An exploratory outcome comparison between an Ericksonian approach to therapy and brief dynamic therapy

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Abstract

The purpose of this study was to determine whether an Ericksonian approach to therapy using hypnosis (ET) was as effective as brief dynamic therapy (BDT), a long-standing and well-researched form of psychotherapy. The study used a comparative pretest/posttest design with four paper and pencil tests [Clark Personal and Social Adjustment Scale (CPSAS), Hopkins Symptom Checklist (HSCL), Target Complaint (TC), and Global Improvement (GI)] and six therapy sessions. The investigators attempted to choose design features that would not interfere with the unique qualities of ET while maintaining empirical regularity. No statistically significant difference was found except on HSCL where ET was superior. An interesting finding was that without direct discussion of the target complaint, ET brought about the same improvement on targeted problems as BDT. ET subjects reported gaining understanding of their problems as much as BDT subjects, but from a different source. The results of this study are a step toward empirical confirmation of ET as an evidence-based treatment alternative for psychotherapy.

Keywords: Clinical hypnosis, therapeutic effectiveness, efficacy in hypnosis, non-specific factors, utilization, unconscious, indirect suggestion.

Milton Erickson has had a profound effect on the field of hypnosis and psychotherapy. A large body of anecdotal literature now exists describing his successful treatments (Zeig, 2006b, 2003, 1983; Erickson & Rossi, 2006, 2006a, 2006b; Haley, 1985 a, b, c, 1973; Erickson & Keeney, 2006; Short, Erickson & Erickson, 2005; Battino, 2005; Lankton, 2004; Simpkins & Simpkins, 2004, 2001a, 2000; Yapko, 2003, 2001; Haley & Haley, 2003), to name just a few. With more than 120 Erickson Institutes (www.ericksonfoundation.org) treating clients and two-thirds of them in countries outside of the United States, Ericksonian theory and methods are being used worldwide.

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**Literature Pro and Con**

Not everyone agreed with Erickson during his lifetime or over the decades following his death. For example, Hilgard held a well-researched, but different view on susceptibility (Hilgard, 1967). Social role-playing and sociocognitive theories reinterpreted the notions of the hypnotic state or an unconscious mind (Sarbin & Coe, 1972; Barber 2000; Kirsch & Lynn, 1995, Lynn & Sherman, 2000). Interest in Erickson’s work has also generated critics who questioned Erickson’s claims (Mathews & Edgette, 1997). Thoughtful rebuttals and useful interpretations such as from Lankton, (Mathews & Edgette, 1997, Lankton & Lankton, 1983) and Gilligan (Mathews & Edgette, 1997; Gilligan, 1987) answered some of these objections and proposed useful modifications for integrating Erickson’s ideas into modern practice.

Even though Kuhn (1962) believed the real work of science begins when a community of scientists adopts a paradigm, Lynn and Rhue (1991) point out that the field of hypnosis continues to remain divided about which paradigm is best. But regardless of disagreements and division, a growing and respected body of research shows that clinical hypnosis is effective for varying problems (Lynn & Kirsch, 2006), and there is a general trend toward validation of hypnotherapy (Alladin, Sabatini, & Amundson 2007).

In Popper’s influential interpretation of science (Popper, 1959), scientific progress results from a combination of innovative, creative theories and careful research. Milton Erickson was a creative innovator who left a legacy for psychotherapy. His method for therapy using hypnosis is certainly worthy of careful research.

**Purpose**

This study was intended as an exploratory step to test the efficacy of an Ericksonian approach to therapy using hypnosis (ET) as a primary treatment method for short-term psychotherapy. The investigators attempted to create a research design that would adhere to as rigorous empirical standards as possible without interfering with the individualistic, nonstandard methods used by Erickson.

Brief dynamic therapy (BDT) was compared to ET in order to have a distinctive contrast. Also, BDT has been validated as a possibly efficacious therapy (Chambless et. al., 1998). Comparing a new therapy with a possibly efficacious or efficacious treatment is one of the design methods suggested by APA for efficacy studies (Chambless et. al, 1998).

**Definitions**

*Psychotherapy Effectiveness*

The effectiveness of psychotherapy is defined as the change in four dimensions: social/environmental, internal/experiential, target problem, and global improvement. Four instruments were used to measure this change: Clark Personal and Social Adjustment Scale (CPSAS), Hopkins Symptom Checklist (HSCL), Global Improvement (GI), and Target Complaint (TC).

