judged best by his facial expression.

Finally the patient began to look first at one hand and then the other. At last, his gaze became fixated on the right hand. The left index or "no" finger raised slightly, then the left middle finger. Then the right index finger with jerky, cogwheel movements began lifting in a perseverative fashion. His left index finger lowered but the middle finger remained cataleptic. His head then began a perseverative affirmative nodding that lasted until he was interrupted by the induction of catalepsy in both hands. His eyes had closed spontaneously when the left index finger was lowered.

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

Finally the patient was aroused from his apparently deep trance by reiteration of the remark about reading the manuscript. He aroused, slowly shifted his position and again remarked that it (hypnosis) wasn't any more harmful than alcohol. Suddenly he noticed the clock with a startled reaction and immediately checked it with his own watch and then the author's. His startled comment was, "I came in here half an hour ago. The clock and our watches say I've been here over two hours—nearly 2½. I've got to leave.

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

Three days later he entered the office smilingly, made a few casual remarks about current events, sat down comfortably in the chair and offered a compliment on a paperweight. He was asked what had happened during the last three days. His eloquent reply was, “Well, I’ve been wondering about that problem I came to you about. I was pretty hot under the collar and I had plenty to say and I said it and you wrote it down word by word. I kept trying to figure out what it was costing me per word to let you take your time just writing it down. It irritated me quite strongly, and when I noticed I had been here 2½ hours just to let you write down verbatim what I had to say, I made up my mind that I would pay you for one hour only and let you argue about the rest. Then when you told me to bring a full bottle of whiskey the next time I came, I felt just as I did about those useless tranquilizers and I had half a mind not to come back. But after I got outside, I realized I was feeling unusually free from tension even though I was late for a business appointment, so I came back to say good-bye.” (The reader will note that this is not the exact-chronological sequence recorded above.) “Then I forgot to take a drink in order to drive to my appointment, maybe because I was irritated about your mention of a full bottle of whiskey.

“Well, let’s see. You were once an editorial writer on a large metropolitan newspaper, and editorials are supposed to hold the opinions of the masses. Tell me, is the opinion molded in the conscious mind of the person or the unconscious mind of the person; and what is your definition of the ‘conscious mind’ and the ‘unconscious mind’?” He replied, “You don’t go through 2½ years of psychoanalysis with wholehearted cooperation and then get brainwashed for another half-year with tranquilizers plus analysis without learning a lot, and losing a lot. All I can give you is an ordinary lay definition, namely, your conscious mind is the front of your mind and your unconscious mind is the back of your mind. But you probably know more about that than I do or Dr. X.” He was
asked, "And is it possible that ever the twain shall meet?" His answer was, "That's an odd question but I think I get what you mean. I think that the unconscious mind can tell the conscious mind things but I don't think the conscious mind can either tell the unconscious mind anything or ever know what is in the unconscious. I spend plenty of time trying to excavate my unconscious mind with Dr. X and getting nowhere, in fact getting worse." Another question was put to him, "Shall I discuss the conscious mind and the unconscious mind with you some time?" His answer was, "Well, if you keep on writing down everything I say and everything you say, and I have all the luck with my problem that I had when you spent the whole time just writing down my complaints the way you did last time—by the way, I had a wonderful afternoon playing golf yesterday with a client, first good game in years and no drinking either—well, go right ahead and discuss the conscious mind, the unconscious mind, politics, hypnosis, anything you wish."

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

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

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

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

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

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

"But what is going on? You sit and write down what you and I say. You don't
hypnotize me, you aren't doing any psychoanalysis. You talk to me but you
don't say anything in particular. I suppose when you get around to it you will
hypnotize me, but what for I don't know. That problem I came in with, psycho-
analyzed without results for 2 1/2 years and brainwashed with tranquilizers and
psychoanalysis for another half-year, and now in two hours without you doing
anything, I'm pretty sure I'm over my problem." A casual reply was made that
therapy usually takes place within the patient, that the therapist is primarily a
catalyst. To this he answered, "Well, 'catalyst' when you get ready. If I can waste
3 years on psychoanalysis and tranquilizers and just get worse and I get better
(note first person pronoun) in two hours watching you write, you can have all
of my time you want. It's wonderful to go to the office and home and to lunch
again and it was good to meet that old friend at the hotel, and that story our client
told me wasn't half bad. When is my next appointment?"

