INTRODUCTION

When we learn to become therapists, we learn particular ways of thinking as much as specific content. These ways of thinking become perceptual lenses. Lenses have advantages in that they focus on important aspects of the patient. They have disadvantages because they also limit perspectives. Additionally, lenses act as filters to the degree that our perceptions circumscribe subsequent actions. In our early training, perhaps in graduate school, lenses are surgically implanted by our teachers. They then become our heirlooms, to be carefully transmitted to patients and subsequent generations of students.

Having studied the hypnotic psychotherapy of Milton Erickson for more than 17 years, I have developed a particular way of thinking about therapy. I want to explore one small concept that has its roots in traditional hypnosis, but occupied a central place in Erickson’s work. Indeed, it could be considered a wide-angle lens of Ericksonian methods. Although the concept is easy to understand it is a difficult concept to master. To loosely paraphrase Jay Haley (1): If I experientially understood this one idea, new worlds would open before me as far as doing psychotherapy is concerned.

In Ericksonian fashion, I will present the concept to you through a series of vignettes and scenes. This follows my commitment to the idea that dynamic experiences should precede dynamic understandings. Therefore, I would like you to react to the following situations and discover what they have in common. You should be able to describe the central theme in one word.

ILLUSTRATION OF THE CONCEPT

Situation 1

As you sit in your chair, you do not have to pay attention to the wall in front of you, to the darkness of the floor, to the color of your clothing, or to the changes in the blink of an eye. And yet you cannot help but pay attention to sounds outside the room, to sounds around you, to the sounds of your own breathing, to the sound changes that gradually occur to you. You can also pay attention to the sensation of your feet on the floor, to the pressure of your body being supported by the furniture, to the presence or absence of a head rest, back rest, arm rest, seat rest, foot rest.

And, in hypnosis, you merely limit the number of foci of your attention, and you allow yourself to attend to what is immediately relevant.

Situation 2

Recently, a couple requested hypnotherapy to stop smoking. He was in his 40s; she was in her 30s. Both were currently in therapy and were referred to me for habit control. As is my custom, I arranged to see them together. I suggested they dispose of their smoking material and put away their ashtrays the night before the session. They would have their last cigarette prior to going to bed, and they were to come in uncomfortable so that I could learn about their unique difficulties in order to individualize therapy.

When they arrived in my office, they reported that they had followed my suggestion, which I regarded as a positive prognostic indicator. In my interview, I asked if they had conquered other habits, and I learned that both of them had had extensive treatment for addictions: They were working a program in Alcoholics Anonymous and Narcotics Anonymous. I inquired about the husband’s pattern of using alcohol and narcotics prior to the treatments. He said to his wife, “I just stopped for a beer, when actually he had imbibed hard liquor and drugs. His pattern of denial...
included bold lies.

I tried to ascertain the styles of the couple. They were both blue-collar workers. The man was superficially gregarious, but distant, avoiding intimacy. In fact, they had had some couples therapy at the wife's request in order to develop more closeness. The woman appeared tough, independent, rebellious, and sardonic. She had arthritis. How do you deal with the discomfort? I asked. She replied, If I have pain, my body says, 'Take it easy,' and I take a bath or a nap. Her pain never caused her to miss work. The husband also had a high pain tolerance.

I switched abruptly from the topic of pain, knowing I would return to it shortly. I asked, I know it is difficult to accurately describe the urge to smoke, but could you try to describe it? As they struggled to articulate the components of the urge to smoke I added, I would like to realize that you could think about the urge in many senses as being a 'pain.' They could accept that the urge to smoke was a pain in many senses.

I then suggested they could have a private signal system that only would be used between the two of them. I reminded them that all couples have a private language that outsiders might not fully comprehend. If either one said the phrase, that pain, as in I am having that pain, it would be understood as indicating the experience of a discomforting urge, which really is not an urge, but a pain. Once the signal was established, each could help the other.

I indicated to the husband: Here's what you can do. Whenever you say to your wife, I am experiencing that pain, she can touch you. She can give you a hug, or put her hand on your lap, or just gently take your hand. When you say, I am experiencing that pain, she will immediately know you openly desired a more intimate marriage. The husband blanched; his response was agreeable but muted.

I turned to the wife: If you say to your husband, I am experiencing that pain, he is to give you space. You are to have five minutes to yourself. During those five minutes, you can take a nap, you can do anything you want. But you must get time by yourself. The wife blanched; her response was agreeable but muted.

I explained to the husband that there was a second part of the therapy; he was to lie to and cheat on his wife on a regular basis. He was compelled to lie and cheat. It would be a good idea if he did it at breakfast, lunch, and dinner, because then he would not forget. We agreed on what suitable lying and cheating would entail. The lies would have to be relatively minor and could not be about addictions. For example, he could say that he took out the garbage, when actually he had not. He could say that he did an errand, when actually he had not.

Her job was to catch him. At the end of the day, they would have an earnest conversation. She would say what she believed to be the incidents of lying and cheating. He would say what the lying and the cheating really entailed.

A third part of the therapy for the husband consisted of a simple thought-blocking technique, which could be used whenever he experienced that pain. The painful urge could be considered an invader; this was part of the artillery that he could use to bolster his lines of defence.

