TWO

Experiential Approaches to Clinician Development

Introduction

"In psychotherapy we struggle endlessly with the fact that most people live fragmented lives. They are preoccupied with the horrors and glories of the past or they are preoccupied with the horrors and the glories of the future. They don't live; they just use their left brain to endlessly think about living. This kind of meta-living is just like meta-communication–the disease that all psychotherapists are suffering from. We spend our lives talking about talking, and many times never say anything …

What is the essential objective of psychotherapy? … maybe it's to get rid of the past (good and bad) and the future (good and bad) and just be. That is, develop your personhood or your capacity to be who you are, wherever you are" (Whitaker, 1982, pp. 495-96).

Broaching the distance from the head to the heart is a problem that concerns therapists of all persuasions. Patients commonly understand their difficulties but fail to take effective countermeasures. However, if clinicians can systematically distinguish between technical or theoretical *understanding* and experiential *postures* or *states*, they more easily can modify the distance between the head and the heart. Moreover, the same distinction can help clinicians develop their own personhood.

I have a number of goals for this chapter, each of which concerns the distinction between technical understanding and experiential realization.

1. I want to reflect on my own evolution as a clinician, with special emphasis on my evolution as a teacher.
2. I want to outline an experiential method of training that I am developing, which is still in its infancy.
3. I want to stimulate clinicians to apply the method both for their own growth and development and as a tool for clinical practice.

Before proceeding I will make three preliminary provisos: One, talking about experiential methods is difficult at best, and deadly at worst. There is too much of a tendency to metacomment, consequently squeezing the life out of vibrant experiences by talking about them. Therefore, I will intersperse some experiential methods into this presentation, realizing that this particular format (print) is more suited to didactic offerings than experiences.

Two, I am going to rely heavily on Milton Erickson as a model. This is not a case of transference; well, maybe there is a little transference. But I have been a student of therapy approaches for quite a while, and I have closely examined the work of masters from many disciplines. However, in the final analysis, Erickson unquestionably has proven to be the most interesting, the most complex and the best clinician I have ever seen, bar none. He had the most extraordinary range in his ability to therapeutically reach diverse types of patients. I am not the only one who has come to this conclusion. Many notable therapists and practitioners have been profoundly influenced by Erickson and his work.

Three, my interest in hypnosis naturally leads me to view things in terms of states. A more recently acquired interest in drama leads me to a perspective on postures. There is overlap between hypnotic states and dramatic postures; they both are inherently experiential. The world of experience, as you will see, is of primary interest.

As an entrée to the world of experiences, let's consider two cases.

Case 1

A couple came to Erickson with the wife's alcoholism as the presenting problem. Her pattern of drinking was covert; for example, she would garden on the weekends and drink from a carefully hidden bottle. The husband counseled, confronted, criticized, and coerced his wife, all to no avail. The wife continued drinking, to her own detriment and to the detriment of the relationship.

It seemed that the husband also had a "little hobby." All weekend long, he sat in the living room reading 'dusty old books, dusty old newspapers, and dusty old magazines.' The wife counseled, confronted, criticized, and coerced her husband, all to no avail. The husband continued his hobby, to his own detriment and to the detriment of the relationship.

In the interview, Erickson discovered two seemingly inconsequential details. The couple had a camping bus they had not used in years, and the couple passionately hated fishing.

Erickson's first intervention was to suggest to the wife that she buy a bottle of whiskey and bring it home. She was to hide it in the house. On returning home from work, the

husband was to try to find the hidden bottle within an hour. If he didn't, she could drink with impunity in the house.

The wife found great delight in finding a place to hide the bottle that no man could find in one hour. But after a few days of this routine, she became disconcerted and her delight grew thin; the couple returned to Erickson.

To the couple's dismay, Erickson directed them to go fishing. When they declined, reminding him of their distaste, he insisted. Ignoring their mounting protests, he became adamant about his directive. Finally, they asked why it was so important to go fishing. "Well," he said, "it's the only correct therapy for you. Wife, if you are in a boat in the middle of a lake, there is no place to hide whiskey. Husband, if you are in the boat in the middle of a lake, there is no place to bring books, magazines, and newspapers. Go fishing!"

The couple rebelled. Instead, they went camping. In doing so, they rediscovered a mutual hobby. They also rediscovered an interest in their relationship. He voluntarily relinquished his isolation. She voluntarily gave up alcohol. They changed on their own initiative; Erickson merely established a climate in which they could examine and alter their behavior.

Case 2

A businessman, caught up in a large deal, came to me complaining of anxiety. When I asked him to specify the feeling, he reported it as "a stone-like sensation" in his chest. When I asked for the internal dialogue that preceded the stone-like feeling, he couldn't identify it. And this was an articulate, psychologically aware man who previously had been excellent at describing his psychodynamics.

I initiated discussion of the topic of reassurance. I asked what kind of reassurance would help him, what kind he needed to hear. He remembered his father, a central figure in his life. His father would tell him that he had done the proper amount of work, "not too little, not too much," therefore, he could "rely on his intuition." The patient was a little older than I, but I straightened up and said, softly but commandingly, "You have done the proper amount of work on your deal. I know it. You've discussed it with me. You can rely on your cunning [something he valued] and your intuition." He started to blink and then closed his eyes.

I told him the story about a dream I had in 1980, prior to the First International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, which was held as a tribute to Erickson. I was the organizer of the Congress. It was the biggest event that I had undertaken; I was only 33 years old, anxious and inexperienced.

In the dream, which occurred the night before the Congress, Erickson, who was confined to a wheelchair when I knew him, walked up to me and hugged me. In the dream, he

said, "I love you." I memorized the phrase. I memorized the feeling of Erickson's body against mine. I awoke, proud of my unconscious mind for supplying the image. On subsequent days, when I proceeded into meeting rooms and when I encountered anxiety, I would bring back the dream including its words and the feeling it produced.

Then I offered another story about how I would ask a friend to hug me before a big presentation. I would remember the hug on stage.

After I finished my stories, the patient opened his eyes and segued to the idea that he was going to see his father's grave because the ten year anniversary of his father's death was approaching. I suggested that he could take something from his yard, perhaps a stone, to the cemetery with him. He could hold the stone against his chest and then place it on the gravesite.

Accordingly, I talked with the patient about the importance of symbolism. I described some of the symbols in my office, a number of which were from Erickson. I indicated how I had incorporated Erickson as a symbolic father in many respects.

All along I was directing my clinical intervention at the following questions. How could I help this man modify the sensation in his chest? How could I help alter its meaning, form, substance, and so on? How could I help him change the associations underlying the difficulty?

