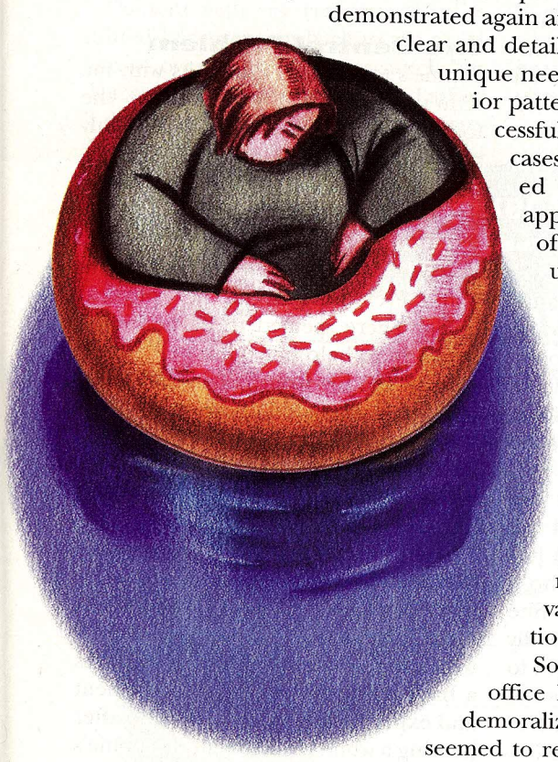
BY DAN SHORT

Erickson's Legacy

Strategic therapy rests on skillful information-gathering

MILTON ERICKSON HAS BECOME a legendary figure among therapists for his skill in standing the traditional idea of "resistance" on its head. With his keen observational skills and his grasp of the multiple dimensions of people's lives, Erickson demonstrated again and again that getting a clear and detailed idea of his clients' unique needs, beliefs, and behavior patterns was the key to successful therapy, especially in cases that hadn't responded to more traditional approaches. Known most of all for his strategic use of existing personality features, he carefully utilized every bit of information he gathered from the client. The case that follows, inspired by his approach, shows the unfolding of a strategic approach as more and more relevant clinical information emerges.



Sophie entered the office looking defeated and demoralized. Every movement seemed to require effort. She had dark rings under her eyes, her short hair lay flat on her head, and she was obese. The therapist who'd referred her expressed concern that her depression was worsening, despite a regimen of antidepressants and supportive counseling.

On her small frame, Sophie carried 191 pounds. "My arms are larger than most men's thighs," she said wearily. During the previous 12 months, she'd watched her weight increase as her motivation for self-care decreased. Treatment wasn't working—even the mental health experts didn't seem to be able to help her—which made her situation seem hopeless. She was slowly sinking into a dark place, from which she could see no escape.

So I asked her, "Will you tell me what it is about the problem of weight that causes you the most distress?" As is often the case, Sophie surprised me with her response. Depression, she said, was the most loathsome consequence of her obesity, because the condition forced her to take antidepressant medication and, as she put it, "These drugs make me feel like I'm not living in my own body." Then she added, "But no one will work with me unless I take medication. What's your opinion?"

I suspected that the question of whether to take medication was an issue of power and control, just as her eating disorder was. In both cases, she felt that she had no control over what went into her mouth, and no more ability to say no to a doctor than to stop herself from overeating. I didn't want to be just one more authority figure telling her what to do.

Nevertheless, Sophie wanted an answer, as well as validation. So I chose my words with care, "I'm not licensed to practice medicine. It isn't appropriate for me to tell you to take medication or to stop medication." Then, leaning forward for emphasis, I continued, "I can only give you psychological advice. And my psychological advice is that you do everything you can to take care of your body."

One of my basic strategies in therapy is to tell clients it's okay for them to take care of themselves as best they know how. This blanket permission was intended to avoid a covert power struggle, help Sophie access her own latent resources, and validate her fundamental right to take care of herself.