*Ericksonian Therapy (ET)*

ET is defined as a form of psychotherapy using hypnosis and originated by Milton Erickson. As used here, ET refers to the five-stage paradigm of the dynamics of trance induction and suggestion introduced by Rossi in 1976 consisting of 1) fixation of attention, 2) depotentiating habitual frameworks and belief systems, 3) unconscious search, 4) unconscious processes, 5) hypnotic response (Erickson & Rossi, 1979; Erickson & Rossi 1983).
This 5-stage paradigm includes less traditional methods of problem solving exemplified in the published works of Milton Erickson (Erickson & Rossi, 2006). More specifically, ET is typified by the use of utilization technique (Erickson and Rossi, 2006a, 2006b; Zeig, 2006a; Short, Erickson, & Erickson-Klein, 2005; Erickson 1965, 1959), therapeutic binds (Erickson & Rossi, 1975), indirect suggestion (Erickson & Rossi, 1976), confusion technique (Erickson, 1964), therapeutic stories (Erickson & Keeney, 2006, Rosen, 1982), naturalistic induction (Erickson, 1958b), and especially, the use of many of these techniques in combination. ET does not rely on conscious insight.

**Brief Dynamic Therapy (BDT)**

BDT is defined as an eclectic approach to therapy that guides clients toward greater awareness and understanding of their problems and the resistances to resolving them. For the purposes of this study, BDT did not use hypnosis. This method relies on conscious insight (Wolberg, 1977, 1964, 1948; Whitehorn, 1947, 1944; Bellak & Small, 1965), meaning a clear, rational understanding of the cause of the target complaint from dynamics, motivations, behaviors, attitudes, and beliefs. Then a working-through phase followed, with corresponding experience of the emotional significance (Wolberg, 1977). Support for appropriate mature restraint, both cognitive and behavioral, was given during this phase. The last stage focused on intervention, both verbal and action-oriented, and expansion of client potentials to resolve the target complaint.

**Unconscious**

The unconscious is the storehouse of learning (Erickson & Rossi, 2006 Vol. I, 1). Erickson believed that unconscious functioning is naturally healthy, filled with potential and positive intelligence (Simpkins & Simpkins, 2001b). The foundation of better functioning should be the naturally healthy unconscious. Therefore, encouraging conscious awareness would not enhance therapeutic progress, but instead, would lead away from the source of healthy functioning. Hypnosis returns clients to the source of their healthy capacities. From there, people can unlearn their learned limitations and then discover and develop better possibilities.

For BDT, the unconscious is defined as a storehouse of repressions and negative instinctual impulses that cause the problematic symptoms. For BDT, the foundation of healthy functioning is through establishing conscious mental functioning. The role of psychotherapy in BDT is to bring the key elements of symptom-causing unconscious processes to consciousness. Then new insights can be learned from them, like the “aha” experience one may have of a pattern in an ambiguous gestalt formation. (Bellak and Small 1965, 32) The experience of insight permits problem solving with better cognitive integration and understanding.

**Conscious**

Conscious refers to deliberate attention to outward or inward events, experiences, thoughts, beliefs, behaviors and feelings involving the use of awareness with cognitive processes.

**Utilization**

Utilization is where the therapist goes along with the dominant presenting behavior, response, or interest as a means of holding the client’s attention, improving rapport, and enhancing the client’s feeling of being understood, as well as encouraging the resolution of the client’s difficulties (Erickson 1959). Personal memories and sensations of the client are the best starting place. By turning attention inwards using hypnosis, people find a wealth of
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experiences to draw on. The approach of utilizing personal experiences has evolved into a method to facilitate psychotherapy more generally: the Utilization Method. (Zeig, 2006a).

**Suggestion, Indirect Suggestion, and Indirection**

This study used Erickson’s definition of suggestion based in the natural tendency of suggestibility: the ability of the mind to respond to an idea. The unconscious mind responds best when suggestions are open-ended, leaving room for the unconscious to respond in its own way and time. This automatic level of functioning can be engaged and used in psychotherapy to help accomplish goals that might be difficult to do consciously. Erickson developed a complex lexicon and syntax of indirect suggestions to communicate with the unconscious (Erickson & Rossi, 2006b).