As the man left my office, he talked about his girlfriend, someone I knew to be important to him. I also knew that he highly valued her supportive hugs. His girlfriend had decided that the picture of his father that had hung in his office should be moved to their home, where all the other family pictures were. As he was walking out of my office at the end of the session, he mused, "I don't think she is right in this case. It would be better if I took the picture back to my office." I took his comment as symbolic confirmation of the effectiveness of the therapy.

For a moment let's suspend customary thinking, which in these cases would examine the dynamics of theory, practice, or even the therapist. Instead, let's consider the posture of the therapist and pose two questions: (a) What position does a clinician take to intervene thusly? and (b) Can a clinician systematically develop the perspective, power, and social role to offer such treatment? If so, how? Let's answer these questions by using Erickson as a model.

Ericksonian Postures

To consider the therapist's posture, I will briefly describe four clinical postures of Erickson: *creating experiences*, *utilization*, *orienting toward*, and *communicating for effect*.

One posture that is a hallmark of Erickson's work is the concept of *creating experiences*. Erickson engineered therapeutic encounters whereby a patient would experientially realize previously unrecognized abilities to cope and change. The case of the couple is

a good example. Erickson knew that they had the inherent (but not fully recognized) power to live more effectively. He merely set up circumstances in which they could access that power, readily recognizing that insight was not a precursor of change. Erickson's therapy (and teaching) eschewed insight in favor of experiential methods.

A second posture is *utilization*, which dictates that whatever exists in the therapeutic situation can be harnessed to achieve therapeutic goals. Utilization is the therapist's posture of readiness to respond strategically to any and all aspects of the patient or the patient's environment. In the case of the non-fishing couple, Erickson used the wife's pattern of hiding, the couple's rebellious nature, and their dislike of fishing.

To give such a cursory explanation of the concept of utilization, as I am doing now, is a travesty, because this undermines its place as a defining signature of the Ericksonian method. During the last twenty years, I have strived to master the utilization approach. Moreover, most of my writing on Ericksonian methods in the last ten years has consisted of explications of the utilization method. I have maintained that utilization is to Ericksonian therapy as interpretation is to psychoanalysis, as desensitization is to behavior therapy. It is true that many great clinicians utilize what the patient brings; however, the extent to which Erickson developed his utilization orientation was unparalleled. (For further information on utilization, see Zeig, 1992).

For a moment, let's accept utilization as a central and defining characteristic of the Ericksonian method, and accede that it has clinical effectiveness. Even so, why is it intrinsically important for clinicians to develop a utilization posture? One reason is that it speaks to an essential aspect of psychological problems. *Psychological problems can be conceived as believed-in limitations.* That is, patients act as if they cannot change or adequately cope. In contradistinction, utilization is a philosophy of sufficiency. The therapist models a proactive stance of alchemy, creating practical, therapeutic gold out of leaden situations. The patient consequently is encouraged to behave similarly.

Utilization is an approach I use in every hypnotic induction. I will take things out of the immediate reality situation and harness them to accomplish trance goals, such as internal absorption and promoting constructive dissociation. For example, in beginning a group induction one might suggest: "You're seated here and you can realize that there may be papers and books in front of you. For a moment you don't need to … really focus intently on what is in front of you. You can allow something in back of your mind to develop, now. And I don't know if your unconscious mind can vividly remember a time in school when you were reading, a pleasant time reading at the beach, at home now. But you continue to enjoy the developing comfort that can be a part of the evolving experience …"

A third posture characteristic of Erickson's method is the emphasis on indirection, a philosophy of *orienting toward* goals. Orienting toward is similar to the manner in which a religious master uses parables rather than stating options directly.

Many texts provide elucidation of the techniques of indirection. For present purposes, let's presume that the technique of indirection and the posture of orienting toward can be remarkably effective on many therapeutic occasions.

One component of the orienting toward posture, guiding associations, is illustrated in the aforementioned Case Two. My method was geared to changing my patient's association to his anxiety. While it is true that effective therapy can proceed by analyzing associations, one also can view therapy as the re-association of internal life (Erickson, 1948) and guide preconscious associations to create effective treatment.

A fourth posture intrinsically bound to Erickson's method is the idea of *communicating for effect*. Of course, all therapists communicate for directed effect, but Erickson, as a hypnotherapist, was keenly oriented to the intended outcome of his suggestions. In contradistinction, many models of therapy are predicated on uncovering the understructure of the pathology in the individual or family. Erickson, on the other hand, was more of a pilot than an archaeologist or oceanographer.

In his years of studying hypnosis, Erickson investigated how people responded to nuance in communication. He was an explorer of human social responsiveness. For example, he used words surgically to elicit response; he used verbal implication, gesture, the implication of gestures, and so on. Especially important to Erickson was the way in which people responded to innuendo without full realization of the response or the stimulus that elicited it. A cousin of this important but insufficiently understood phenomenon is the way one person will cough in an auditorium and others will echo, the way strangers sitting side by side will unconsciously synchronize their breathing rate and/or posture. Again, communicating for effect is an area to which I cannot give deserved attention in this chapter; still, it is of essential importance in Ericksonian methods.

So many experts discuss their work vertically, describing the depth of dynamics in the presenting pathology, history, or family pattern. Conversely, as an expert in hypnosis, Erickson set sights on the horizon; he demonstrated people's ability to respond specifically to nuance such as the locus of voice, intonation change, and alterations in tempo.

These four postures–creating experiences, utilization, orienting toward, and communicating for effect–are core concepts in my therapy. To understand why I refer to them as *postures* and even *states*, let's examine their essential nature.

On Experience

Consider the four postures: They could be seen merely as techniques, and in some sense they are. In fact, they, or related methods, are described as techniques in a number of effective approaches to therapy. At present, however, I would like to think of them as experiential postures that a clinician can maintain. This is an important distinction that reflects on training: Techniques can be taught didactically; experiential postures

cannot. Therefore, a method is needed to train experiential postures; they are important for both clinicians and clients.

Experiential postures are essential for patients because some concepts can be mastered intellectually; others, such as being happy, cannot. Happiness is an experiential reality; one cannot *do* happiness intentionally. Happiness must be realized, not learned; there are few rational lessons that one can be taught overtly to promote happiness.

Some of the seeming obscurity of Erickson's clinical methods might arise from the distinction between lessons that can be learned didactically and those that must be realized experientially. More often than not, Erickson resided in the experiential latitudes. This was true in both his clinical work and his teaching.

