ASSESSMENT IN ERICKSONIAN PSYCHOTHERAPY AND HYPNOSIS

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ABSTRACT

Assessment serves the function of collecting information that influences the course that psychotherapy will take. In Ericksonian terms, material gained during assessment forms the basis for utilization. Utilization guides the selection of methods, techniques, and interventions. Assessment is continuous, occurring throughout all stages of therapy and during every session. This paper outlines a number of relevant areas for assessment. These include general matters such as readiness for treatment and expectancy as well as more specific stylistic characteristics that patients bring to treatment. These dimensions of assessment are useful in both clinical hypnosis and in nonhypnotic brief therapy.

Therapy begins with assessment. Therapy ends with assessment. Assessment occurs before intervention. Assessment happens after intervention. Psychotherapy and clinical hypnosis involve a continuous flow of the complimentary processes of assessment and intervention. In Ericksonian therapy, the principal that connects assessment and treatment is Utilization. In assessment, the clinician decides *what* to utilize. During treatment, the therapist decides *how* to utilize it.

UTILIZATION

Utilization is the central, guiding dynamic in Ericksonian psychotherapy. It follows from Erickson's admonition, "Take what the patient brings." Psychotherapy is the application of utilization, as the clinician gathers, sorts, and uses variables to promote change. Conceivably, anything can be utilized in treatment. Aspects of the patient (e.g., achievements, learning, talents, aspirations), phenomena from the environment (e.g., sounds, sights, events in the news), and variables of the therapist (e.g., associations, memories, training) are all available for utilization in the treatment context. The therapist is active and watchful in the Ericksonian approach, constantly evaluating and experimenting with factors that can promote progress toward therapeutic goals.

DIMENSIONS OF ASSESSMENT

"Utilization theory emphasizes that every individual's particular range of abilities and personality characteristics must be surveyed in order to determine which preferred modes of functioning can be evoked and utilized for therapeutic purposes" (Rossi, 1980, p. 147). Much

assessment of the patient occurs before therapy begins. There are a number of general variables that are important to evaluate with all patients in the beginning stage of therapy.

TREATMENT READINESS

It is important to assess the extent to which a patient is motivated to participate in psychotherapy. In some contexts, motivation is nonexistent if the patient is being ordered or forced into treatment. In settings in which people are voluntarily presenting, there is typically some level of initiative and preparedness to participate in the therapeutic process. Still, mindfulness of the level of motivation is important. Fisch, Weakland, and Segal (1982) proposed a brief but highly useful classification of patients in terms of their readiness to engage in psychotherapy. Those authors divided patients into three types according to the manner in which the patients would answer two questions: (1) "Is there a problem?" (2) "Are you willing to work on the problem?" Those authors hypothesized three "types" of respondents to these questions. A "window-shopper" [patient] would respond "No" to both questions, indicating a lack of willingness to become involved in therapy. A "complainant" responds "Yes" to the first question but "No" to the second. This demonstrates some level of treatment readiness but also hesitance that must be considered and accommodated. Such reluctance to extend effort toward resolution of the problem customarily undermines the ultimate success of therapy. A "customer," the third category of patient, answers affirmatively to both questions, suggesting positive motivation for involvement in treatment. Assessment of these "types" of patients is generally informal but the determination can be vital in influencing the scope, length, and type of therapy that is undertaken.

INSIGHT

The extent to which a patient is aware of his/her problem and cognizant of the resources that can potentially be utilized to treat it is an important consideration in how to initiate treatment. Evaluation of insight can help a therapist to determine whether or not psychoeducational services are necessary, the balance of direct and indirect methods that will be employed in treatment, and the general psychological sophistication of the individual engaged in the therapeutic relationship. Though insight itself is not a quality that directly promotes change, its assessment prior to the initiation of treatment can help to guide the types of interventions that are ultimately employed.

EXPECTANCY

One of the most salient considerations in the assessment of what patients bring to therapy is the set of expectations they have about what will happen and what is possible. Expectancy, in general, refers to the perceived likelihood that something will occur. Some patients enter treatment with very little in the way of expectancy. They are not experienced in the processes and methods of psychotherapy, unaware of how change occurs, and not influenced by crystallized notions of specific outcomes. Other patients present with unrealistic aspirations regarding outcomes that can occur in therapy. This is especially true – but not limited to – patients who seek clinical hypnosis. Some of these people want troublesome experiences removed (e.g., pain, craving for chocolates), others seek sweeping, characterological change that simply cannot occur. And, they want it to happen in a very brief period of time.