The technique is called Visual-Auditory-Tactile 4, 3, 2, 1. He was to think to himself the sentence stem, Now I am aware of, and silently say four visual things: Now I am aware of the wall. Now I am aware of the darkness of the floor. Now I am aware of the color of my clothing. Now I am aware of changes in the blink of an eye. Then he would say four auditory things: Now I am aware of the sounds outside the room. Now I am aware of the sounds around me. Now I am aware of the sound of my breathing. Now I am aware of the sound of changes. Then he would describe four tactile things: Now I am aware of the sensation of my feet on the floor. Now I am aware of the pressure of my body supported by furniture. And so on.

After completing four sentence stems with visual, auditory, and tactile words, he was to complete three stems that were visual, auditory, and tactile; then two; then one. He was told it was not so much a distraction technique as it was a method to lose your mind and come to your senses. After finishing the exercise, he would have a heightened sensory awareness. He might even feel a bit high.

I ended the session by saying that we had done enough. We would meet the next day for more therapy, which would entail formal hypnosis. I would meet individually with each for half an hour. My implication was that they would have no problem in maintaining a smoke-free environment until we next met for the real treatment.

The next day, I met with the wife first. She glibly said, I have decided to stop smoking. I had no problem staying off cigarettes since I saw you last. It's just like alcohol. I decided to stop. I replied: I would like to be careful that you are not too cheerful about stopping smoking. If your husband sees that you are not struggling, he may have a problem. So, even if it is not true, especially if it is not true, tell him on a regular basis that you are having difficulty stopping smoking, because I think it is easier for you to stop smoking than it is for your husband. We both know truthfully that he is kind of a baby. And, I do not want him inadvertently to sabotage you.

The wife agreed that her husband could be a baby about difficulties, and we discussed ways in which he might inadvertently sabotage her if he were smoking and she was not. I conducted a ceremonial trance with her so that she would have something to discuss with her husband and he would know that she had received treatment. In the trance, I told her stories about adolescents who had learned to do things for their own benefit, even if authority required those things to be done. The therapy for her was complete.

The husband arrived and I met with him individually. He said, I laughed all day yesterday about your ideas. Why did you tell me to cheat? He added, I did not say, 'I have that pain,' to my wife. I was comfortable. I admonished him, You are really going to ruin the therapy. You have to tell your wife 'I have that pain.' I continued: You know, your wife really wants to be helpful. She has a veneer of being though. She might be suffering more than she lets on through her veneer. Inside, she is much more sensitive than she discloses. In fact, it could be more difficult for her to stop smoking than it is for you. He has agreed with my assertions. I added that because she also a helpful side, he should say, I have that pain, as often as possible so that she could reach out to him, touch him, hug him, and feel useful to him in the process of
their quitting smoking. If he only had a little discomfort, he could exaggerate it and say, I have that pain. Even if he was comfortable, he could bend the truth a little and say, I have that pain.

His trance consisted of learning self-hypnosis to bolster his lines of defense. Similar to the Visual-auditory-Tactile 4, 3, 2, 1 technique, he would use self-hypnosis to abort any urge. I presented the method as a hypnotic program that he would work.

Five months after the sessions, I received a note from the husband, who indicated that both of them were cigarettes. They were grateful for my help, although they did not understand exactly why my methods had worked.

Situation 3

Here is another case with a similar theme. Consider the interaction between Jeff Zeig, an aspiring student of therapy, and Milton Erickson (1). At the time, I was an avid pipe smoker. It was a hobby. I had a number of expensive pipes, custom tobacco blends, and other accoutrements. It fit with my image of being the young psychologists.

Erickson saw me smoking my pipe in his backyard prior to our session. When we met, he began a long, lighthearted story about a friend of his who was a pipe smoker. The friend, he said, was awkward. He was awkward because he did not know where to place the pipe in his mouth. Should he place it in the center of his mouth, a centimeter to the right of center, a centimeter to the left of center? He was awkward.

He was awkward because he did not know how to put the tobacco in the bowl. Should he use his pipe tool? Should he use his thumb? Should he use his forefinger? He was awkward.

The friend was awkward because he did not know how to light pipe. Should he light the pipe by putting the flame in front of the bowl? In the back of the bowl? On the right side of the bowl? On the left side of the bowl? He was awkward.

All the time, I was thinking, Why is he telling me this story? I don't look awkward smoking a pipe. Erickson continued. The friend was awkward when he held the pipe. Should he support the pipe with his left hand or with his right hand? Should he hold the bowl of the pipe or the stem? He was awkward.

The friend was awkward because he did not know where to put the pipe down. Should he told it in his hand? Should he put it on the table? He was awkward.

This story seemed to go on for an hour. I never knew there were so many ways of being awkward while smoking a pipe.

The day after that session, I left Phoenix to drive back to the San Francisco area, where I lived at the time. When I reached California, I said to myself, I am not smoking anymore. I put away my pipe forever. I did not want to smoke a pipe. I never smoked a pipe again. Never.

Part of Erickson's technique was pattern disruption. I became overly conscious of the process of smoking, which effectively made me awkward. Moreover, if there was anyone to whom I did not want to seem awkward, it was Milton Erickson. Subsequently, smoking a pipe did not seem appealing. But the credit for deciding to stop was all mine.