On Training

I will diverge for a moment to describe Erickson as a mentor. My instruction under Erickson's tutelage was as uncommon as his therapy. He never saw me do hypnosis or therapy, although he sought out reports on some of the cases he referred to me. He rarely provided didactic input; rather he taught as he conducted therapy, by using experiential methods. He offered hypnosis, stories, tasks, allusions, and so on. Not only did he eschew cognitive learning, he opined that it often was more of a hindrance than a benefit. Of course, one could and should read to learn content. For example, Erickson was well aware of the psychoanalytic approaches of his day, having collaborated with Lawrence Kubie and having worked with analysts, including Spurgeon English and Ives Hendricks. However, in interpersonal situations Erickson did not teach content; more commonly, he oriented to the development of the clinician's experiential posture and referred students to books for learning content.

There is an implication in Erickson's teaching method that has influenced my training of clinicians: Training must develop the self of the clinician, not just his or her technical ability. This does not mean personal therapy for the clinician. There are many aspects of self that can be evolved in the clinician in addition to those that can be developed through personal therapy.

As I will demonstrate, systematic methods can be used for overall clinician development.

Before discussing clinical development, I will outline my training model so that the clinician development section can be understood in perspective. (An elaboration appears in Zeig, 1992.)

My Didactic Approach

My teaching model is based on five intervention choice points; namely, *goals*, *gift wrapping*, *tailoring*, *processing*, and *the position of the clinician*. I use some experiential

exercises in each of the components to help students master principles and practice. To teach the position of the clinician, I use experiential exercises almost exclusively. Let's briefly examine the first four aspects of the model and then address the fifth in its unique role as an axis on which the other four revolve. Each choice point has a primary question.

The *goal* question is, "What do I want to communicate to the patient?" The goal component that I teach consists of information on data gathering, and instruction on refining the problem and its definition.

The *gift-wrapping* question is, "How do I want to communicate the goal?" The didactic component concerning gift wrapping is one of the most extensive and consists of information on techniques, including the structure of hypnosis; the use of anecdotes; the interspersal method; symptom prescription; and reframing. Techniques of therapy are seen as ways of presenting gift-wrapped ideas to patients; they are not curative in and of themselves.

The third component, *tailoring*, asks, "What position does the patient take?" This component focuses on assessment of the patient's intrapsychic and interpersonal style. It gathers information, which is useful both in modifying the gift wrapping to fit the style of the individual and on using the patient's position to establish treatment goals. An example of altering gift wrapping to fit the uniqueness of the individual would be to alter a hypnotic induction to an intellectual person as compared to an artistic person.

The fourth question is, "How can a dramatic *process* be created to make the gift-wrapped and tailored goal come alive?" There are three stages in the process: the *setup*, *intervention*, and *follow-through*.

Attending to these four intervention points can enhance the power of inventions. One of the obvious merits of this model of intervention is its immediate clinical utility. For example, by using it, the therapist has more choices when encountering resistance: One can change the goal, gift wrapping, tailoring, or process as needed. Moreover, and perhaps most influential in improving therapy outcome, is the last choice point, the position of the therapist. If resistance occurs the therapist can also be changed. No, I don't mean referral. I mean accessing a previously dormant ability within the clinician. As we will later see, systematic experiential methods can be valuable in training the ability of the clinician to be flexible in bringing forth therapeutic abilities.

Figure 1 illustrates the model.

The Therapist's Posture

To consider the *therapist's position* one can ponder, "What position does the clinician take?"

The position of the therapist can be divided into four subcategories, *lenses*, *muscles*, *heart* and *hats*, each of which has a professional and personal aspect, modified by experience. First, *lenses* represent the ways of viewing. On a professional level, lenses learned when studying family therapy diverge from those learned in behavior therapy. On a personal level, the lenses learned growing up in one's family of origin differ from those learned in the neighbor's family. Second, *muscles* are the way of doing. Psychoanalysts, for example, often hypertrophy their interpretation muscles, while Ericksonians develop their orienting-toward abilities. Third, compassion is manifested in the *heart*. And fourth, the *hats* symbolize the therapist's social roles.

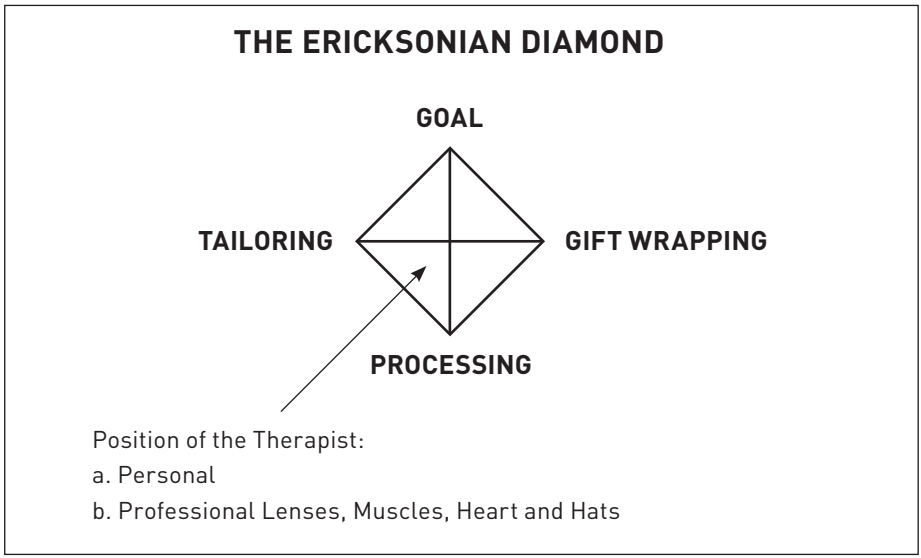

Figure 1. Intervention Model

On Therapist Evolution

Aspects of the therapist's posture continue to evolve through training and experience. Traditional professional sources of growth and development include graduate school, post-graduate training programs, supervision, and experience with a variety of patients. Also contributing are lectures, modeling by experts, personal therapy, supervision, books, tapes, co-therapy, and supervision through a one-way mirror in which a teacher speaks through a trainee. Although these are effective methods in improving the therapist's abilities, they are not especially cohesive or experiential.

I suspect most therapists, regardless of their theoretical persuasion, would ascribe their professional evolution to some combination of the aforementioned sources.

A reflexive response to querying clinicians about the primary source of their growth and development is, "I have learned the most from my patients." However, I am suspect of the unspecified nature of this proclamation. Learned what? Learned how to suffer unduly? Learned how to be inflexible, resistant, rebellious? Okay, I should not be such a smart aleck, but I am pushing for a point: Why should an important issue like professional growth and development be left to chance? Can we have a systematic method?