Expectancy is potentially one of the therapist's strongest allies in treatment. One wants patients who are motivated and hopeful, optimistic that beneficial change will occur. Conversely, unrealistic expectancy can be the biggest hindrance to progress. If a patient's expectations are not reasonable, therapy is doomed to failure, for it will always fall short of satisfying the unattainable objectives that the patient desires. So, the assessment of expectancy prior to the initiation of treatment is of ultimate importance. General, open questions can be useful in assessing expectancy, such as, "What do you hope will happen during therapy?" or "What do you want to achieve from coming here?"

PATTERNS AND SEQUENCES

The form that therapy takes can be influenced by the extent to which discernable patterns in a problem can be identified. In cases in which such exist, problems are usually more chronic in nature and this can to some extent dictate the length and type of therapy that is recommended. This variable is correlated with insight; some patients are very aware of patterns in their life, others are completely ignorant. If the therapist and patient together can identify sequential steps in which difficulties occur, a more specified and targeted form of intervention is possible.

HYPNOTIC PHENOMENA

Clinical hypnosis involves the utilization of a state of focused awareness. The aims are positive, therapeutic. Hypnosis entails the strategic employment of hypnotic phenomena (e.g., age regression, positive hallucination, anesthesia), the mechanisms of therapeutic change during the elicited focused process. Psychological and medical problems also involve states of focused awareness. In these, however, the content and results are not positive. Still, the structure of problems is similar to that in the focused awareness of hypnosis. Namely, the hypnotic phenomena comprise the form and substance of the problem. For example, age regression is customarily a prominent feature of trauma. Catalepsy is frequently seen in depression. Jealousy is fueled by positive hallucination (figuratively, through imagination). Hypnotic interventions can utilize the hypnotic phenomena of problems. This can be done in two ways. "Complimentary" techniques can be chosen in which the opposites of the identified problem phenomena are utilized therapeutically. So, the trauma patient can be treated with age progression (the opposite of age regression). Movement can be suggested to the depressed patient to offset the immobility ("catalepsy") that is a hindrance. Alternately, the therapist can utilize "isomorphic" interventions, using the problem phenomena in the same form. For instance, the jealous patient can be encouraged to continue to use positive hallucination but with more benign content that calms rather than arousing anger. Or, in some cases of trauma, age regression can be helpful in reducing the emotional reactivity associated with memories. Assessment of the hypnotic phenomena that are involved in patients' problems can generate numerous treatment strategies. Conceptualizing clinical issues in these terms can allow a therapist to "think hypnotically" from the moment that assessment is initiated and form a ready bridge to implementation of hypnotic interventions.

The diagram below, "The Process of Ericksonian Hypnosis," illustrates the manner in which assessment of hypnotic phenomena in clinical problems can be integrated into treatment planning. After the absorption of induction is accomplished, the therapist chooses how to utilize the identified

phenomena of the problem, in a complimentary or isomorphic manner. This is at the discretion of the therapist. The therapist's judgment, experience, and knowledge will guide the choice of interventions ("vehicles" in the diagram) and the direction of utilization of the assessed phenomena (i.e., complimentary or isomorphic) in the hypnotic session. The diagram shows how central to treatment the hypnotic phenomena are, both in problems that patients present and in the therapeutic planning and delivery the therapist implements.

Diagram, "The Process of Ericksonian Hypnosis" about here

VALUES

During the past two decades, Shalom Schwartz and various colleagues (Bilsky & Schwartz, 1994; Schwartz, 1992; Schwartz & Bilsky, 1987; Schwartz & Sagiv, 1995) have systematized and greatly advanced knowledge about values. These are primary motivational forces in peoples' lives that "guide selection or evaluation of behavior and events" (Schwartz & Bilsky, 1987, p. 531). As such, values are exceedingly important matters for assessment. As clinicians identify patients' value priorities, a great deal of information unfolds about the reasons behind choices, preferences, satisfaction, and discontent. Values can be utilized in myriad ways, both in hypnosis and in non-hypnotic brief therapy (Geary, 2001). The reader is encouraged to learn more about the social psychology research on values, for this is a deep and rich area with far-reaching implications for psychotherapy.