Situation 4

Consider a patient who described low self-esteem as follows: 1) He would wonder if he had the ability to cope adequately with the required task. 2) He would decide, No, it's not present. 3) He would develop a heavy feeling in his stomach like a stone.

My hypnotic induction with this man was the following sequence (2):

- Make yourself physically comfortable and then perhaps you can watch some spot and use that to focus your attention ... all along just waiting, for a certain signal, a certain sensation, a certain sign in your body that you know will be there. A feeling I will name later.
  1) But first, mentally, the process can interest you. Because you can be thinking to yourself about the eye changes, and you can be wondering to yourself, Will my eye behavior change? Will that fluttering sensation be there? Will there be an alteration in my blink reflex?
  2) And then you can decide, Yes, there can be that steadiness around the eye, and Yes, there can be that pleasant fluttery feeling, and Yes, there can be that change in reflex.
  3) Then there is that physical sensation; for example, there is a feeling that can be described as a kind of numbness that can happen in the center ... of your hands. And later there can be an uplifting movement ...

Utilization Revisited

Reflect on the four experiences I just presented; I have asked you to ascertain what these situations have in common. What theme can be found in each? The theme can be described in one word: utilization.

Utilization is a central principle in Ericksonian therapy. It is a hallmark of the Ericsonian approach (2). Moreover, it is an important wellspring from which successful psychotherapy often proceeds. Erickson described the utilization method in this way (3).

Therapists wishing to help their patients should never scorn, condemn, or reject any part of the patient's conduct simply because it is obstructive, unreasonable, or even irrational. The patient's behavior is part of the problem brought into the office. It constitutes the personal environment within which the therapy must take effect. It may constitute the dominant force in the total patient/doctor relationship. So whatever the patient brings into the office is in some way both a part of them and a part of their problem. The patient should be viewed with a sympathetic eye, appraising the totality which confronts the therapist. In so
doing, therapists should not limit themselves to an appraisal of what is good and reasonable as offering a possible foundation for therapeutic procedures. Sometimes, in fact, many more times than is realized, therapy can be firmly established on a sound basis only by the utilization of silly, absurd, irrational and contradictory manifestations. One's professional dignity is not involved, but one's professional competence is.

In another article, Erickson (4) augmented these ideas: Although he was specifically discussing the induction of deep hypnosis, the concepts also are applicable to psychotherapy.

Such recognition and concession to the needs of subjects and the utilization of their behavior do not constitute, as some authors have declared, unorthodox techniques based upon clinical intuition, instead they constitute a simple recognition of existing conditions, based upon full respect for subjects as functioning personalities.

What is utilization? It is the readiness of the therapist to respond strategically to any and all aspects of the patient or the environment. Utilization is the therapist's trance. Stephen Gilligan (personal communication) described the state of the hypnotherapist as an externally focused trance as compared with the internally directed trance of the patient. This externally focused trance is a state of response readiness to seize the moment by capturing and utilizing whatever happens.

Hypnosis can be defined objectively as a state of response readiness because the patient assumes a posture of responding to subtle cues presented by the therapist. In interactive terms, hypnosis can be defined as the response readiness of the patient as a function of the response readiness of the therapist.

If the therapist wants to promote a state of response readiness within the patient, the therapist should be willing to show the same kind of responsiveness. The therapist models a readiness to discern and utilize even minimal patient behaviors and previously unnoticed aspects of the environment. The four scenarios at the beginning of this chapter demonstrate the use of such unrecognized facets of experience.

An assortment of examples of utilization was provided: utilizing something from the environment, like the pressure of the back rest; utilizing something from the patient, such as idiosyncratic language, an appreciation of humor, avoidance of intimacy, the problem sequence, or the symptomatic behavior itself (as Erickson did in the case of my pipe smoking). Even the therapist's family can be used (see (5)) for cases in which Erickson used members of his own family to facilitate treatment). Whatever exists in the environment, in the patient's problem, in the therapist's office, can be utilized. In Ericksonian methods, we take things from the immediate situation and harness them in a constructive direction.

As Erickson would have admonished his students, one of the most important things to be utilized is the unconscious of the therapist. The therapist relies on a wealth of experience that is, in essence, convertible currency that can be used to reach the patient. Even the therapist's handicaps can be used. For example, Erickson explained that polio was one of the best teachers he ever had about human behavior. He used that infirmity constructively. I remember a time after a session when I tried to help him move his wheelchair up an incline. He looked back at me pointedly and explained, No, there are some things a man needs to do for himself. I things watched him struggle to complete the task. It was a way of punctuating the day's message of self-reliance for a young student and making it memorable. In the process, Erickson demonstrated that a therapist's limitations can be used.

Utilization signals that the therapist is an active participant in the process of co-creating patient-based change. He or she is a companion traveler—not a tour guide who metacommends on the inadequacies of patients who repeatedly step into ruts of inefficiency in the process of traversing the rocky path of life. The therapist is actually with the patient for a few of the steps—not merely asking the patient to analyze and understand flaws. In essence, the therapist helps the patient to realize the virtues of his or her faults. A close examination of Erickson's cases indicates that they are studies in the application of the utilization principles.