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

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

"I wonder if the reason for these panics isn't my wife's irritation with me. She
has always wanted me to see things her way and it always made me mad. So I
wonder if I get into these panics because they irritate the hell out of her. You
know, I think that's the underlying cause. What I suspect is that somehow you are
making me tear up the old problem and scatter it around like confetti. I wonder if
that's what I'm doing, tearing up my problem and just throwing it to the wind. I
wonder why in three years I never told my analyst about my wife's antagonism.
Four or 5 or more hours a week for 3 years ought to drain dry every idea a man has. Why did I tell you? You never asked! Oh yes, I played two days of golf the way I like to play, no drinking, no panics. Then on the way here, I got a panic as I stepped outside the office building and so I went into the (adjacent) bar, ordered 3 double shots of whiskey, paid for them, looked at them all lined up for me and never saw a sillier thing in my life. So while the bartender just stared at me and the untouched drinks, I walked out. I didn’t have a panic.

“Now you have been writing about ½ hour on what I’ve been telling you, and that clock there says its half-past the hour and I’m willing to bet the next time I look at it, it will be on the hour.” (The implications of this remark are obvious.)

Slowly, gravely, the answer was given, “You are entirely right.” Immediately his eyes closed and a deep trance ensued at once. He was promptly asked to review the progress he had made and the account of the current interview was read slowly to him. As he listened, his head slowly nodded perseveratively in an affirmative fashion.

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

The appointment was made.

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

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

“No with your permission, I’m going to—no, I don’t want your permission because I decided to do it and I’ve been doing it for almost a week. What I do is this. The first day I got in my car, I deliberately had a short panic after the first block or two, and then drove on to the office comfortably. The next day I drove still further and deliberately had another brief panic and drove on. The same thing is done when I go home. I’ve only got about enough distance left for about 4 or 5 more short panics. Then I’ll be through. But I’m not going to stop seeing you. It’s worth it to have a conversation with you once a week if you don’t mind and I expect to be charged for it.”
Therapy has continued in this fashion; at first a simple report by the patient of his "own behavior" with no expectation of any comment from the author and a general conversation on various related topics. Thus did the patient take over the responsibility of his own therapy, doing it in his own way at his own speed.

He is still continuing his weekly visits, sometimes on a purely social level, sometimes discussing the teen-age behavior of his children not as a problem but as an interesting contrast to his own. His own problem has vanished so far as any personal difficulties are concerned. That he is willing to pay a psychiatric fee for social visits suggests that unconsciously the man wants the assurance of a continued friendship for some length of time from one who aided him to achieve a satisfying sense of masculine dominance without compelling him to go through a long, dependent, submissive, and fruitless relationship in search of therapy, but who, instead, simply placed the burden of responsibility for therapy upon him and his own unconscious mind. However, as the weeks go by the evidence is building that he will soon be reducing the frequency of his visits. Early summer plans have been repeatedly mentioned and these, as they are outlined, will make visits impossible. Thus, his unconscious mind is informing the author of the impending termination. Invariably he goes into a spontaneous trance of 5 to 10 minutes duration as the end of the hour approaches. In this trance he remains silent and so does the author.

Similar therapeutic procedures have been employed in the past, not exactly in this fashion but in a decidedly comparable manner. One patient will make an appointment phrasing his request, "so that I can have my batteries recharged" (meaning a trance, sometimes with helpful suggestions, sometimes merely a trance). Other patients come in seemingly for no more than a "casual" conversation, eventually discontinuing this practice. In the past, such therapeutic procedures have sufficed to achieve long-term satisfactory results, as witnessed by follow-up inquiries 5 and 10 years later.

SECOND FIELD EXPERIMENT

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

"Psychodynamically oriented" psychotherapy was undertaken by various psychoanalytically trained psychiatrists. The girl, a college student of distinctly superior intelligence, made mockery of them, ridiculed psychoanalytic concepts, placed the psychoanalysts in a self-defensive position or else angered them and was regarded by them as "not amenable to any kind of psychotherapy." Electroshock therapy was recommended but refused possibly by both the relatives as well as by the patient. (The father, a dentist, had sought counselling on the matter from two other psychiatrically trained psychotherapists who had advised against it as too soon to be warranted. Hence it is not known whether the father or the patient refused, or both, the patient stating very simply, "I would not tolerate having my brains scrambled for thumb-pushes on a button at $30.00 a push").