For instance, can one conceive of therapy training as sports training, which requires exercise, practice and discipline? If so, therapists could regularly train (and cross train) to improve their development. Thereby, techniques would not predominate; rather emphasis would be placed on training therapeutic postures, on growth, and on development. In an attempt to advance the growth and development of the therapist, I have developed a systematic experiential training system that I will outline shortly. First I will describe how the model is derived from Erickson's work.

Erickson's Self-training

A model of the self-training of postures is suggested in Erickson's work. He reported a number of exercises that he used to train himself. To compensate for omissions in his medical school education, internship, and residency, he said that in one of his early jobs, he would get a social history from the social work service, and then intuit and write a mental status examination based on the written history. Then he would take a mental status examination and compare the intuited with the actual mental status examination. Subsequently, he would reverse the process; he would get a mental status examination, write an intuited social history, and compare it with the actual social history. He said that he did that exercise with hundreds of patients. His attempt was not to learn content, but to master a posture, a style of understanding human circumstances.

Also, Erickson reported that he attended to nuances in human social behavior and wrote his extrapolation of what they meant. Working like Sherlock Holmes, he would see a clue and venture a written prediction. He then deposited it with his secretary to await confirmation. For example, perhaps he noticed tell-tale behaviors and ventured, "this man is having an affair." Again, he seemed to avidly work to develop a posture of extrapolating from minimal cues. He was not focused merely on increasing his base of cognitive knowledge.

Erickson was dedicated to his growth and development throughout his life. Just before his death, I asked him a simple administrative question. He responded, but answered by using an indirect technique. He told a story. I had to *unwrap* the answer. His failure to reply directly interested me. I had the sense that he was playing–even more, that he was exercising his *orienting toward* muscles, wanting to maintain tonus.

Moreover, Erickson gave me personal-development assignments, although not systematically. For example, he told me to go to a school yard and watch children. (If

you do this, remember, do not wear a trench coat!). I should predict which child would go to which toy next. Which would leave the group first? The idea of extrapolating and projecting future patterns from small bits of behavior was near and dear to Erickson, and he promoted this posture in his students.

Preserving this tradition, I often adopt a theme of the month, something I work to develop on a professional or personal level. For example, I might dedicate time to being more visually perceptive. I might work on a technical issue, such as developing mastery of the use of hypnotic amnesia or the applications of symptom prescription.

To promote the philosophy of self-training, I provide pragmatic guidelines for students to do the same. In workshops I give students problems for monthly therapist development. For example, here are twelve challenges from recent workshops:

1. For each client, consider the question: What does the patient value? Be specific and write out two or three adjectives per patient.
2. For each client, indicate a specific answer to the following question: How do you, the clinician, know the patient can change or cope better?
3. In each session, use the method of utilization once.
4. Smile when offering hypnotic inductions; gesture freely and congruently while the hypnotized patient's eyes are closed.
5. When you see a new patient, after the first five minutes, predict which hypnotic phenomenon you believe he or she will accomplish best.
6. Collect separate stories about human rigidity and flexibility. When appropriate, tell them to patients.
7. For each patient you see, write a sentence summarizing the patient's unique style of responding.
8. Take away your primary strength for a month. Don't use the method that you most overuse. For example, if you are Ericksonian don't tell stories. If you are analytic, do not make interpretations. See what you develop in its place.
9. Make a specific prediction about how the patient will resist your assignment or therapeutic directives.
10. For two weeks, write out how patients confuse you. For the next two weeks, write out how you confuse them. Be specific.
11. Make a list of how you desire to evolve as a clinician. Say it silently to yourself before each session as an affirmation.

12. Think in terms of analogies. Take the patient's problem and describe it as a color, a tool, a plant, and a vessel to contain water. See how this influences your treatment.

Don't miss an extended application of this training method: Specific weekly or monthly challenges can be given to patients for their growth and development. This makes good sense. The therapy becomes a game of hot potato. The patient offers problems to the therapist and the clinician presents a problem back to the patient.

I have a reflection on such assignments, and it is a personal reflection. A Native American saying goes, "Tell me and I'll forget. Show me and I may not remember. Involve me and I'll understand."

Clinical Example

Let's extend the method and think about experiential interventions for issues of transference, remembering that it is a topic about which I am naïve, (Is that transference itself?) and in which I am not classically trained.

In a recent Ericksonian supervision group in Brazil, I worked with a woman who suffered from perfectionism. She indicated that her father was a primary source of her striving. Modifying a technique I learned from the Gouldings, I asked her to look successively at each group member and to hallucinate her father's face and hear the words, "You must succeed perfectly." Subsequently, I asked her to conduct the same exercise, using Erickson's face (someone she admired) and hearing in her native language the message, "Dealing adequately with the good and bad alike is the real joy of living." She was quite moved by this simple experiment. My sense is that dreams are not the royal road to the unconscious–experiences are.

Yes, there is a strong experiential tradition in psychodynamic methods, dating at least to Franz Alexander and the corrective emotional experience, but it seems to me that in dynamic methods, experiences are the by-products of understandings. To me, experiences should be the main course, understanding the dessert. Dynamic experiences can precede dynamic understandings.

It is a problem–perhaps with an Oedipal imprint–to reflect on the nature of therapy and training and look back on the development of therapy, which has a history of a little more than a hundred years.

Historical Reflections On Training

In psychotherapy's early days, there wasn't much to learn regarding technique. Inquiry in those days focused on theoretical and conceptual issues. Training emphasized

the development of the therapist. Consequently, individuals who elected to become psychoanalysts spent years undergoing a training analysis, thereby learning to rid themselves of their own distortions and transference. The purpose was to develop the analysand as a tool of therapy.

After World War II, however, with the burgeoning number of divergent schools of psychotherapy, attention focused on the methods of psychotherapy, and the development of the therapist receded into the background.

Yet when one conceives of therapy as an art more than a science, it behooves us to train ourselves as artists. That requires an entirely different approach to learning therapy. If we want to learn how to do physics, we can learn the rules of physics by going to a classroom and listening to scholarly lectures about physics. But if we want to learn how to do drama, theater or art, then we are not going to be able to learn it in the lecture hall. Rather, we are going to learn it from the inside out, by discovering something inside ourselves rather than learning a specific set of rules.