**THE HISTORY OF UTILIZATION**

The concept of utilization appears in Erickson's early experimental work. Erickson (6) dated the method to a 1943 investigation that used hypnotic age regression to effect therapy. A woman had developed a traumatic phobia of orange juice so that she could not tolerate the smell or sight of oranges. She imposed her problem on others by proscribing their behavior around orange juice. Although she wanted therapy, for some reason, she was ambivalent about accepting it. Erickson utilized the naturalistic social situation of a party to conduct a demonstration of hypnosis, using the phobic woman as a subject. During the demonstration, he regressed her to a time before the orange-juice trauma happened and arranged that she would be given a glass of orange juice, which she drank comfortably. He then gave her an amnesia for the experience. He reported a complete cure as a result of the procedure.

Ernest Rossi (7) dates the concept of utilization to Erickson's recovery from polio at the age of 17, during which time he was paralyzed and confined to bed. While recuperating, he made use of a concept we describe in hypnosis as ideomotor behavior (ideodynamic activity involves thinking about something so intently that actual behavior follows. For example, if you think about a piece of fudge, you can begin to salivate ideosensorily; if you are on the passenger side of the car and you want the driver to stop, you might step on the nonexistent brake ideomotor.) He watched his young sisters learn how to walk in order to reteach himself. By observing them intently, his body remembered how to move the muscles.

The concept of utilization was so important that it appeared in a 1954 definition of hypnosis that Erickson wrote for the Encyclopedia Britannica:

Another essential consideration in the technique of investigative or therapeutic work is the utilization of the subject's own pattern of response and capacities, rather than an attempt to force upon the subject by suggestion the hypnotist's limited understanding of how and what the
subject should do. The failures in hypnotic therapy and experimental work often derive from dealing with the subject as an automaton expected to execute commands in accordance with the hypnotist's understanding, to the exclusion of a recognition of the subject as a personality, with individual patterns of response and behavior (8).

The principle of utilization has been developed and extended by a number of important thinkers, who have carried on traditions initiated by Erickson. References are so extensive that it is possible to mention only a few contemporary contributors.

Erickson and Rossi (9) outlined the utilization theory of hypnotic suggestion; Haley (10) described the importance of accepting the resistance; the Lanktons (11) discussed Erickson's conception of utilizing resistance; Yapko (12) further articulated the therapeutic utilization of the trance state; and Gilligan (13) indicated how the client's individual pattern of expression constituted the basis of establishing trance. Also, Dolan (14) explored the nature of Ericksonian utilization with resistant and chronic patients; de Shazer (15) described how to utilize the patient's history of exceptions; O'Hanlon and Wilk (16) outlined how utilization could be used to design and deliver therapeutic interventions; and O'Hanlon (17) proposed the utilization approach as Erickson's most lasting contribution to therapy.

Suffice it to say that all of Erickson's followers have addressed the principle of utilization and incorporated it into their theories and methods. In fact, it can be said that utilization is to Ericksonian therapy as analysis is to dynamic approaches; as conditioning is to behavior therapy. Utilization is a central facet of the Ericksonian model and can be used in hypnosis as well as psychotherapy.

UTILIZATION IN HYPNOSIS

In practicing therapeutic hypnosis, even using traditional methods, therapists make use of utilization whether or not they realize it. For example, the traditional hypnotist might suggest, With each breath you take, with every sound you hear, you will go deeper and deeper into trance. In this utilization technique, something from the environment is associated with the goal of going deeper into a trance.

In the Ericksonian approach, a therapist works to elicit resources from the patient, rather than authoritatively programming suggestions into a supposedly passive person. Rote hypnotic techniques are eschewed in favor of utilization methods that automatically individualize treatment. Following are six utilization techniques (see also 2).

Ratification

The process of trance induction customarily involves two progressive steps: absorb and ratify. First, the patient's attention is absorbed in a sensation, a perception, a fantasy, a memory, and so on. Then this absorption is ratified: Changes that happen as the patient became absorbed are acknowledged through simple declarative sentences. For example, the therapist might reply, As you have been listening to me, your pulse rate has changed; your breathing rate is different; your head is no longer in the same posture that it was before. The utilization method of ratification has the implicit meaning, You are responding; you are showing desirable changes.

Attribution

Attribution is an indirect form of utilization related to ratification. Ratification specifically implies hypnotic responsiveness; attribution assigns additional meanings that can be used for more general goals. Consider carefully this offering to the hypnotized patient who is slowly nodding his head: You're nodding your head differently now because your unconscious mind has its own way of agreeing. Here, the patient's emitted behavior is given an implied meaning-in this case, Your unconscious mind is cooperating with me.

Symptom Prescription

Using symptom prescription, the therapist encourages symptomatic behavior and then subtly shapes it in a desired direction.

Here is an example from my own experience. As a master's degree student (prior to my first visit with Erickson), I had a psychiatrist supervisor for my practicum. I asked him if he would teach me hypnosis. He invited me to his office and motioned me to sit down. I was nervous. As I sat in his office chair, I unconsciously rolled my fingers on the arm of a chair. Picking up on that, he quickly suggested, You can tap your fingers more quickly. And as you tap your fingers, notice the rhythm of the movement; notice how it changes. As the rhythm slows down, you can take a deep breath, close your eyes, and go into a trance.