DISSOCIATION

Dissociation is the "… unexpected partial or complete disruption of the normal integration of a person's conscious or psychological functioning" (Dell & O'Neil, 2009). Like the hypnotic phenomena mentioned above, dissociation is a central dynamic in both hypnosis and in peoples' problems. Indeed, dissociation is necessary for trance phenomena to operate. Braun (1988), in the "BASK Model," outlined four spheres of experience in which dissociation occurs:

Behavior: Activities are carried out without conscious recognition and/or recollection.
Affect: People become detached from emotional processes and reactions.
Sensation: Feelings in the body are ignored, modified, or eliminated.
Knowledge: Pieces of personal and/or general information are not summoned or recalled.

Dissociation commonly occurs in everyday life. We do have to think about every aspect of highly routinized functions, such as walking, driving, cooking, and the like. We want our surgeons and air traffic controllers to put emotions aside in order to focus on the important activities they carry out. Awareness of bodily sensations can be significantly reduced while people listen to an interesting lecture or watch an enthralling movie or engage in an interesting conversation with a

friend. And we have all experienced lapses in our ability to produce information in one form or another, the "tip of the tongue" phenomenon perhaps the most familiar example.

But dissociation can also be dysfunctional and pathological. Habits and compulsive behaviors are frequently supported by dissociation of behavior. Patients complain. "I'm just doing it (e.g., biting fingernails, pulling out hair, lighting a cigarette) and I'm not even aware." Dissociation from affect is common in depression ("emotional numbing"), shock, and traumatic disorders. People who struggle with obesity often demonstrate dissociation in sensation, as do others with sexual dysfunction. And dissociation from knowledge is a well known feature of depression, trauma, and cognitive disorders.

It is apparent how dissociation operates to engender the hypnotic phenomena. The classical technique of arm levitation is produced by avolitional behavior, analgesia and anesthesia are created by dissociation from sensation. Amnesia is elicited through dissociation from information a person possesses.

The present writer believes that there are other ways in which dissociation is manifested. Since I believe there is "more" to dissociation than BASK, I propose the "MORE Model" that expands the realms in which dissociation is seen:

Movement: Patients become "stuck" by problems, failing to move ahead toward goals and aspirations. This is particularly common in depression but anxiety disorders and other problems can very much impede movement in peoples' lives.

Orientation/Optimism: The final operation of hypnosis is to "reorient" the patient. It is customary for hypnotic subjects to temporarily lose awareness of time and space. People with problems also lose orientation, whether to social relations, or identity ("I don't know who I am anymore!"), or commitment to personal ideals. This writer also believes that optimism is a vital feature of orientation. When optimism is curtailed or reduced, orientation to striving, personal development, and sense of community can be drastically diminished.

Resources: Most patients present for psychotherapy due to dissociation from resources. In essence, the function of therapy is to enhance the ability to identify, elicit, and utilize resources within oneself and in the environment. Erickson conceptualized hypnosis as a context in which unconscious resources can better be brought to bear to help people learn, develop, and solve life dilemmas. So, therapists seek to lessen the dissociation from resources that patients experience. In hypnosis, this is accomplished by actually utilizing dissociation in a strategic manner to enhance recognition and availability of resources.

Energy: Again, dissociation from energy is clearly illustrated in hypnosis. People become relaxed and do not want to move. The mind remains active but the body is de-energized for a time. But many people experience a negative dissociation from energy, whether in depression or problematic relationships or physical ailments. Hypnotic subjects become re-energized at the termination of trance and the dissociation is ended. Unfortunately, this is not so easy for individuals who have been dissociated from energy by circumstances and difficulties.

The addition of these domains also serves to highlight the importance of the role of dissociation in eliciting the hypnotic phenomena. Positive hallucination, hypermnesia, and age regression are all accomplished by dissociation from orientation. Catalepsy is the absence of

movement. And dissociation creates the opportunity for enhanced access to unconscious processes in hypnosis and the resources that can thereby be utilized.