Theater As A Model

A couple of years ago, I became preoccupied with the idea of therapy as art, and I began to wonder, "Are we using the wrong model for training therapists? If so, what would be a better model?" I decided to study theater–more specifically, improvisation. Whenever we interact with another human being, we are doing improvisation. Similarly, in psychotherapy, communication is more improvisation than science. So I took a class to learn how theater experts teach improvisation.

Interestingly, many important contributors to psychotherapy had backgrounds in acting and drama. Fritz Perls, Peggy Papp, Jacob Moreno, and Virginia Satir had various amounts of experience in acting, which they used as a tool in the craft of clinical influence.

I joined a small group of 20 year olds for a six week adult education class that was led by a woman who had a Ph.D. in drama. I eventually took two more six week courses in acting and improvisation. We began the initial session by introducing ourselves and saying a word about why we had come. The first student gave his name and said, "I'm here because I want to do theater." Next person: "I'm here because I want to be in the movies". Next person: "I want to do commercials." Next, "Dr. Zeig, why are you here?" "I'm a spy. I want to learn how a dramatist teaches improvisation."

After the introductions, we all stood in a circle to do our first acting lesson: la-las. The task was to repeat a vocal pattern–la-la-la-la-la-la-la, la-la-la-la-la-la-la, la-la-la, la-la-la, la-la-la, la-la-la-la-la-la-la–while adding a body motion such as handclapping.

At first, the teacher led the exercise and we were to copy what she did. After a bit, the teacher turned to me and said, "You be the leader. Pick a different sound. Use the same

rhythm. Choose a different motion." So I went, "Pa-pa-pa-pa-pa-pa-pa" and made a cradling motion. Everyone copied me. The next student selected 'ga-ga', and a new movement. During this, the teacher stepped outside the circle and gave us feedback. "No, Jeff. Your movements aren't sweeping enough. Watch the leader closely and copy her. Not ga-ga. GAH-GAH." Then the exercise was over, and to my astonishment we simply went on to the next exercise. No discussion. No processing of what had just happened. No analysis. No sharing.

When my expectations for follow-up were not fulfilled, I entered a state of confusion. "Wait a second," I protested in my head: "Aren't we going to analyze this? Pick apart the meaning of this experience?" I can be a shredder. Give me something, and I will dissect it, shred the chaff from the kernel. Patients tell me things. I dissect them. They tell me their histories, and I dissect them. They describe relationship problems, and I dissect them. I reduce them to little pieces and feed the components back to them. I'm very skilled at this regurgitation process–chewing up a story, digesting it, and returning it to the patient in a more palatable form.

But in this class, we were not dissecting. I couldn't just mindlessly digest and regurgitate. Suddenly, I had to think, "What is this about? What am I learning? What skills are being taught here? What skills are necessary to do drama?" One necessary skill, of course, is articulation. To do any kind of stage work, the actor must have good articulation. I recalled the teacher's observation, "No, Jeff. Not ga-ga. GAH-GAH." I was learning articulation.

A stage actor also needs big gestures. As a psychotherapist, this element was most foreign of all to me. I sit when I work, restraining my body motions as much as possible. Now suddenly I was being asked to use gestures for effect.

The final lesson I learned from this exercise was the importance of modeling. To act you must model. If you are going to become a character, a taxi driver let's say, you had better be able to observe taxi drivers and model what they do. Maybe you need to be a street person. If so, then you had better be able to look around, find a street person, and see what it is that a street person does.

I concluded from the exercise that these three skills–articulation, big gestures, and modeling–are important in acting, but no one said that. The teacher didn't begin class with a lecture: "The first three rules of acting are articulation, big gestures and modeling." Rather we did an exercise, and it was understood that somehow we would realize and appreciate that once we got on stage we would access the postures of articulation, big gestures, and modeling. Subsequent improvisational training proceeded one exercise after another.

This was not the kind of learning to which I was accustomed. This was on par with wheeling a bicycle out to the end of the drive for the first time, straddling the top tube, and pushing off.

Learning to ride a bicycle is a visceral learning. You don't learn to ride a bicycle in your left hemisphere. You don't learn the physics of riding a bicycle. It won't help you. You learn to ride in your body. To learn about momentum, you have to be on the bike, try to keep your balance, develop awareness of all the ways your body movement affects the direction and stability of the bicycle. You try it and you fall and you try again. And after a while, suddenly you are doing it. Your body learns, and you've got it.

Remember the breathless "Aha!" feeling you got when you suddenly learned how to ride a bicycle? I think psychotherapy training should be like that. In fact, psychotherapy should not only foster that breathless "Aha!" in patients, but psychotherapy training should also foster a similar feeling in students.

Psychoaerobics[SM]

I am about to present my model of training that derives from improvisational training. First, let's take a moment to condense and review what has been covered so far. There is a basic subjectivity about offering psychotherapy that cannot be avoided. For one thing, the experiential posture of the clinician is too idiosyncratic. It is projected into the therapy situation and forms part of its core. Therapists whose postures are didactic expound teaching methods and use them effectively. Charismatic practitioners will have that attribute as a therapeutic core, and so on.

There can be alternatives to training by didactics, supervision, modeling, clinical experience, books, tapes, cotherapy, and the one-way mirror. Clinical training should develop the clinician's posture/style/selfhood/orientation/ways-of-being/states. Moreover, a systematic experiential program is desirable. As I have evolved as a teacher, I have added a core component to my teaching. I developed a method to teach experiential postures. Yes, they are Ericksonian methods, but I hope the scope and implications are wider. All therapies should expand training to elicit and evolve core postures. Therefore, after the extended prologue, I will get to the point. I have developed an experiential training system that I call *Psychoaerobics*[SM].

Let's examine a few of the 70 existent psychoaerobic exercises. There are two classes of exercises: One set of exercises warms up skills that will be later developed and accesses positions that are generic across therapies; the second set consists of more elaborate exercises that develop postures specific to Ericksonian practice.

Warmup Exercise Three

Warmup Exercise Three can be conducted in a group. One member becomes the *Pitcher.* It is his or her job to tell an emotionally revealing personal secret to the group. However, rather than saying it verbally, the Pitcher communicates the emotional secret in one of three ways: (1) by mouthing the words but not allowing sounds to emerge; (2) by writing out the secret in the air in complete sentences while experiencing the emotion;

or (3) by telling the secret verbally, using a single syllable to mimic words–such as "bah"–the other members of the group become *Receivers*.

In one variation, the Receivers guess the underlying emotion, naming it in one word. (Isn't it convenient that all emotions can be named in one word?) That is not the variation that I commonly use because I am not focused on training skills in diagnostic empathy: Most clinicians have developed this skill prior to attending one of my workshops. In the variation I commonly use, I train what I call *experiential assessment*. In response to the Pitcher's communication, the receiver must move continuously, allowing his or her body to *resonate* with the perceived emotion.