This was my first personal experience with utilization. It was so interesting to me, as utilization experiences tend to be, that I remember that incident as vividly today as when it happened 18 years ago.

Incorporation

Incorporation is a variation of utilization technique, similar to ratification and attribution. One can incorporate disparate things from the reality situation into the induction pattern. For example, if a door suddenly opens during an induction, the therapist can say, You can constructively open disparate things from the reality situation into the induction pattern. The therapist often has the therapeutic goal of helping the patient show a constructive response to outward events. If the therapist wants the patient to develop the ability, he or she can model it, for example, by utilizing incorporation.

Hypnotic Redefining

Another utilization technique is hypnotic redefining. If a person describes an aspect of the problem as being the experience of pressure, in the induction of hypnosis, the therapist can begin orienting the patient to the pressure of the support of the chair, the back rest, arm rest, leg rest, and so on. Thereby, the concept of pressure is subtly redefined in more positive terms, and a symptom word is used as a solution word.
Symbolic Injunction

In traditional psychotherapy, the practitioner often interprets the symbolic behavior and idioms of the patient. If the patient states, My neck hurts, the therapist might interpret the patient. Who is being a pain in the neck to you? Interpretations of this sort follow from the traditional psychotherapy, which extols the importance of conscious understanding.

In Ericksonian fashion, therapists could apply the utilization method by thinking, If a patient can communicate symbolically, then I can be equally intelligent and communicate symbolically to the patient. Instead of interpreting symbolism, I can use symbolic processes constructively and create therapeutic symbols.

For example, during an induction, Erickson placed a hypnotized woman's left hand on her right bicept (18). Her posture then became one in which she seemed to be hugging herself. The symbolic message was You can protect yourself; you can comfort yourself. Subsequently, Erickson used that reference experience.

Here is another example. In doing an ego-building induction, I suggested: As you go into a trance, your head is aligned straight and can feel good on your shoulders. Your head can seem further away from your feet. Your left shoulder can seem further away from your right shoulder. Symbolically and idiomatically, having a straight head, a good head on your shoulders, feeling tall, and being broad shouldered are somatic aspects of positive self-esteem. The hypnotic communication forms may seem primary process, but in trance, patients can be more literal in their response pattern. Also, indirectness adds to the drama and thereby may enhance the effectiveness of the suggestions. An important proviso is in order here: In hypnotic utilization methods, as with all techniques, communication is judged by the response of the patient, not by the cleverness of the structure. If a positive response to the implication is not forthcoming, the therapist proceeds with a different technique.

Having examined some methods of utilization in hypnosis, discussion can proceed to the use of utilization in individual and family therapy.

UTILIZATION IN INDIVIDUAL AND FAMILY THERAPY

Utilization techniques can be extended from hypnotic induction to psychotherapy conducted without a formal induction. Here is a case example.

LEAVE NO STONE UNTURNED

I had a patient who suffered from what I thought was depression. She explained to me, however, that she had psychosomatic problems. I did not interpret her psychosomatic problems as masked depression. Instead, I asked her to carry around a rock. She could find a fist-sized rock, paint it black, and carry it around for 10 days. After I returned from traveling, she would see me in two weeks for the next appointment. This patient knew she could expect some seemingly unusual assignments from me, and she readily accepted the task. At the second interview, she indicated she had done the assignment and had carried around the rock. I inquired what she had done with the rock after the 10 days. She replied, I really didn't know what to do with the rock, so I put it in my husband's library. I said, You know, I think it would be good idea if we did some couples therapy and got your husband involved in the next session.

I merely traded symbols. She gave me a symbol (her psychosomatic problem), and as a matter of kindness, even as a matter of politeness, I returned a symbol: I suggested a black rock, which I thought would symbolize depression. Actually, the problem was not so much depression as it was a couples issue. She symbolically corrected my misinterpretation when she chose a place to put the rock.

Essentially, my intervention was to utilize a symbolic process. Then I could monitor the response to my symbolic task and appropriately adjust my method. The following is an example of utilization in family therapy.

UTILIZING THE TOOTH OF THE TIGER

Fred, an obnoxious 10-year-old, was obstinate, attention-seeking, and negative. He would not sit up straight on the office chair. Rather, he reclined in odd postures or sat on the floor. Frequently, he was disruptive, and he was consistently argumentative when confronted. Fred was unpredictable; he would not anticipate the consequences of his actions or take personal responsibility for his behavior. His tantrums were major league.

As I observed him interact with his parents in a family therapy session, three patterns of behavior were especially noticeable: (1) his use of distraction to get attention; (2) his oppositional behavior; and (3) his ability to find a flaw in anyone's argument.

Fred's stepmother told him that if he simply would sit in the chair and engage in conversation for 10 minutes, he would earn back one of the numerous toys he had lost at home as a result of infractions. Fred made a meager attempt to comply. I picked up on Mom's challenge and asked Fred if he could distract, say the opposite of what I said, and/or find a flaw in my position. He argued that he could. I had some doubts. I explained that if he could do these three things, he would earn one point. His father added that if he earned five points, he would get back a toy.