So, part of assessment can be a "Dissociation Diagnosis" in which the therapist identifies ways in which patients are experiencing problems due to lack of integration in the above eight domains. Some types of dissociation will be more prominent than other forms. And assessment in this dimension helps in the formulation of hypnotic intervention. Once again, the therapist is conceptualizing presenting problems in a "hypnotic" manner, anticipating the ways in which dissociation might be employed later in treatment.

ASSESSMENT OF PATIENT STYLES

As therapy begins, there are a number of dimensions in a patient's presentation that can be assessed with, as always, an eye toward utilization. These are more specific, "microdynamic" aspects of behavior, perception, and orientation of the patient. By considering these facets of style, the therapist increasingly hones in on the particular aspects of the individual patient that will influence the tailored approach to treatment.

TIME

A therapist can assess to what aspect of time a patient seems most oriented: *Past, present, or future*. Some disorders will necessarily influence the focus. Anxiety, for example, is always a future-oriented condition, since the source of fear is what is going to happen. But even anxiety patients often point to seminal experiences in the past and spend much time discussing how life was different before. Many depressed patients and those with pain disorders have little sense of the future. Other patients concentrate on what is transpiring in the moment in the therapeutic context, some vigilant for nuances and cues in the therapist's behavior (indicating acceptance, rejection, sympathy, etc.). A patient's orientation in time is worth noting as a consideration for treatment planning. The reader is directed to fascinating research that the social psychologist Phillip Zimbardo, Ph.D. has conducted (Zimbardo & Boyd, 2008).

INFORMATION

Patients present information in a variety of ways. Some are quite *focused*. They discuss matters in an orderly, organized manner, concentrating on salient features of the problem. Other individuals are *diffuse*, more scattered, perhaps even tangential. They might have difficulty staying on topic, interject extraneous information, and require much longer times to explain themselves. There are patients who are *undependable* in their personal accounts, for one reason or another. Some people are ashamed to discuss personal matters, some are characterologically unreliable and manipulative, others feel a need to control the therapeutic relationship or protect themselves. The way in which a patient is oriented to providing information is an important variable to assess.

STYLE

The manner in which treatment is undertaken can be influenced by the personal style of the patient. Some patients enter therapy in a *bold* manner. These people often see themselves as capable and behave in a frank, forthright manner. They have chosen therapy as a context in which they can confront difficulties and they usually express confidence that those difficulties can be overcome. Other patients present in an *ambivalent* way. They might express doubts about whether or not therapy is going to be helpful, whether they can be helped, and vacillate between optimism and pessimism. A third category is the *frightened* patient. Not only are these people often overwhelmed by their problems but they fear discussion of them and are apprehensive about what might be involved in treatment. Usually, style is easy to assess and can be done so rather quickly. It should not be overlooked because the approach taken in therapy can be highly influenced by the style that the patient brings.

PRESENTATION

People have a variety of ways in which they view the etiology and effects of their problems. Some people take a *logical* approach, hypothesizing about cause and effect, presenting linear explanations related to disorders, and discussing ramifications in a rational tone. Other people present an *emotional* discussion. Their conversations very much center on nonrational aspects of dilemmas and emotions take center stage in the personal dramas that are outlined. Other people have a more *detached* presentation. Their self-report can almost make it sound like the problems are happening to someone else. Often these people do not make connections among events, behaviors, emotions, and consequences. Sometimes there is a naïveté about these patients, in other cases a tangible dissociation is present.

LEVEL OF COMMUNICATION

Most experienced therapists are familiar with the patient who speaks in metaphors, analogies, and symbols. These people are quite *abstract* in discussing their lives and they tend to be quite general, sometimes even resistant to dealing with specifics. Other people are *concrete*. They might be rather unsophisticated in terms of awareness of psychological processes, emotions, and even relationships. Other peoples' level of communication is more *undefined*. They can be practical in their understanding but have difficulty recognizing implications of events and behavior. They might have difficulty truly understanding the meaning of circumstances but can still be capable of a more slowly developing insight that might progress during therapy.

PLACE

As patients talk, therapists will get the impression that they are *here, there,* or *nowhere*. Some patient focus on the conversation within the consulting room very much oriented to the interaction in which they are involved. Other patients fill their discussion with events outside. They are sometimes almost oblivious to dynamics occurring within the therapeutic relationship, focusing on matters that transpire at home, at work, with friends, and the like. Other patients give the impression that they feel as if they belong nowhere. They do not feel "rooted" anywhere, do not feel a sense of belongingness or affiliation. They frequently present existential quandaries such as lack of purpose and direction.