**Erickson’s Creative Research Methods**

Milton Erickson had strong opinions about how his method should be researched, which he discussed with the investigators on many occasions (1976-1980). One common assumption in laboratory research is that if all factors are kept equal, identical conditions should yield identical results. However, due to the unique and individualistic way people respond to hypnosis, Erickson believed that identical inductions might not necessarily yield identical trances. “An awareness of the variability of human behavior and the need to meet it should be the basis of all hypnotic technique.” (Erickson, 1958a, 71) This insight was pivotal for researching hypnosis.

Erickson felt that restricting and isolating variables in the laboratory risks creating an artificial situation that does not reflect the complexity of the actual phenomena of hypnosis. With this recognition, if research is to yield useful data, it should make room for variability in human behavior by individualizing the therapeutic experience. According to Erickson, neither researchers nor therapists should impose their will, but instead should just set the stage for subjects to be able to respond as they would naturally. Erickson found: “The simpler and more permissive and unobtrusive the technique is, the more effective it has proved to be, both experimentally and therapeutically, in the achievement of significant results” (Erickson, 2006, Vol. I, 15).

Erickson addressed these problems by doing his own research naturally (Erickson, 1958b; Simpkins, 2003). The naturalistic approach allowed him to observe phenomena in the midst of their interrelationships without intruding artificially. The uniqueness of the individual and his or her situation was not subtracted from the experiment so it could be studied. He observed many subjects under similarly flexible conditions to help him formulate generalized conclusions that would influence his therapeutic work in years to come. His approach informed this study.

**Problem Statement**

The question this study asked was whether ET is as effective as, or more effective than, BDT in terms of treatment outcomes on the following measures: Clark Personal and Social Adjustment Scale (CPSAS), Hopkins Symptom Checklist (HSCL), Global Improvement (GI), and Target Complaint (TC).

**Hypothesis**

\[ H_0: \mu_{ET} - \mu_{BDT} < 0. \quad ET \text{ will be less effective than BDT on the measures used.} \]

\[ H_1: \mu_{ET} - \mu_{BDT} \geq 0. \quad ET \text{ will be at least as effective as, or more effective than BDT on the measures used.} \]
Experimental Design

The study used a comparative pretest/posttest design employing two groups, Group I, ET, and Group II, BDT. Each participant received a preliminary one-hour interview, two pretests, six 1-hour weekly treatment sessions, four posttests and one final debriefing interview. A BDT Checklist and an ET Checklist served as general guidelines to direct the client’s therapeutic processes as well as to standardize the treatments used by the investigators.

Participants

Investigators made a deliberate effort to solicit a random sampling of subjects. Participants \((n = 27)\) were chosen at random using a pseudo-random number generator from a pool of people who answered signs posted in public areas. Signs were placed in a wide variety of settings (universities, grocery stores, the YMCA, health food stores, and businesses) on notice areas in upper, middle, and lower income communities throughout San Diego to attract as wide a range of subjects as possible. The research offered low-cost, ($60 for 6 sessions and two interviews) short-term treatment.

Participants were between the ages of 21 and 65 years, 13 men and 14 women with a median age of 38. They came from a broad range of lifestyles, communities, socioeconomic status, and races. Occupations included homemakers, students, unemployed, laborers, business executives, secretaries, professionals, nurses, and artists.

None of the participants had any prior experience with psychotherapy or hypnosis. No specific class of problems was petitioned, but each participant was asked to choose some problem or difficulty to focus on as the target complaint. Problems included: interpersonal difficulties, life goals that included job and direction, stress, anxiety, uncomfortable body, difficulty concentrating, lack of motivation, creative blocks, insecurity, low confidence, and poor self control in weight and smoking.

Therapists

The therapist/investigators had equal experience and training in both ET and BDT. Their training in ET came from direct personal studies with Milton Erickson and Ernest Rossi. Rossi was consulted during this study to ensure authenticity of the paradigm used. The investigators also trained in hypnosis under G. Wilson Shaffer at Johns Hopkins University and Harold Greenwald at U.S.I.U. Their training in BDT came from a number of varied sources. They did personal studies with John C. Whitehorn and Jerome D. Frank along with an internship at Johns Hopkins University Phipps Clinic. They also trained with Lawrence Kubie and did an internship at Sheppard Pratt Hospital under Kubie. They received supervision under James Spivack of Towson State University in BDT with outpatient populations as well.