Hearing this, Sophie seemed more animated. She began telling me how miserable she was on her medication, of which she'd tried a variety. She'd been depressed most of her life, with good reason. Her mother had abused her, as had her husband, a crack cocaine addict, until the day she found him dead, having committed suicide. "After his death, I gained 40 pounds," she said. "At this point, I've experienced a complete loss of motivation. I can't make myself exercise, or even clean my house."

I let her continue telling her story uninterrupted until she seemed content to stop, then told her I was sorry that she'd experienced such terrible events. People like Sophie, who've been abused since ►

childhood, tend to blame themselves for all the bad things done to them, and often have never been told that they don't deserve to suffer. I don't like to focus on the past or on a person's symptoms, but people shouldn't suffer alone, so I listen to these stories with respect and acceptance.

Then, I inquired about her goals. "Now tell me, what do you really want?" Suddenly, a different Sophie appeared. With energy in her voice, she said, "I have eight grandchildren who I absolutely adore. I want to be there for them. I'm also good at my job and like the recognition I get. I don't want to be forced to do things I don't want to do. I don't want to be forced to take medication! I want to get off my blood-pressure medication. I want to be able to eat food and enjoy it. I want to live life." She paused, "I want you to use hypnosis to make me lose weight."

Sophie wanted me to "make" her lose weight. The only way she could see herself succeeding was for someone to take control. This put me in a bind. After a lifetime of resenting always being told what to do, she'd resent me, too, if I did as she asked. At the same time, refusing her request would only add to her sense of powerlessness. So I replied, "I'll agree to use hypnosis with you, as you've requested, but first you must get your weight down to 185 pounds." She stared in confusion: "But how?"

"Use any means that you can believe in." By saying this, I was able to show a willingness to do what Sophie asked of me, as long she demonstrated a willingness to cooperate. I learned from Erickson that, while therapy should help a person learn to believe in his or her capabilities, it's this spirit of cooperation that gets the client's energy activated.

For her second visit, Sophie entered my office making jokes about her progress. She'd lost eight pounds in seven days! She held out her hands and feet to show me that they were no longer swollen. "I think all eight pounds were water." She attributed her rapid success to her own decision to stop taking antidepressant medication. Ironically, by exercising her right to take care of herself, as suggested, she'd helped herself by rebelling against the people seeking to help her.

As the session progressed, Sophie described deep feelings of worthlessness and a chronic need to punish herself. "I know I set myself up to be in an unhealthy relationship and stay in it. I somehow just have to keep hurting myself," she insisted. Because it seemed highly unlikely that I'd be able to convince her otherwise, I decided to use her existing belief as a therapeutic contingency.

After asking her to close her eyes and go into a trance, I stated in a frank tone of voice, "You've made it clear that you're unable to stop punishing yourself, so you might as well face the facts and punish yourself with clear intention. You feel very little self-worth. You'll spend more money than you can afford buying gifts for others, but you won't buy anything nice for yourself. I know that it's almost painful for you to do anything kind toward yourself. Therefore, this upcoming week, you're to punish yourself with acts of self-kindness!"

The strategy here is that, if a negative behavior can't be stopped, it should be made useful by connecting it to something positive. One of many benefits of this approach is that it helps clients feel less helpless and less antagonistic toward their behavior.

Starting the third visit, Sophie was smiling and laughing as she told me about a very positive review she'd just gotten from her supervisor, who'd called her a "model employee." She looked healthier. She told me proudly that she'd been feeling less of a need to punish herself, and that her internal voice was less condemning. She'd also bought herself a new bedroom suite.

Then, without my asking, Sophie shared some very painful information about her mother. Eyes cast downward, she said, "She was physically abusive." I could tell from her eyes and posture that she didn't want to say any more. She'd been thoroughly conditioned as a child to respond to authority with slavish obedience, but making her talk about painful memories wouldn't be different from forcing her to take a pill she didn't want. Neither of these are intrinsically problematic, but when this type of client feels forced by the therapist to suffer through a healing ritual, then there's risk of creating greater amounts of depression. Following a lifetime of education in learned helplessness, Sophie needed to see that she has choices. So, after a brief pause, I asked her what she'd like to use the rest of our time talking about.