She was asked what she wished of the author. Her statement was, "I have a
family that think you can hypnotize me into sanity as they call it. God, how I hate them. So they just signed me out of the state hospital and brought me here willy-nilly. Now what kind of an ass are you going to make of yourself?"

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

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

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

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

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

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

At first her expression was one of scornful mockery but she suddenly declared in amazement, "My right hand is lifting, I don't believe it, but it is and I'm not in a trance. Asked if her unconscious mind thought it could communicate with me. In astonishment she declared, "My head is nodding 'yes' and I can't stop it, and my right index finger is also lifting too. Maybe my unconscious mind can communicate with you, but make them stop moving."

"If your unconscious mind wants to stop them, it will do so itself" was the answer given to her.

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

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

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

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

**THIRD FIELD EXPERIMENT**

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

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

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

"You working?"
"No, leave of absence psychiatrist friend say see you—get help."
"Want help?"
"Yes."
"No faster than I can give it?" (that is, would she accept help at the rate I considered best. I wanted no expectation of a “miracle cure.”)
"Yes."
"May I start work on you now?"
"Yes, please, but no good, all clinics say hopeless, painful. Everybody enjoy himself but I can’t. I can’t live with my husband, nothing, just paid, no hope, doctors laugh at me see you for hypnosis."
"Anyone suspect psychogenic origin of pain?"
"No, psychiatrists, neurologists, Mayos’—all clinics say organic, not psychogenic."
"And what advice do they give you?"
"Endure; surgery, alcohol, last resort."
"Do you think hypnosis will help?"
"No, organic disease, hypnosis psychological."
"What do you eat?"
"Liquid."
"How long does it take to drink a glass of milk?"
"Hour, longer."
“Trigger spots?”
In a gingerly fashion she pointed at her cheek, nose, and forehead.
“So you really think hypnosis won’t work! Then why see me?”
“Nothing helps, one more try only cost a little more money. Everybody says no cure. I read medical books.”

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

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

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

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

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

She was aroused from the trance by saying, “As I just said, before I make any beginning of any sort, I will want to offer you some general explanation. Then we can begin.” To this was added with a pointed inflection; “Is that all right with you?” Slowly, over a period of two minutes, she opened her eyes, shifted her position, wiggled her fingers, twisted her hands, and then answered very easily and comfortably in marked contrast to her previous labored and guarded answers, “That will be perfectly all right.” Immediately, in a most startled fashion, she exclaimed, “Oh my goodness, what happened? My voice is all right and it doesn’t hurt to talk.” With this she gently closed her mouth and slowly tightened the masseter muscles. Promptly she opened her mouth and said, “No, the neuralgia is there just as severe as ever, but I’m talking without any pain. That’s funny
I don't understand. Since this attack began it's been almost impossible to talk and I don't feel the air on my trigger points." She fanned her cheek, nose and right forehead, and then gently touched her nose with a resulting spasm of extreme pain.

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

She was asked, "How long have you been in this room?" Wonderingly she replied, "Oh 5 minutes, at the very most 10, but not really that long." The face of the clock was turned toward her (its position had been carefully changed during her trance). In utter bewilderment she exclaimed, "But that's impossible. The clock shows more than an hour!" Pausing, she slid her watch from under her sleeve and said again (since her watch and the clock agreed) "But that's utterly impossible" to which the author said with great intensity, "Yes, it is quote utterly impossible unquote but not in this office." (The indirect hypnotic suggestion is obvious to the reader but it was not to the patient.)

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

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

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

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

Searching inquiries revealed a well-adjusted parental home, a happy childhood, and excellent college, marital, economic, social and professional adjustments. It was also learned that her first attack had begun in 1958, had lasted continuously for 18 months during which time she had futilely sought medical or surgical aid from various well-known clinics, had undergone psychiatric examinations to rule out possible psychogenic factors, and had consulted various prominent neurologists. She was a psychiatric social worker, and had a cheerful habit of softly whistling merry tunes almost continuously while at work or even walking down the street. She was exceedingly well-liked by her colleagues and explained that she had been referred to the author by an old-time friend of his, but that all others had commented most unfavorably about hypnosis. To this she added, "Just meeting a medical man who uses hypnosis has already helped me. I can talk easily, and this milk took me 5 minutes, and it usually took an hour or more. So it wasn't a mistake to come here."