We conducted one trial to be certain that Fred clearly understood the rules: I would provide a stimulus sentence and he would respond with distraction, the opposite, or by finding a flaw. After a few stimulus sentences, it became clear that Fred was very good at finding flaws. In fact, he was better at finding flaws than he was at distracting or being oppositional. However, I insisted that he practice all three methods, and because he was so insistent on finding a flaw, I indicated that there would be a fourth technique, which would be to repeat the last technique, thereby demonstrating that he could stubbornly stay in a rut.

After a few trials, we changed the rules of the game so that he would do each of the four operations in order. First, he would distract, then he would say the opposite, then he would find a flaw, then he would stay in a rut. My stimulus sentences were primarily empathic in content because Fred demonstrated little ability to identify feelings. As the session
progressed, I changed stimulus sentences. At a juncture, when Fred was required to be oppositional, I said to him, You can't control your own behavior. He replied, I'm sitting still now.

The game looked like fun, so Mom took a turn at giving stimulus sentences; then Dad took his turn. During the time that he was in the office, Fred redeemed 11 toys. At the end of the session, Fred looked up at me and offered a charming Thank you. It was the first nonconfrontational communication he had directed to me. Previously, Fred's patterns of behavior had served to alienate him from others. I utilized these behaviors to promote closeness. They became a game. In the process, Fred demonstrated that he could control his behavior that, in fact, he had exquisite control. Moreover, the patterns became clearer to his parents, who began to feel as if they had some tools with which to proceed.

This game was merely one component of a comprehensive therapy with the family. In this case, the identified patient was addressed directly, using a modified symptom-prescription technique. The therapeutic intent was to establish some control and good will in a chaotic situation. Subsequently, these changes could be developed within the family.

Having examined utilization as a concept, having described its history, and having indicated examples of its use in hypnosis and therapy, next examined will be what I call the principles of utilization.

THE PRINCIPLES OF UTILIZATION

Principle No.1. The therapist's induction comes first. The first step of treatment in an Ericksonian approach is not to induce the patient into hypnosis; rather, it is to induce the therapist to utilize. The therapist initiates therapy by assuming a mentality of utilization, by accessing within himself or herself a readiness to respond constructively to the patient's responses. This externally directed state was a central facet of Erickson's presence. He was alive to the intricacies of the moment and interested in harnessing them.

Principle No.2. Whatever the patient brings can be utilized. Whatever exists in the therapy situation can be utilized.

Whatever the patient brings is not grist for the mill. It is fuel to propel forward into new space. The patient's values can be utilized; the patient's situation can be utilized; the patient's resistances can be utilized; the patient's symptom can be utilized. Examples of utilization methods in each of these cases were presented above.

It is also true that the mechanism by which the symptom is maintained can be utilized. It is axiomatic that although symptoms appear to occur automatically, actually the patient does something to maintain the symptom. For example, depressed people do something to maintain their depression. It is best to think of depression as something that one does, not something that just happens. The therapist can think, How is the patient doing depression? Once the mechanism that the patient uses to do the problem is discovered, it can be utilized. An example of utilizing such a mechanism was the sequence induction presented in Situation 4.

Principle No.3. Whatever technique any patient uses to be a patient can be harnessed by a therapist.
Techniques do not come merely from a book; they can be developed from studying patients. For example, if a patient tells stories to be a patient, the therapist can tell stories to be a therapist. If a patient is confusing as a patient, the therapist can be confusing constructively (19).

Take the example of stammering: A patient might stammer as a problem. The therapist can stammer with any patient as a therapeutic maneuver. I have used a technique of stammering constructively in conducting hypnotic inductions with nonstammering patients. I suggested, Hypnosis can be imagined and experienced as a present ... uh ... pleasant feeling. And as you go ... uh ... grow ... uh ... go inside, you can enjoy it in many ways. In this case, the patient can respond to any of the words on which I stammered. The experience can be pleasant or present; the feeling can be one of glowing, growing, or going inside. My stammer energizes the suggestion by making the key words stand out.

Principle No.4. Whatever responses you get, develop them.

The following case illustrates a number of utilization principles and techniques. It also illustrates how to develop a response. Once the patient responds, it is the job of the therapist constructively to develop and harness the response. It is as if the therapist takes any bit of gold the patient provides and then helps to fashion it into something useful.

Erickson (20) made a house call on a patient who was dying of cancer. Her internist invited Erickson to consult with Kathy because she was in severe pain and unresponsive to conventional treatments of the day. When Erickson arrived, Kathy was lying on her left side in a fetal position, chanting. Don't hurt me, don't scare me. Don't hurt me, don't scare me. Don't hurt me, don't scare me. How might this patient be approached? Should the therapist disrupt the patient by saying, Excuse me, I am your consultant? I'd like to talk with you. Could you please stop chanting? Put yourself in Erickson's position: If you practiced hypnosis, would you say, Excuse me, I know you are chanting, but would you please stare at a spot on the wall so that you can go into a trance? In contradistinction, what would a therapist do who was wedded to the idea of utilization? Erickson looked at Kathy and said, I'm going to hurt you. I'm going to scare you. I'm going to hurt you. I am going to scare you. I am going to hurt you. I am going to scare you. Kathy replied, But I don't want you to hurt me. Erickson continued, But I've got to hurt you to help you. I've got to hurt you to help you.