Measures

Four measures were used: CPSAS, HSCL, TC and GI. This study chose these four measures because they covered four different dimensions: social/environmental, internal/experiential, target problem, and global improvement. All four measures are well researched and have been used by the Johns Hopkins Hospital Phipps researchers who had conducted comparative studies of different methods of therapy over a 25-year period. These four measures used in combination could also reveal comparative data about possible differences between treatments.
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The CPSAS (Clark, 1968) is a self-report instrument composed of 14 multiple-choice items about work, family, self, and interpersonal relationships. The CPSAS was designed to assess clients’ evaluations of general feelings about life, job, and interpersonal relationships in common sense terms, to show adjustment or lack of it in the client’s systems of interaction. The assumptions behind the test include the expectancy that harmony with the often contradictory demands and needs of one’s social network is important (Clark, 1968). The test score total is found by adding the scores for each of the 14 items. When the score goes up between pre- and posttest, improvement is indicated.

The CPSAS measure correlated relatively high ($r = .77$) with the Social Ineffectiveness Scale validated by (Gurland et al. 1972). The test has continued to be used in therapeutic effectiveness studies (Rosenberg, NK, Hougaard, E., 2005). Reliability was .70 over a 6 week period for psychotic inpatients at Bayview House Psychiatric Hospital and validity scores of patient samples ($M = 4.39$) compared to normal students ($M = 7.88$). The adjustment measure correlates 0.56 with the 100-item true-false self-report Cornell Index that measures adjustment ($p < .01, df = 42$) (Clark 1968).

The HSCL (Derogatis et al., 1974) is a self-report instrument that asks clients to rate a wide variety of somatic and psychic complaints such as subjective experiences of uncomfortable thoughts, body sensations, emotions, and lack of confidence. The test consists of 58 multiple-choice items. The rating is from “least distressed” to “most distressed” over the previous week. Scores for each item are added together for the total. When the sum of the scores on the items goes down, improvement is indicated.

The HSCL was tested with 2500 subjects: 1800 outpatients at 3 psychiatric hospitals and 700 normals. Reliability coefficients in test-retest were 0.75. Internal consistency coefficients were 0.80-0.87. Construct validity was tested in several tests and the degree of separation between mean distress levels of normal samples and the two outpatient samples ($n = 2000$) provided substantial measure of construct validity (Derogatis et al., 1974).

The GI (Frank, Hoehn-Saric, and Gurland, 1968) is a self-report measure that asks clients to rate their degree of change or improvement in general from “worse” to “a lot better” since therapy began. The GI is a posttest or follow-up test only. This test helped to balance the CPSAS and HSCL by giving clients the opportunity to evaluate their general functioning as contrasted to the detailed complaints described in the CPSAS and HSCL. This test has been used in numerous research projects and has been judged by experienced practitioners to possess adequate face validity (Fink, Hoehn-Saric, and Gurland, 1968; Frank et al., 1974).

The TC (Battle et al., 1966) is another posttest and follow-up measure. The TC allows clients to directly describe and rate their problem specific to the therapeutic goals. The TC met the needs of this investigation in providing a measure that focused on only one problem as the therapeutic goal. Validity on the TC was found by comparing it to the GI, the Social Ineffectiveness Scale, and the Discomfort Scale (Battle et al., 1966). Reliability was tested by measuring the stability of clients’ perceptions of their main problems before and after treatment. Therapists’ ratings were also compared with each other and with client ratings. From these studies, Battle determined that target complaints could be obtained reliably from the patient (Battle et al, 1966).

Interview Procedures

In the initial interview, all clients were asked general history and background questions from an Interview Checklist. The questions covered three main groups of data: general information, personal information, and the background and nature of the target
problem. Following the interview, participants were given a general description of the two treatment modalities. The theoretical premise of each method was stated briefly, and then subjects were assigned to one of the two groups by mutual consent. A cooperative approach to the treatment situation was encouraged just as in a typical psychotherapy initial interview. (See Discussion)

The two pretests were administered. Participants were told that any questions about the tests or the study would be answered in the final debriefing interview.