Consider two resonant tuning forks placed on a conductive surface. If one of them is struck, the other vibrates, albeit to a lesser degree. Similarly, the Receiver allows his or her body to mold itself into a posture that reflects the emotion/meaning underlying the Pitcher's secret. When the Pitcher is finished, the Receiver holds the posture so that the Pitcher can examine and discern whether or not the message sent is approximately the message received. Group discussion may or may not follow.

Therapists can experientially assess patients' emotional state by monitoring themselves during the session, including their own physical posture. If the clinician notices herself slumping in the chair, perhaps she is responding to the patient's underlying depression. Most therapists cognitively learn verbal empathy at an early stage of their career. Experiential assessment also can be valuable.

Warmup Exercise Three is designed to stimulate openness, cooperation, and playfulness. Moreover, this exercise accesses and primes a skill that, as we will see, is subsequently developed in the second set of exercises, Psychoaerobic[SM] Exercises One and Two. Before presenting those exercises, I want to reflect on the way in which this warmup exercise can be generalized into the treatment session to add an experiential component to the therapy.

Options For Warmup Three:

Clinical options are only limited by the inventiveness of the user. For example, Warmup Three could be used experientially in the therapy of a regressed patient who lacks the ability to discern others' feelings. Practice could occur in individual, group, or family therapy. The patient could access and verbally identify communicated feelings. The assignment could be homework: A rigid family, for example, could take turns playing the exercise at dinner.

Furthermore, the exercise could be used fruitfully with children, either in individual treatment or in a group. It could help them develop their skills at verbal empathy. It could be used similarly as a supervision task with notice therapists.

Warmup Exercise Three

Clinician Posture to Develop: Resource states for participating in Psychoaerobic[sm] exercises–disclosure and experiential assessment (empathy).

Format: Dyads or group

Roles: One person is the Pitcher; the other is the Receiver.

Method: The Pitcher tells an emotionally and personally revealing secret, but speaks sub-vocally. Using normal gestures, the Pitcher mouths the words, speaking in complete sentences, but does not let sounds come out. The Receiver attends empathetically and allows his/her body to intuitively discern the Pitcher's emotion. The Receiver should stay kinetic, moving constantly in response to his/her perception of the Pitcher's emotion. When the Pitcher completes the secret, then and only then the Receiver becomes a statue and holds his/her final pose so that the Pitcher can see the Receiver's physical portrayal of empathy. The Receivers should not openly guess the emotion behind the secret.

The pair switches roles. The new Pitcher tells a secret and the new Receiver tries to *resonate* with the Pitcher's emotion.

Variations:

1. Conduct the exercise in a group of five or six. Circulate so each member has a turn as Pitcher.
2. Tell the secret in gibberish, rather than subvocally.
3. Pantomime writing out the secret.
4. Tell the secret using one syllable only such as "Bah," "Ru," or "Lee".
5. The Receiver can guess the emotion, naming it on one word.
6. The Receiver(s) can mirror the Pitcher as a technique to discern the underlying emotion.
7. Do not look directly at the secret-teller. Watch with peripheral vision only.
8. Discuss the exercise after completing the task.

Extensions:

1. Practice in therapy sessions (individual, group or family) with patients who have difficulty with empathy.
2. Assign as homework, within the patient's family.
3. Practice as a game with children to teach empathy.

Attitude: The ideal state for Psychoaerobic [SM] exercises is playful, cooperative, open, and nonjudgmental.

Note: As with any experiential exercise, only do those that are comfortable to you.

Figure 2. Example Exercise.

Please understand the underlying philosophy. Empathy cannot be learned didactically any more than one can learn to swim on a piano bench, or learn to be a chef by being handed recipes. Empathy must be learned experientially, and only practice will lead to improvement. Figure 2 shows the text of Warmup Exercise Three to provide an idea of the actual design of the Psychoaerobic℠ Exercises.

Warmup Exercise Nine

Warmup Exercise Nine also warms up the first two Psychoaerobic℠ Exercises. Whereas experiential assessment is primed in Warmup Three, Warmup Nine primes the ability to change states.

Warmup Exercise Nine is presented in dyads with a Pitcher and a Receiver. The Pitcher offers a series of compliments to the Receiver, who mentally discounts them and physically enters a defensive state. When the defensive state has been achieved, the Pitcher asks the Receiver, "How specifically do you know that you are defensive?" Responses are sequentially eliminated until the Receiver can no longer maintain the defensive state. For example, if the Receiver says, "I know that I am defensive because my arms are folded," the Pitcher requests, "Unfold your arms." If the Receiver says, "I know I am defensive because I am saying negative things inside my head," the Pitcher requires, "Stop saying negative things."

Eventually the exercise reaches a point where the defensive state no longer can be maintained. Upon completion the roles are reversed, and the new Pitcher provides compliments. The new Receiver enters a state of self esteem, which then is similarly broken down.

Accessing and changing states facilely can be quite valuable for therapists. The exercise also can be extended to patients. Try asking a savvy depressed patient, "How specifically do you know that you are depressed?" After the patient responds, subsequently suggest that the patient make appropriate reversals.

After priming with Warmup Exercises, the formal Psychoaerobic℠ Exercises are offered. In the next section I will describe exercises to develop professional "muscles" and "lenses".

Psychoaerobic℠ Exercise One

Exercise One is designed to develop the Ericksonian skill of *orienting toward*. Orienting toward could be considered a "muscle," a way of *doing*. For present purposes, orienting toward is considered an experiential posture or "state" of the clinician, not merely the technique of using indirection.

The exercise is conducted in a dyad with a Pitcher and Receiver. Prior to commencing the exercise, the Receiver studies the Pitcher for a minute or two and writes five yes

or no questions that are relevant and not obvious. For example, asking a meticulous person, "Do you like to play in the mud?" would not be productive because the answer would be obvious. Asking the same person, "Do you like to dress neatly?" would be relevant, but again too obvious. Perhaps a meticulous person could be asked, "Do you like classic movies?"

The five questions are asked and answered sequentially. The Pitcher is to reply truthfully to the questions, but is placed under severe restrictions that make treasured and effective methods unavailable. That is, the answer must be gift wrapped in a story that is to be told in a slow measured monotone. Moreover, no obvious gestures can be made by the Pitcher. The story should be simple and of limited duration. For example, the Pitcher could talk a few minutes about walking to grade school as a child. The content of the story does not have to be relevant, but the meaning of the story must be shaded to indicate yes, no, or sometimes. Nonverbal cues cannot be used.