Erickson then induced a trance by using an elegant technique of utilizing Kathy's memory. He told her, Kathy. I can not explain to you all of the things I am going to do, but I'd like you to remember what it was like when you turned over from your left side to your right side. Close your eyes, and really remember what it was like to turn over. Erickson utilized Kathy's memory of pain as an absorption device to facilitate hypnotic induction.

Kathy told Erickson, I'm on my left side; I think I'm on my left Side. Erickson continued, Kathy, I'd like you to go
inside and develop the most horrible, the most intolerable, the most awful itch that you can possibly develop in the base of your foot. Kathy tried and failed: I'm sorry Dr. Erickson, I can't develop a horrible itch in the base of my foot. All that I can get is a sort of horrible numb feeling.

It was at this point in which Erickson developed her response: Well, that's all right, Kathy. What I'd like you to do is to develop that numbness and allow the numbness to spread over your legs, across your hip, up your body, and into your arm, but not in that area where your left breast used to be. Kathy developed a generalized numbness. Erickson was expectant and response ready. He would utilize whatever Kathy developed in reaction to his offering. If Kathy had developed tingling instead of numbness, he would have used that. If she developed nothing, he could have used that; for example, Kathy let the nothingness spread up her body. Erickson also used Kathy's psychology. He left an area discomfort (one breast), knowing that patients must often take out feelings on themselves, he left that possibility intact.

Utilization is an ongoing process. It is not something that the therapist starts and stops. The therapist's attitude of utilization is developed throughout the treatment and is integral to the process of therapy.

Figure 1. The Ericksonian diamond.

UTILIZATION IN THE PROCESS OF THERAPY

The following metamodel is based on a structural communications approach. This approach uses social influence to harness structures existing in the present, including intrapsychic, interspersal, and environmental structures, in order to achieve future goals. It is a model that addresses how to elicit change, rather than analyzing why people are as they are.

Figure 1 shows a diagram of the model. The aspects of this model can be presented and examined only briefly here. In addition to the principle of utilization, there are four other components: (1) setting the goal; (2) gift wrapping, (3) tailoring, and (4) establishing a dynamic process.

SETTING THE GOAL

The therapist begins therapy by setting the goals and asking himself or herself: What do I want to communicate to the patient?

The particulars of establishing goals for any specific psychotherapy are numerous. There are two methods that I commonly use: making the problem into a process and dividing the solution into manageable bits.

1. Making the problem into a process. If one views the problem as a sequential process, often avenues for intervention become immediately apparent. A goal of the therapy would be to help the patient modify the habitual sequential behavior that leads to the problem. Perhaps the therapist could accomplish this by adding a step to the sequence. For example, with a smoking problem, a patient can be asked to stroke his or her arm prior to inhaling, thereby adding a step to the habitual sequence. If the intervention is sufficient, systemic change can follow. An underlying premise is that patients will gravitate toward more healthful, effective patterns once an habitual sequence is modified.

2. Dividing the solution into manageable bits. This method of establishing goals requires the therapist to determine how the patient accomplishes the problem. For example, if the patient has been lowering his or her self-esteem, the therapist can wonder how that process is accomplished. Perhaps, among other things, the patient does not trust himself or herself, does not trust others, directs attention inward, and finds personal flaws that he or she exaggerates. These maneuvers can be conceived of as sensible things to do to achieve a goal; that is, if the intended outcome is lower self-esteem, it would be wise to distrust oneself, distrust others, be internally preoccupied, and find exaggerated flaws. The solution would be the reciprocal (opposite) of the problem strategy; namely, trust oneself; trust others; be aware, rather than withdrawn; and find internal strengths. Each of the components of the solution could be treated as a separate goal to be addressed and elicited. Once a patient trusts himself or herself, trusts others, enjoys awareness, and finds internal strengths, then overall self-esteem improves.

Once the therapist has a goal in mind, the next step is to find a way of presenting the goal to the patient. I call this process gift wrapping.

GIFT WRAPPING

If the therapist has a component solution to present, a method is needed to offer the strategy to the patient so that the patient can retrieve that previously dissociated ability. For example, take external awareness as a goal. The therapist can gift wrap the idea be external in many ways. The therapist can direct the patient. Open your eyes, look at the world, and be aware of and notice things around you. In my experience, however, patients resent paying an hourly fee for that kind of advice. Rather, the solution segment can be gift wrapped by presenting the theme within a technique rather than directly. One way of gift wrapping an idea is to present it under hypnosis.

A newspaper reporter interviewed me last December for an article on hypnosis. She inquired, Dr. Zeig, what is hypnosis? I replied, being seasonal, Structurally, hypnosis is merely one way of gift wrapping ideas.

Solution components can be gift wrapped by using hypnosis, symbols, metaphors, symptom prescription, anecdotes, reframing, and so on. These techniques are powerful formats for offering simple ideas. The therapist wonders, How can I present the goal? and then decides
upon a technique. As has been implied, techniques are selected by using methods to which the patient commonly or historically subscribes.