**Therapeutic Procedures**

Therapy was conducted in a team manner with an unrestricted give and take flow from both investigator/therapists with the participant/clients. Both investigators recorded on separate copies of the checklists, thus ensuring objectivity.

**Procedures for ET**

The target complaint that was to be the focus of therapy was determined at the time of the interview, but was not discussed directly during the sessions. Each session began with a 10 minute general discussion of whatever was of interest to the client. This allowed time to focus the client’s attention on his or her own concerns. Without specifically referring to the central concerns, trance was induced using the orienting mode most natural to the client. Incorporating utilization, contents for trance inductions were determined by the client’s interests during the session. Trance techniques were chosen from the ET Checklist. Techniques systematically chosen from all five sections were used with every subject in each session, to lead them into trance.

The ET Checklist had five parts: fixation of attention, depotentiating conscious sets, unconscious search, unconscious processes, and hypnotic response. Ideomotor signaling was established to stay attuned to the client’s experiences. Clients related to the therapeutic process through varied hypnotic phenomena such as changes in muscle tonus, inability to move, hand levitation, automatic writing and drawing, and speaking in trance. Indirect suggestions and stories guided clients into a broad range of hypnotic experiences including sensory experiences, images, memories, and hallucinations.

**Procedures for BDT**

Therapy began with a description of the problem area and proceeded through the three stages from the BDT Checklist: uncovering, working through, and expanding potentials. The six sessions drew from all three stages of the checklist, but earlier sessions used the first and second stage while middle and later sessions drew more from the second and third stages.

Stage one taught clients how to observe their thoughts, emotions, and sensations without judgment. Clients were encouraged to bring out related feelings, memories, attitudes, and experiences. They were taught to recognize subtle body feelings, emotions, and peripheral thoughts.

Stage two concentrated on patterns of defense, attitudes, beliefs, and values. As these were discussed, clients were encouraged to feel as well as observe the underlying emotions that were elicited. Special attention was given when values, beliefs, and attitudes were in conflict with each other and with emotions. Personal meanings of experiences were discussed as well.

Stage three emerged from the added insights and feeling-sense of the conflict that clients uncovered in the earlier stages. Clients explored new perspectives and flexible use of defenses. By the time they had gone through the three stages, they expressed an
understanding of where the problem came from, insight into the nature of the conflict with recognition of the defenses involved, and ability to distinguish between their actual personal situation and their distortions. The final session emphasized work on new potentials for change with some practical ways to implement these changes into everyday life.

Posttest and Debriefing Interview

The eighth meeting began with administration of posttests followed by a final interview. Clients were asked to elaborate on change in the target complaint, general changes, and any tools or learning they felt they had acquired from treatment. After all therapeutic procedures and research procedures were completed, clients were encouraged to ask any questions about the research. Candid disclosure of the project was then given.

Data Analysis Methods

CPSAS and HSCL were calculated for means for pretest scores, posttest scores and pre/post difference scores. The student $t$ test for significance was applied to all three sets of data at $p < .05$. The GI and TC, being posttests only, were calculated for the posttest scores, and the $t$ test applied to these data. Distributions percents of scores for each test were graphed and labeled for comparison to normal distributions (Figures 1-8).
Results

Hypothesis

For three of the four measures, there was no significant difference at $p < .05$ between ET and BDT. At $p < .05$, CPSAS $t(27) = 1.99$, TC $t(27) = 0.36$, and GI $t(27) = 0.63$. ET was significantly more effective than BDT on the HSCL $t(27) = 4.11$ at $p < .05$. Therefore, the null hypothesis was rejected.

Regarding power, $1-\beta = 0.92$ for CPSAS and TC strongly recommended rejecting the null hypothesis. GI had weaker power ($1-\beta = 0.41$). The power on the HSCL measure ($1-\beta = 0.59$) made it moderately likely that there was a significant difference between the two groups.