She raised her head and a smile shot across her face. "I made my phone call to get signed up at a gym!" she replied. We spent some time marveling over this wonderful accomplishment and her stunning progress in therapy, and then talked about possible solutions for her problems with one of her daughters and a grandchild for the rest of the session.

The Central Problem

Sophie's fourth and fifth visits with me didn't go as well. She came into the fourth session criticizing herself harshly and left doing the same. "It's my complete lack of self-discipline that keeps me fat," she doggedly insisted. At the start of the fifth visit, she was still clearly in an unhappy state, insisting that she hated everything about her physical being. There seemed to be nothing I could do to help her think well of herself. All the joy from her initial breakthrough had faded. It seemed as if Sophie was sliding back into the darkness that had dominated most of her life. I was reaching out with a helping hand, but didn't know where to grasp.

Then I remembered one of my basic therapeutic guidelines: whenever you're uncertain of what to do, collect more information. Like riding a teeter-totter, highly complex therapy requires a back-and-forth process of assessment and experimental intervention. So after pausing a while to silently study Sophie's demeanor, I decided to risk a question designed to stir up emotions and, hopefully, help me better understand her needs: "Sophie, what secret are you still keeping from me?"

Hearing my question, Sophie regressed. It was as if the reply were coming from the lips of a 6- year-old child. "I dirty my panties," she whispered. In short, fragmented sentences, she alluded to problems with involuntary discharge of urine and feces, which she'd suffered with intense shame for decades.

After sharing such a carefully guarded secret, the most urgent question in Sophie's mind must have been, "Will he now reject me?" I wanted to communicate complete and total acceptance. However, it would have been impossible to show I accepted her fully, even with her problem, if I immediately tried to fix or eliminate it. So, I looked directly into her eyes and told her warmly that I was very pleased she'd found the courage to share her secret with me.

She visibly relaxed. My response seemed to communicate that, whatever her circumstances, she was fundamentally alright as she was.

Content with my response, Sophie shifted her attention back to the problem of overeating. This was much less distressing for her to talk about. I asked if there was a food that she felt was irresistible. Sophie responded without delay, "Krispy Kreme donuts!" Merely talking about the donuts seemed to create excitement in her. I asked if it seemed logical that once cured of her addiction to this most irresistible food, she'd be able to gain self-control in relation to all other foods. Sophie agreed that this made sense, but as she put it, "There's no way you can get me to stop eating Krispy Kreme donuts."

I agreed with her, but qualified her statement. "There's no way I can get you to stop eating Krispy Kreme donuts unless you give me permission to. If you give me permission, then I can help you end the addiction this week, and it won't even require the use of hypnosis."

Sophie shook her head. "This is my week to go on vacation to Puerto Penasco. My favorite thing to do there is to treat myself to all the wonderful greasy food you can buy from street vendors."

I responded enthusiastically. "This is perfect! All you have to do is give me permission to intervene, and then follow my instructions as fully as possible."

Sophie cautiously agreed, so I explained the intervention. "After you leave my office, buy yourself half a dozen Krispy Kreme donuts. Take them home and put each donut in a baggie. You leave for your vacation tomorrow, so you can pack the donuts in your suitcase tonight. While on vacation, eat all the food you want during the day. Don't deny yourself anything. Then each night, just before you brush your teeth, pull out one of the baggies and eat a Krispy Kreme donut. Do this every night. It'll be difficult, but do your best to eat all six donuts."

To understand the logic behind this intervention, it's important to recognize the large number of failure experiences Sophie had accumulated while trying *not* to eat this type of food. She was waiting for me to ask her to do something that she knew she couldn't do, and if I had, the exercise would have doomed her to more failure. However, asking her to do something which she believed she couldn't stop herself from doing was a safe way of laying a foundation for hope.

Sophie looked at me with an incredulous stare and said, "You just don't understand how much I love these donuts." Then she agreed to give the exercise a try.

Sophie came in for her sixth session wearing a mischievous smile. After exchanging a few pleasantries, she caught my eyes in a sideways glance. "You already know that I'll never again eat Krispy Kreme donuts, don't you?"