RESPONSIVENESS

As a therapist, one encounters *informative* patients who freely, sometimes extensively, offer facts, opinions, and beliefs about their lives, others' roles, and their personal history without much questioning or provocation. Other patients are not so voluntary but assume a *responsive* stance, providing information as requested after inquiry from the therapist. Other patients are *secretive*, withholding information, divulging sparingly, and leaving the impression that more was left unsaid than was revealed.

AGE

Patients present as *mature, developing*, and *regressed*. In addition to chronological age, it is wise for a therapist to assess the developmental age of the patient. Some present themselves and their personal stories in a mature, adult manner. They might demonstrate wisdom, acceptance, and other aspects of mature development. Other patients are clearly in the process of "growing up." They likely will exhibit some aspects of maturity but at other times show characteristics and ideas that are indicative of emerging growth. Other patients take a regressed position, childlike and dependent in their behavior and affect. This dimension can affect the role that the therapist assume, adapting to the type of relationship appropriate for the developmental stage of the patient.

PHYSICAL

It can be useful to assess the spectrum of physicality that patients bring to therapy, both within the office and as a general characteristic in their lives. Some patients are quite *active*, energetic in therapy, busy and involved in their everyday affairs. Other patients are more *passive*, perhaps sedentary at work, in pastimes, and in their presentation at the therapist's office. At the other extreme from active, some patients are *cataleptic*. They do little, move little, and are generally inert in leading their lives.

The foregoing dimensions are generally relatively easy to assess and they can be valuable in influencing treatment planning in a number of ways. Identification of these patient characteristics can help to guide the pace of the therapy. They provide valuable information regarding the tone and course of the therapeutic relationship. These dimensions can help the therapist to decide the types of homework assignments that are suggested and the relative level of responsibility that is given the patient in the treatment process. Assessment of these characteristics can be useful in determining the balance of direct and indirect methods that are used, both in hypnosis and nonhypnotic therapy. Most importantly, these specific variables promote targeted, individualized methods since these will be designed to address particular features of the person's phenomenology.

OTHER ASSESSMENT CONSIDERATIONS

The above discussion centers on some of the most significant areas for assessment from an Ericksonian perspective. There are, of course, myriad other items that can – and often should – be evaluated. There are many forms of brief therapy and the particular model will guide the areas of assessment on which the clinician focuses. Psychodynamically oriented therapists will look into ego strength, defenses, and the like. Systemic professionals will explore birth order, nuclear family relations, and other such matters to design interventions. Brief cognitive therapy will delve into a different set of variables that are related to identifying and treating dysfunction through that model. Some therapists utilize psychometric instruments to aid in assessment, others employ structured interview techniques. Assessment of physical status, possible presence of substance abuse, employment issues, and other life areas is routinely accomplished regardless of technical or theoretical model. Naturally, in brief therapy, one of the most germane assessment considerations is whether or not a patient is a viable candidate for treatment or if a longer course is required.

Assessment occurs after each intervention. It is only by evaluating the relative success (or failure) of a technique that therapy can proceed in an organized manner. So, not only does therapy itself begin and end with assessment, so does each session. At the beginning of a session, the therapist inquires about response to homework assignments and other interventions. There will be a discussion about events that have transpired since the last meeting. During the session, assessment continues, the therapist ever alert for what to utilize. At the conclusion of the meeting, the therapist (and the patient) will assess outcomes, progress, and ideas about what to do in the future.
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CONCLUSION

Assessment is an ongoing process that commences with the initiation of treatment, occurs throughout every session, and generates the decision regarding when therapy is terminated. From the Ericksonian perspective, assessment provides the material for utilization, the structure and substance of the methods that form therapy. Consequently, there is an enormous amount of material that can be assessed. The therapist is an active agent, probing for and sorting information that ultimately will comprise the fabric of treatment. Not everything can be utilized, there is simply too much. So, an integral task of assessment is distilling the most relevant material that can be used to make a difference in patients' lives. Assessment is the key that opens the door to discovery with each moment that is spent with a patient and creates the opportunity for different and better days to come.

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