Assumption

The assumption that all distributions would approach the normal curve was supported for all of the curves except for the GI measure for BDT, which was skewed at the high end (Figures 1-8). Although there were differences between variances of some of the distributions of the scores, this did not violate the assumption for the $t$ test (Witte & Witte 1980). “In practice $t$ test gives pretty accurate results even when there are fairly large differences in the population variances” (Aron & Aron 2003, 356).
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Table 1: Pre/Post CPSAS Means, Standard Deviations, Effect Size

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Pre-treatment Mean</th>
<th>SD</th>
<th>Post-treatment Mean</th>
<th>SD</th>
<th>t</th>
<th>d</th>
<th>1-ß</th>
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<tbody>
<tr>
<td>ET</td>
<td>16</td>
<td>38.87</td>
<td>7.39</td>
<td>43.06</td>
<td>5.76</td>
<td>1.99</td>
<td>.13</td>
<td>.92</td>
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<tr>
<td>BDT</td>
<td>11</td>
<td>40.09</td>
<td>5.60</td>
<td>42.40</td>
<td>4.84</td>
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Table 2: Pre/Post HSCL Means, Standard Deviations, Effect Size

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<th>SD</th>
<th>Post-treatment Mean</th>
<th>SD</th>
<th>t</th>
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</tr>
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<tbody>
<tr>
<td>ET</td>
<td>16</td>
<td>32.37</td>
<td>7.39</td>
<td>17.34</td>
<td>9.31</td>
<td>4.11</td>
<td>.80</td>
<td>.59</td>
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<tr>
<td>BDT</td>
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<td>34.09</td>
<td>25.15</td>
<td>30.90</td>
<td>25.40</td>
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Table 3: Posttest TC Mean Scores, Standard Deviations

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<th>Group</th>
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<th>t</th>
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<th>1-ß</th>
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<tbody>
<tr>
<td>ET</td>
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<td>4.18</td>
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<td>.31</td>
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<td>.92</td>
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<td>BDT</td>
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<td>4.09</td>
<td>.67</td>
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Table 4: Posttest GI Mean Scores, Standard Deviations

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<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>d</th>
<th>1-ß</th>
</tr>
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<tbody>
<tr>
<td>ET</td>
<td>16</td>
<td>4.18</td>
<td>.73</td>
<td>1.90</td>
<td>1.12</td>
<td>.41</td>
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<tr>
<td>BDT</td>
<td>11</td>
<td>4.81</td>
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Discussion

Psychotherapy has made progress in understanding therapeutic effectiveness and the factors that influence it. Pioneers such as Jerome D. Frank and the Johns Hopkins University Phipps Clinic psychotherapy research group (Frank, Hoehn-Saric, Imber, Liberman, & Stone, 1978) ushered in a new era for psychotherapy research. Their 25-year Psychotherapy Research Project gave an early template for non-specific factors as ingredients of successful psychotherapy (Simpkins & Simpkins, 2002; Frank and Frank, 1991). Recent meta-analyses (Miller, Duncan, & Hubble, 1997, 1996) have continued to confirm what Frank and his team first concluded: psychotherapy is effective, but there is no significant difference between effectiveness of methods used to accomplish it. This research along with clinical experience led the investigators to form their hypotheses.
Assignment of Treatment Method

The attempt to identify empirically supported therapies (ESTs) imposes particular assumptions on the use of randomized controlled trial (RCT) methodology that appear to be valid for some disorders and treatments, but substantially violated for others (Weston, Novotny, & Thompson-Brenner 2004, 631).

What Weston, Novotny, & Thompson-Brenner advocate is “a thorough going assessment of the empirical status of not only the data, but also the methods used to assign the appellations empirically supported or unsupported (Weston, Novotny, & Thompson-Brenner 2004, 632). The current study attempted to be sensitive to possible design features that could interfere with the special needs for testing ET, beginning with the assignment of subjects to treatment group.

In private practice, some clients strongly request hypnotherapy whereas others are adamantly against hypnosis and prefer a talking form of therapy. Some of the general, uninitiated public experience hypnosis through the filter of such concerns as losing control, religious issues, and invasion of privacy to name a few. Thus, when participants learn that hypnosis might be involved and that they could be randomly assigned to receive hypnosis, those who had a prior bias against hypnosis would be likely to either drop out or resist. Furthermore, if someone entered the study to receive hypnosis and was not given hypnosis, they might be disappointed and resistant. Although sophisticated hypnotic practitioners and researchers know that these concerns can be sensitively addressed, they are issues that could intrude upon the cooperation of a research subject. To best replicate the real-world clinical situation and attempt to bypass these potentially intrusive factors, the investigators decided to randomize before assigning treatment methods, and once admitted into the study, allow subjects to participate in choosing their treatment method.