With a chuckle, I confessed, "I've had the unhappy experience of eating old, stale, soggy donuts out of plastic baggies. It really ruins your taste for donuts!"

Then she confessed. "I stopped eating them after the third one. I thought to myself, 'There's no way I'm going to eat these things, no matter what Dr. Short says!'" The situation was comical and Sophie was enjoying herself. Even more important, she'd learned she could look in the face of an authority figure and joyfully confess that she'd followed her own will, not his.

The Power of Hope

Having shifted toward an internal locus of control, Sophie confidently declared, "Once I get disgusted with something, I'll make whatever changes I need to make." She was now ready to take on the central problem, so I asked one last set of questions before discussing an intervention. I wanted to make absolutely certain I had an accurate understanding of the situation.

"I'm sorry to have to bring up this unpleasant topic, but I feel that I need to know a little more about the problem of your dirtying your panties," I said gently. I didn't want to be in a position of trying to help her change something I didn't fully understand and, at the same time, I didn't want to shame her in any way.

As she talked more about this, it turned out that the behavior dated back to early childhood, when Sophie was severely beaten by her mother after accidentally staining her panties. From that point on, this part of her biological functioning became the focus of obsessive, negative attention. The mother even got the family doctor to examine her daughter for defects, which Sophie experienced as painfully intrusive and mortifying. The doctor told her that she should do Kegel exercises to strengthen the muscles used to hold back urine, which only increased her anxious preoccupation with this part of her body.

Sophie began checking her panties several times a day and hiding them in the trash whenever she thought they were dirty. This habit carried over into adulthood. With a look of shame, she confided, "The problem happens while I'm at work. I hide my panties in the trash, feeling that everybody in the building knows that it's me doing this. It's so humiliating." Because of the problem, she felt horribly inferior to others, and lived in constant fear that somebody might discover her "dirty" secret.

After she finished this sad story, I said, "Would you like me to help you cure yourself of this?"

Sophie's face turned pale. "But it's impossible," she said. But the idea had so riveted her attention that she didn't seem to be breathing.

I responded with great confidence, "Sure it's possible! I can help you initiate the cure in a single session."

Sophie was highly skeptical. "But the doctors have already tried everything. I did the Kegel exercises; they didn't work. When I had my hysterectomy, the surgeon went in and surgically altered my bladder, but it didn't help, ►

either. They told me nothing else can be done."

"The doctors that worked with you can believe whatever they'd like. But I happen to believe that you have perfectly good muscles in your body, and I can prove it to you by asking a single question."

Still fresh from the Krispy Kreme donut cure, Sophie was ready to place tremendous confidence in our alliance. More important, she was ready to be released from the bondage of her neurotic behavior. So I asked a question to which I already knew the answer, "Do you ever dirty or wet your panties during the night?" Sophie shook her head no. I gleefully responded, "There you have it! If your muscles are good enough to hold your urine during eight hours of sleep, then they're certainly good enough and strong enough to hold your urine during the four to five hours between your daytime bathroom breaks."

Sophie began to get enthusiastic, "You mean if I can keep clean at night, then I can keep clean during the day!?"

"Yes," I said. "You just have to give your unconscious mind permission to start using the ability you already have."

With eager anticipation Sophie asked, "But how do I do that?"

I felt there could be added value in helping Sophie say "no" to me. So I indulged my creative side and gave her a plan I thought she'd reject. My plan involved a paradoxical ritual that was likely to work, but wasn't right for her. She quickly exercised her option to reject it.

"Well," I responded, "if you don't want to do it my way, then you can come up with your own plan. We'll have you implement that one first, and if it doesn't work, then you always have my plan as a fallback."

Sophie thought for a moment, asked some questions about self-hypnosis, and decided she'd go to bed each night repeating to herself, "Unconscious mind, make my bowels and bladder work as well during the day as they do at night." She'd repeat this until she fell asleep. The plan was clearly identified as hers, and I conceded that perhaps it was better for her than my plan, which, of course, was true, because it gave her greater agency.