The Receiver is to attend via experiential assessment (a posture primed in Warmup Three), rather than conscious deliberation. One way to attend experientially is for the Receiver to monitor his or her own physical responses. If the Receiver's head nods (or shakes), that answer can be accepted. Similarly, a beginning smile or opening gesture on the part of the Receiver can be taken as a yes, while a tilt of the head or a slight wavering of the hands could indicate sometimes.

At the end of the exercise, answers are not compared. Being correct is not the goal of the exercise. Rather, at the conclusion, the participants strive to define their respective states when they were at their optimum. Here the talent of entering and exiting states is accessed and harnessed from Warmup Exercise Nine. The Pitcher is to describe the accessed state of orienting toward, answering the question "When I was *best* at orienting toward, what *specifically* was I like?" The Receiver is to describe the gift-unwrapping state. Each can provide feedback to assist the other in this difficult task.

Exercise One is a typical Psychoaerobic[SM] Exercise, meant to develop core *postures* (in this case *orienting toward* and *gift unwrapping*) in a core manner; namely, experientially by relinquishing overused and well-developed skills. *Orienting toward* and *gift wrapping* are treated as talents that must be learned experientially in the way bicycle riding must be learned viscerally. *Indirection* may be a technique. *Orienting toward* is considered a state that the therapist can access, similar to compassion or concern. It is posited that through continued practice, the state can be accessed and developed more fully.

The Psychoaerobic[SM] process is somewhat like physical exercise through circuit training, in which muscle groups are isolated and developed. Moreover, in Exercise One, a talent–communicating directly with words and gestures–is restricted so that latent abilities can emerge. It is a bit similar to the treatment of amblyopia (lazy eye) in which the ophthalmologist patches the good eye to foster development of an inferior function. Also, in Exercise One, the function of *being right* is restrained. Participants

cannot compare answers. Thereby, they can focus more fully on accessing states; in this case, orienting toward and gift unwrapping.

Psychoaerobic℠ Exercise Two

Exercise Two immediately follows Exercise One, but in Exercise Two the roles are reversed. This time there are two conditions, not five questions. In the first condition, the new Pitcher describes an object, such as a tennis racket. (Stories are not told.) The description must *mean* a negative emotion; for example, guilt or fear. The emotion is to be fixed prior to the description and cannot be changed during the description. It is technically best if the Pitcher eases into the emotion gradually and orients toward it progressively. Again, gestures and tone are restrained.

The Receiver accesses a state of experiential assessment and discerns the projected feeling through the self-monitoring of minimal cues: A beginning frown might indicate displeasure; a curl of the mouth, frustration; a welling in the eye, sadness. The Pitcher continues the description until he or she can discern an overt behavior indicating an emotional response in the Receiver.

In the second condition, a new object is described; for example, a half-filled glass of water. A positive emotion is pitched, for example, joy, excitement, or confidence.

At the end of the exercise, participants are restrained from comparing answers. Again, the goal is to define the respective states, orienting toward and gift unwrapping. The exercise is not a competition to be correct. Describing a state is hard but valuable. It is also highly individual. For example, how could we describe the state of curiosity? Could you say, "I know I'm curious because I'm sitting forward, my head is cocked to the side, one eyebrow is higher than the other, there's a feeling of excitement and anticipation in my stomach. I'm waiting to know what comes next. I'm thinking, 'This is interesting!"

To further elucidate the purpose of Exercises One and Two, let's consider a technical method that Erickson used, called the *interspersal technique*. Two outstanding examples come to mind. In working with a pain patient who was a florist, Erickson talked about the growth of tomato plants, interspersing suggestions of comfort into the description. In another case, he told stories to an anorexic and interspersed suggestions of hunger while also stimulating a range of emotions. Although it is interesting to speculate about the techniques and theory of this approach, for present purposes I will limit my discussion to training clinicians.

Let's assume the interspersal technique is valuable. To train therapists to use it, I could take an approach of breaking it down into technical components and, for example, describe and teach indirect forms of communication, such as truisms and presuppositions. Alternately, I could say that the technique of indirection is part of a larger experiential method, an experiential state of orienting toward, based upon a

posture of the clinician. Then it would be beneficial to conduct Exercises One and Two to garner the posture of orienting toward.

Consider Exercise One. The object of the exercise for the Pitcher is to orient toward a thought (yes, no, or sometimes). In Exercise Two, the Pitcher orients toward a feeling. Much of the interspersal technique is based on these processes: One orients toward a thought; one orients toward a feeling; one orients toward a behavior. Eventually preconscious associations elicit constructive action by virtue of what is called the ideodynamic effect, which has to do with the ways in which ideas and associations stimulate action. Essentially, in the interspersal method, the patient is induced into a state of experiential assessment of the clinician's method.

Experiential assessment can be considered integral to hypnosis. Hypnosis does not have to be considered trance, it could be defined as a state of experiential assessment. Hypnotic suggestions could be conceived as ways of guiding associations. In Ericksonian therapy, associations are not analyzed; they are elicited and utilized.

Realize that Exercises One and Two, like physical exercises, should be repeated regularly. These techniques are best developed through regular practice.

Of course, in the training that I conduct, I train both technical methods and experiential postures, but in recent years I have been more inclined to the latter. I even use group hypnosis before and after the exercises to further experientially consolidate learning.

Orienting toward is one of the essential postures in the Psychoaerobic℠ system. It is a therapeutic muscle. I arbitrarily chose it as the first to be developed. Other postures specific to Ericksonian practice include *developing acuity, communicating for effect*, and *utilization*. I will discuss these briefly and provide examples of exercises to develop each of them. Again, keep in mind that I am describing them as postures, not techniques–which they also may be.

The point: After practicing the exercises and accessing postures, when the clinician gets onto his or her therapeutic stage, the Psychoaerobic℠ states will be available.

Acuity Exercises

The largest number of exercises in the Psychoaerobic℠ system are those that elicit acuity and develop the therapists' lenses. There are a number of subdivisions of acuity, each of which has specific exercises, including visual attention, auditory attention, concentration, detection of pattern, extrapolating from minimal cues, noticing conspicuous absences, and perceiving expectations (rather than realities). As a warmup for acuity exercises, I might offer students a group induction, because hypnosis itself focuses perception.