Subjects in this study could enter into collaboration by taking part in selecting the treatment method they preferred. “The ideal ‘scientist subject’ can be cultivated in both clinical and experimental laboratory settings by forming an investigator-subject partnership aimed at producing the most accurate data” (Barabasz & Barabasz 1992, 199). This study, therefore, was able to better maintain collaboration while at the same time creating a context to examine the process of psychotherapy’s effective action. Allowing subjects to participate in selecting their treatment included the subjects’ natural inclination toward one method or the other, to permit the positive effect of non-specific factors with both methods. A future study could be done using random assignment of subjects to treatment as a means of comparison, to attempt to bypass the effect of each individual’s personal concerns. A much larger sample size or meta-analysis might correct for the potential randomization problem.

ET Results Discussion

The statistics indicated that there were generally similar effects from the two treatments but that there were some specific differences that were revealed by the measures. ET had a larger change and effect size on the HSCL, a test that addresses physiological and internal discomforts. This finding supports some of the recent research that has found hypnosis especially helpful for pain (Miller, & Bowers. 1986; Hilgard & Hilgard, 1975) headaches (Llaneza-Ramos, 1989), anxiety (Benson et al., 1978), obstetrics (Abramson & Heron, and 1950), general women’s discomforts (Hornyak & Joseph, 2000), stress (Bryant et al., 2005), and other problems that typically involve physical discomfort. Hypnosis clients often reported feeling more comfortable, less anxious, and less stressed, which is a typical
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byproduct of hypnosis. Therapists who do not use hypnosis as their primary treatment might want to add this skill to assist with these types of problems. Research supports hypnosis as an adjunct to cognitive behavioral therapy (Kirsch, Montgomery & Saperstein; 1995; Allison & Faith, 1996).

The ET group never received any direct work on the target complaint, but the results on the TC measure were very similar for both groups. This statistic shows support for Erickson’s idea that therapy is not just the specific result of the therapist intervention: change takes place within the client. This finding can encourage therapists to offer open-ended interventions that elicit personally meaningful responsiveness from clients and encourage inner processing instead of directing the client with overly specific or standardized techniques. As further support for this idea, Lynn, Green, Jaquith, & Gasior, (2003) found that subjects receiving lenient instructional sets far outperformed subjects who were given stringent instructions when tested for suggestibility, subjective involvement, involuntariness, quickness of response, satisfaction, and imaginative ability.

Qualitative Information

The closing interviews revealed some additional information. All participants were asked to specify what they had learned from treatment. Everyone expressed satisfaction that they had gained new tools for working with themselves, but the two groups reported receiving different skills.

ET participants felt that they could trust and use their unconscious mind as a tool. Often they experienced this as simply happening without quite knowing why. One participant said, “Things are just kind of happening; I’m not sure why, but I am more relaxed, and I can trust my intuitive self.” Another said, “My unconscious has opened up more and it does more. This feels good.” The tools this group acquired tended to be an intuitive ability to sense their inner needs and a willingness to listen to their inner voice.

BDT participants felt that their awareness acted as a distinct guide to sense situations, notice reactions, and trace feelings and thoughts. “I’m looking at feelings as opposed to surface thoughts. I can examine them since I am aware of them,” remarked one BDT participant. Another said, “It’s the awareness: stopping, stepping back, away from being immersed in it all, to look at it from the outside. I’m noticing things more and making an effort to observe my surroundings.”

Many ET participants also expressed a new ability to be objective, like the insight participants. One ET client said, “It feels like something, a clouded something in me has helped me stand back and look at things more objectively and be more relaxed instead of getting freaked out.” So, despite differences in treatment methods, participants seemed to develop a similar objectivity. Though both groups felt they gained objectivity, each believed it came from a different source: BDT from a clear awareness, and ET from a supportive unconscious. Both groups felt they gained greater understanding of themselves and their problems.

The research indicates that ET can be an effective method to bring about psychotherapeutic change. Further research will disclose more. As Heraclites, the wise early Greek philosopher said, “Wisdom is one thing: to grasp the knowledge of how all things are steered through all” (Barnes 2001, 53).
References


Ericksonian approach to therapy and brief dynamic therapy comparison


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