The seventh visit would be my last opportunity to meet with Sophie. She came in smiling and let me know early in the session that she was ready to continue her progress on her own. Raising both arms in the air like an exotic belly dancer, she happily announced, "I feel so good about myself, I hardly care if I lose any more weight . . . but I have a strong feeling that I will." It was clear that things were going well. Interestingly, she didn't bring up the topic we'd discussed in the previous session.

Eventually, my curiosity got the best of me. Apologetically, I asked, "Sophie, it's really not any of my business, so you do not need to answer this question, but I'm wondering how the self-hypnosis worked?" With a coy smile, Sophie cautiously stated, "It came so close to being a perfect week." Then a tear ran down her cheek, "I'm almost too scared to think that it's true."

At first, I misinterpreted her statements. I insisted, "Even just one day of clean panties is a wonderful accomplishment you can continue to build on!"

She interrupted, "No. I made it to the bathroom each time! It's just that I was so scared I'd dirty my panties that I kept running to the bathroom to check. I must have gone to the bathroom 300 times this week, but each time there was nothing there."

My jaw dropped, "Amazing!" I said, "You managed to pull off a complete cure on your first attempt. Congratulations!"

Sophie left the office full of pride and enthusiasm for the future. A year has now passed without her requesting any further assistance.

When a clinician uses a strategic approach to therapy, it means that each interaction is guided by an understanding of what variable experiences the client needs to glean from therapy. To work strategically, you have to get to know the person in front of you. It isn't enough to read textbooks or study group statistics. Most important, it's necessary to recognize that healing emerges from within the client and, therefore, that's where a foundation of hope is constructed.

As this case illustrates, life transformations occur by simply shifting clients' attention away from that which they've failed to do, onto those things that they can, without question, accomplish.

CASE COMMENTARY

By Carol Kershaw

"We tell ourselves stories in order to live," a haunting line from Joan Didion's *The White Album,* came to mind as I read this case by Dan Short. While the hypnotic story his client tells herself is one of obesity and imprisonment by a shameful secret, Short succeeds in focusing her on possibility rather than deficit. As her depression begins to lift, she becomes more interested in losing weight her way. Rather than siding with her victimhood, he sides with her strength and self-empowerment.

As with many overweight patients who begin to have success losing weight, Sophie stumbles and stops her self-improvement program. Short senses there's something unspoken and asks her to reveal the secret. Sophie is relieved to tell the truth to someone who's fully accepting of her problem. Convinced that Sophie has the internal resources to keep from having accidents while asleep, Short helps her develop her own plan for successfully controlling her soiling.

Theory often follows the successes of an astute clinician, and in Erickson's case, there are many interpretations about what he did. While Short emphasizes Erickson's devotion to doing strategic therapy, some people believe he did neurolinguistic programming, and others insist he did paradoxical therapy. Still others focus on the symbolic-communication aspect of his work. In fact, he did all of this and more. He was a master at assessing what clients needed to learn and how to help them do so, no matter how unorthodox the methods required.

Throughout this case, Short mentions some of the general therapeutic strategies that guide his work. But such general strategies must always stand the test of their relevance to an individual case and I had some questions about the overall relevance of some of the strategies he mentions. For example, he says, "One of my basic strategies is to

tell clients it's okay for them to take care of themselves as best they know how." Of course, this isn't something we'd say to a child abuser. Sometimes the best way clients know how to take care of themselves is through harmful measures. A better guideline might be to emphasize the part of the client that wants to make "better choices."

Elsewhere Short says that if a negative behavior can't be stopped, try to make it useful by connecting it to something positive. But the opposite can also work. It can be helpful to suggest the negative behavior is an attempt to learn something and query what that might be.

Short also states that whenever you're uncertain of what to do, start collecting more information. While this may work sometimes, it's frequently more helpful to be quiet and allow your own unconscious mind the opportunity for creative thought, which will also make the client carry more responsibility for change as well.

AUTHOR'S RESPONSE

The reviewer makes an important point that I'd like to further emphasize: skillful therapy requires discernment. It isn't enough to memorize a set of rules and then rigidly apply them to every person who enters the office. Paradoxically speaking, one should never sacrifice learning for the sake of preserving absolute generalizations. ■

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