Due to space limitations, I will only outline a few acuity exercises and present them as simply as possible. An exercise to access *visual perception for details* is as follows: Two

participants, one Pitcher and one Receiver, face each other. The Receiver "memorizes" the Pitcher and then closes his or her eyes. The Pitcher then makes three physical changes; for example, removes a watch, changes the location of jewelry, unfastens a button. The Receiver then opens his or her eyes and discerns the changes.

In an exercise designed to enhance *perception of pattern*, one member of the group, who is a native speaker of a foreign language, tells two brief stories in that language, one of which is true, and the other of which contains an emotionally significant lie. The group works at discerning the speaker's pattern of lying.

In an exercise on *extrapolation*, working in dyads members make predictions about each other, based on minimal cues.

After each of the exercises, discussion centers on accessing and developing a robust acuity *state*. Clinical extensions are offered: Similar exercises could be given to depressed patients to stimulate an external awareness that is antithetical to the inward pressures of depression, thereby disrupting the depressed state and eliciting a more helpful externally oriented state. For example, such patients could be given the task of noticing patterns in the clouds as they did as children. They could be given the assignment Erickson gave to me, to go to a schoolyard and examine specified patterns in children.

Likewise, exercises could be practiced in families. My 11 year old daughter and I play a game at restaurants. We sit down at a new table and I close my eyes. She makes three changes, and I open my eyes and try to discern the things that she modified. Then we switch roles.

In fact, I once asked a researcher in neuroanatomy if, before and after practicing such exercises for an extended period of time, by using state of the art equipment, changes could be noticed in brain functions. He replied, "Most definitely."

Communicating The Effect

There are a number of exercises to develop the posture of *communicating for effect*. In one exercise, I have participants conduct hypnosis using gibberish. In the next, I have them induce hypnosis by repetitiously using only one word. In a subsequent exercise, they can only repeat one sentence. Repetitions cannot be monotonous. Each must contain a novel variation in tone, tempo, gesture, voice locus and so on. Clinicians who have done this exercise often appreciate the experiential learning of how nonverbal methods can elicit targeted responses. Again, the focus is on developing posture, not competence in technique. Competence in methods should stem from posture, rather than vice versa. This is the reverse of customary training, in which one first learns the technique and posture flows.

Utilization

Exercises on *utilization* are based in hypnosis because the method is so integral to Ericksonian hypnotherapy. One exercise is conducted in triads, with a hypnotist, a subject, and a coach. After the hypnotist elicits a trance, the coach calls out items at regular intervals from a list of provided categories that includes sounds, objects in the room, and emotions. Subsequently, the hypnotist must incorporate the called-out items into the ongoing trance patter, utilizing them to advance trance goals such as absorption and deepening. Again, technical mastery is not sought. The purpose of the procedure is to provide moments in which the clinician experientially accesses the utilization state. Once the state is secured, it can be accessed in future therapy as needed.

Preliminary Conclusions

At this stage of my evolution as a therapist and trainer, I distinguish between technical methods and clinician postures. In the forms of psychotherapy with which I am familiar, it is possible to teach theory and practice didactically, and that almost always is the starting point. In contradistinction, I maintain that providing therapy is more a matter of posture than technique. Therefore, in my contemporary training, "state" can precede method.

Therapeutic practice is composed of techniques and postures. Consider the fact that light can be considered a wave and a particle. In studying light, sometimes it is best to think of it as a wave; at other times as a particle. Similarly, when considering the therapist, we can emphasize postures sometimes, and techniques at others.

There is a considerable corpus of knowledge of theory and practice in each school of therapy, and technical adequacy can be garnered through cognitive study. That is all well and good. However, the emphasis in training on didactics may inadvertently lead clinicians into counterproductive directions. The primary goals of therapy are helping people cope, change, activate, realize self-esteem, assume responsibility, and so on. These results are achieved through postures that must be learned experientially. If treatment is to be experiential, the training of therapists should stress systematic experiential methods.

The concept is a bit Zen. There is a distinction between what we study and what we live. Psychotherapy training and practice, like Zen, can stress living experience first.

Using Erickson as a model, I have tried to separate experiential postures from technique. I have attempted to develop a systematic program for the experiential learning of experiential postures, although it is still in its preliminary stages.

I hope the model has greater applicability than just teaching Ericksonian concepts. I would hope that one could invent a Psychoaerobic[SM] to model any master clinician. If one were modeling Aaron Beck, one could ascertain the therapeutic postures of this

master cognitive therapist and create experiential exercises for each. One could model Kernberg or Masterson for psychodynamic methods. One could model Minuchin for family therapy, and so on. Moreover, the model could be extended to other fields such as teaching or parenting. What are the experiential postures of a great parent? What exercises could help teach these postures?

Certainly the method could be applied to patients. Clinicians could help a depressed patient develop postures of being externally aware, positive in outlook, and oriented to a goal, by means of experiential methods to help access these state. Of course, techniques also could be used, but my predilection would be to access postures first. A similar model could be used for developing self-esteem in patients. Divide the goal into postures and devise appropriate experiential exercises for each.

My only proviso would be to encourage a systematic excursion into experiential territory, using experiential methods. One also should promote recursive techniques of learning.

There is the old joke about the man who is lost in the downtown area of a city. He is in a new territory and cannot find his bearings. Finally, he sees a man walking towards him, carrying a violin case. He approaches the musician avidly and says, "Sir, please excuse me. I am a bit bereft; I am in a new territory. I don't know how to find my way. Can you please tell me, sir, how do you get to symphony hall?" The violinist replies, "Practice, practice, practice."

I suggest that we consider both the technical and the experiential, but let's start with the experiential. We can consider that, in lessening the distance from the head to the heart, it is more important to start first from the heart.

References

Erickson, M.H. (1948). Hypnotic psychotherapy. *The Medical Clinics of North America*, May. Also cited in E.L. Rossi (Ed.), *Collected papers of Milton H. Erickson, Vol. IV: Innovative hypnotherapy*, pp. 35-48. New York: Irvington.

Whitaker, C. (1982). Keynote address: Hypnosis and family depth therapy. In J.K. Zeig (Ed.) *Ericksonian approaches to hypnosis and psychotherapy* (pp. 491-504). New York: Brunner/Mazel.

Zeig, J.K. (1992). The virtues of our faults: A key concept of Ericksonian therapy. In J.K. Zeig (Ed.) *The Evolution of Psychotherapy: the Second Conference* (pp. 252-66). New York: Brunner/Mazel.

"Experiential Approaches to Clinician Development" was published originally in Zeig, J. K. (1997), *The Evolution of Psychotherapy: the Third Conference*, Brunner Mazel,(pp. 161–176).