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

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

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

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

At the end of four hour-long sessions her pain was gone, and she raised the
question at the 5th, “Maybe I ought to go back home.” In a jocular manner the
author said, “But you haven’t learned how to get over the recurrences!”

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

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

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

As she entered the office at the next appointment she remarked, “I just am at a
loss about everything today. I don’t need to come, but I’m here and I don’t know
why. All I know is the steak tastes good and I can sleep on my right side and every-
thing is all right but here I am.” The answer given was, “Certainly you are here, just
sit down and I’ll tell you why. Today is your ‘doubt day’ since anybody who has
lost that much trigeminal neuralgia so fast is entîled to some doubts. So, slap your left cheek hard.” Promptly she administered a swift stinging slap, laughed and said, “Well, I’m obedient, and that slap really stung.”

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

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

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

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

DISCUSSION AND COMMENTS

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

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

On several occasions this author has had opportunity to do special work with congenitally deaf people, and those who had acquired nerve deafness in childhood, one an instance of a man who acquired nerve deafness after the age of 30, and one an instance of a woman who had acquired nerve deafness after the age of 40. All of these people had been trained in "lip reading," although most of them explained to the author that "lip reading" was "face reading," and all of them could do sign language. To prove this, one of these deaf people took the author to listen to a Sunday sermon by a heavily-bearded minister and, by sign language, "translated" to show that he was "face reading," since the author then could read sign language. Further experimentation with this deaf man disclosed that if the minister spoke in a monotone or whispered, his face could not be "read."

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

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

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

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

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

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

In this way, it is believed by the author, hypnosis can be best induced and that a good hypnotic technique so organized can be remarkably effective even under seemingly highly adverse circumstances. However, the author has so far always failed with behavior merely personally objectionable to the subject but entirely legitimate. An account of an instance of this is given in THIS JOURNAL,* Vol VI, 3, Pp. 201, and more than one otherwise compliant subject has “shut off my hearing,” or awakened.

In this particular paper a total of 4 subjects were dealt with by a single technique with only slight modifications to meet the requirements of sex, intelligence, and educational level. All 4 represented different types of resistance, different backgrounds and different types of problems. One was a rather severely maladjusted person, the second was unhappily governed by peculiar circumscribed uncontrollable maladjustments, the third had a long history of general maladjustment eventuating in a state hospital commitment with a diagnosis of “psychosis, paranoid type, probably schizophrenic,” and the fourth was a patient diagnosed repeatedly at competent clinics and by competent neurologists and psychiatrists as suffering from a hopeless organic condition characterized by occasional brief remissions and treatable only in a partially satisfactory manner by organic measures entailing undesirable results. Five years experience of excruciating pain had firmly convinced and conditioned this last patient to the understanding that the condition was untouchable by psychological measures, and only hopeless desperation led to the seeking of hypnotherapy.

The technique employed so successfully upon 4 such diverse patients was essentially a rigid arresting and fixation of their attention and then placing them in a situation of extracting from the author’s words certain meanings and significances that would fit into the patterns of their own thinking and understanding, their own emotions and wishes, their own memories, ideas, understandings, learnings, conditionings, associational and experiential acquisitions, and into their own patterns of response to stimuli. The author did not really instruct them. Rather he made statements casually, repetitiously, permissively, yet authoritatively, but in a

manner so disguised that their attention was not directed away from their own inner
world of experience to the author but remained fixated upon their own inner pro-
cesses. Consequently a hypnotic trace state developed, one in which they were
highly receptive to any general ideas that might be offered to them to examine and
to evaluate and to discover for themselves any applicability to their problems. For
example, the second patient was not told to develop his brief and “silly” panics, nor
was he told what plan to work out governing his control of his daily trips. Nor was
the origin of his condition ever asked for; his intelligence told him it had an origin
and there was no need to tell him to search for it.

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

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

As concluding statements, in the therapeutic use of hypnosis, one primarily meets
the patient's needs on the terms he himself proposes; and then one fixates the pa-
tient's attention, through adequate respect for and utilization of his method of pre-
senting his problem, to his own inner processes of mental functioning. This is ac-
complished by casual but obviously earnest and sincere remarks, seemingly explana-
tory but intended solely to stimulate a wealth of the patient's own patterns of
psychological functioning so that he meets his problems by use of his leartitig already acquired or that will develop as he continues his progress.