The process of linking solutions and gift wrapping can be considered psychotherapy by reciprocal association. The therapist's technique associates the patient to a solution component, which is elicited via the ideodynamic effect. Gift wrapping is selecting a technique with which to offer ideas. It is not enough merely to gift wrap solution components. It is best to individualize the therapy. The process of addressing the unique style of the patient is referred to as tailoring.

TAILORING

The therapist who is kind enough to gift wrap an idea for a patient can further improve the presentation by tailoring. It is nice to have a present, but if the present is individualized, it is even nicer. And it is more effective. Erickson emphasized the point by saying, Psychotherapy for Patient A is not psychotherapy for Patient B.

To tailor, the therapist thinks, What does the patient value? What is the position that the patient takes? What is the patient proud of? Subsequently, the therapist individualizes the approach. For example, if the patient values adventure, therapeutic tasks can be done because they are adventurous. If the patient values slow understanding, the therapist can conduct slow therapy.

Let us go back to the goal of external awareness. If the patient is intropunitive (hard on himself or herself), the therapist could suggest, I want you to be more aware because it will be really hard on you. If the patient is extropunitive (hard on others), the therapist can suggest to the patient, I want you to be more aware because it will be hard on those around you. Thereby, the therapy is tailored to the patient's values and world view (21). The therapy is filtered through the patient's inner lens. Sometimes the tailored therapeutic offering does not make logical sense. However, it may make emotional sense to the patient because it fits the patient's model of the world.

After determining a strategy for tailoring the technique, the therapist needs to create a method for presenting the offering over time. This method could be considered processing.

PROCESSING

It is not sufficient to identify the goal and create a way to gift wrap or individualize it. In addition, the therapist works to create a process, a drama, through which the goal is offered. This process (Figure 2) involves a period of time, a time-line sequence of psychotherapy, that seeks optimally to evoke and utilize the patient's internal and social dynamics. The therapist begins by evoking the patient's motivation, which is then shaped into responsiveness, especially to subtle cues. This is a way of working the soil so that it is fertile. The step of building responsiveness can also be thought of as conducting an induction.

Throughout the process, the therapist has in mind a tailored main intervention. This could be a symptom prescription, ordeal, or anecdote. Rather than moving directly to the main course, however, the therapist seeds the main intervention by creating an indirect illusion to the technique that is to follow. Basically, this is a method of foreshadowing (For more information on seeding, see 22). Next the therapist proceeds in small steps toward the main intervention, which is succeeded by a period of follow-through. This procedure has been named SIFT (5). The therapist moves in Small steps, Intervenes, and then Follows Through. Processing makes therapy into a Significant Emotional Experience, SEE (23), around which change can constellate.

WHY UTILIZE?

Utilization is a bridge between setting goals, gift wrapping, tailoring, and processing. To set goals, the therapist can utilize the patient's ability to divide the problem into component bits, so that the reciprocal of each becomes a mini-goal. To gift wrap, the therapist can utilize the technique that the patient uses to be a patient. To tailor, the therapist utilizes what the patient values as a motivator (... because it would be hard on you). To create the process, the therapist utilizes the sequence that the patient uses to create or experience a problem. All good communicators in any field utilize.

In the psychotherapy arena, utilization energizes therapy and makes it engaging. Utilization is respectful of the patient; it recognizes the patient's individuality. Utilization also encourages the patient to be alert and it keeps the therapist alive to the moment.

I remember when I first went to see Milton Erickson in 1973. At this point in his life, he was confined to a wheelchair and was in constant chronic pain. He had his own way of personalizing the philosophy of utilization. He said proudly, I don't mind the pain. I don't like the alternative.

Erickson would start the day slowly speaking through his
pain. I was energized and glad to be visiting him. I strained to catch his every word, his every nuance. I tried to classify in my mind all the different techniques he was using. I wondered to myself, How is he effecting utilization now?
As time went on, I got wearier. I could not cognitively fathom all the things that he was doing. As the hours passed, Erickson became further removed from his pain. Perhaps he was utilizing his interest in talking to me as a distraction technique. In any case, he became even more animated and alert. At the end of the day, I was worn out and Erickson was energized!

This leads me to posit the criteria for successful therapy. If the therapist feels better at the end of the session, probably it was a good one. And for the therapist to feel better, the concept of utilization is often central.

The metamodel has now been presented in its most general form. Treatment is based in the present and directed toward the future. The model's basic philosophy is that there are few new (profound) things to say to patients; there are, however, new (profound) ways to say what patients need to hear. To subscribe to this approach may require a modification in a therapist's definition of therapy.

REDEFINING THERAPY

Utilization requires a new definition of therapy in which it is no longer viewed as education or analysis of what is going on in the understructure of the patient's unconscious or family system.

To the practitioner of utilization, therapy becomes an appeal. Therapy is about appealing to the constructive history. Patients are seen as having what is needed to solve the problem in their experiential background. Every smoker knows how to be comfortable without a cigarette. Every schizophrenic knows how to communicate cogently. These talents exist in the patient's history. The therapist assumes that the patient has a history of functioning adequately and effectively. Therefore, the therapist does not have to teach the patient how to be adequate. Rather, the job of the therapist is to help the patient unlock the constructive history that is dormant. Therapy becomes a process of stimulating resources into play-resources that have been long closeted.

In Erickson's terms: Psychotherapy is the reassociation of internal life.

REFERENCES