

INTERVIEW WITH DR. WESLEY ANDERSON
DOCTOR OF CLINICAL HYPNOTHERAPY

By Ashley Guthrie, Ph.D.

Q. Dr. Anderson, tell me first, how do you define addiction?

A. Well, I am a radical about that. First of all, “addiction” is just a model. It is not something that’s real. It’s a way of describing a set of phenomena, and it has been a really useful model for certain kinds of things, for example, alcoholism and heroin addiction. It doesn’t exist though. It is just something that somebody made up. Now, there are some physical characteristics that people have been able to associate with the model like certain kinds of changes in the brain and certain neuroreceptor sites and that kind of thing. My opinion is that, although those associated physical characteristics are interesting, and perhaps even important, they are not really the crux of what is going on with someone who is experiencing a difficulty with abusing or overusing a substance. Pretty much the universal definition of addiction is that people have cravings for substances when their blood levels of the substance drop, and they have a difficulty in discontinuing the habit of use. And so, we can look at a scientific definition, which I do not use with my clients because the people who I am dealing with are not scientists. They are basically just the general public, and what they mean when they say they are addicted is that they have been having a hard time quitting. They mean that they want something that they do not want to want anymore. They wish to stop using that substance, nicotine, for example. And, they mean that they are conflicted about it and they are having a difficult time quitting. *That* is really what most of them mean when they say they are “addicted”.

Q. In this case, do you feel that addiction is a disease?

A. I do not think “addiction” fits the disease model very well. For one thing, if we look at mumps or Alzheimer’s disease, there are certain kinds of physiological and pathological changes that are going to occur consistently in people with mumps or Alzheimer’s disease. That is not true with addictions. What you get is a set of behavioral changes that are generally similar without overt pathology. The pathologies are a consequence of the substance abuse.

Let’s take a look at alcoholism in which somebody who is considered an alcoholic binges once every three months, or who once a month will go on a two-day binge. Then there is the alcoholic who drinks a little bit every day. They feel as though they can’t stop. These people feel like they have got to have a certain amount, but they might not drink nearly as much as the alcoholic who binges. Yet they are drinking every day and are becoming psychologically dependent on the drinking. Then there are the ones who drink heavily every day. That is a pretty broad range of behaviors and of consumption to be all lumped into one thing. So, I think the model developed because in earlier people who drank too much were considered to have a moral defect in their character. So the people who promoted the disease model basically were trying to counteract and replace the character deficit model. So, they said, “Let’s call it a disease. A disease doesn’t have moral implications.” So that is really what they were all about. They were trying to take the moral stigma out of alcoholism and drug abuse.

I actually had an interesting experience with someone who was deeply committed to the disease model

once. A therapist who worked in a drug rehab hospital did a presentation at a hypnotherapy association meeting and she spoke about alcoholism disease. I asked her, "Well, what are the advantages and the disadvantages of the disease model, and what other ways do you have of thinking about it?" And her answer was to basically go blank. She had no answer at all, because it never occurred to her that "addiction" could be anything other than a disease. No one ever taught her it was a model. She thought it was real. It's not real. Addiction is not real. Addiction as a disease is not real. It is just a way of thinking about things and as a metaphor it has proven to be very powerful and very useful in a great many circumstances.

I don't think of it as an illness. For one thing, it is not contagious. It is not something like leukemia or lupus or any of the other "real" diseases. There are real, major distinctions to be made between the two phenomena.

Q. So, in that case, there has been research done that shows that alcoholism, in particular, can be familial. Studies have been done where I think they studied so many men only who were children of alcoholic parents but were not raised by the biological parent. They were actually raised by the adopted parent in an environment other than the home of the biological parent and, yet, these studies have shown that almost every one of these men showed alcoholism traits. Do you feel that there is something to this familial theory?

A. I haven't seen the research so I can't comment on those specific research findings. My guess is there probably is something to it although maybe not what people make of it. There are frequently any number of ways of interpreting the same set of data. It may well be that there are genetic predispositions. For example, I understand that American Indians tend to have a great deal less tolerance for using alcohol because they do not have a genetic tolerance for alcohol. American Indian's use of alcohol doesn't go back any more than about 400 years. Whereas, in Europe and Asia, people have been using alcohol for millennia and they have actually had a chance to develop a genetic tolerance to the poisoning. Alcohol is actually a poison and the drug affects are due to the body responding to it as a poison. I would guess that the whole thing about familial and genetic predisposition has something to it. The important thing to notice is that even with the predisposition, somebody doesn't have to have an alcohol or drug problem. Unless we have a case like a cocaine baby, nobody is born addicted to anything. I don't know enough about that research *per se* to make an argument one way or the other about it.

When I see a client, it doesn't matter to me whether they have a familial influence, or genetic influence, or anything like that in terms of the substance they may be abusing, because I look at each of them as an individual - each perfectly capable of changing whatever behaviors they are engaging in.

They complain, and they whine, and they tell me that it's not possible, and all that kind of self defeating nonsense. But, that is just hypnosis they have done on themselves, and they are trying to do it to me. It doesn't work. I am the hypnotist. I do the hypnotizing, not the client. At least, I hope so. So, I think of the research as interesting. It may have some validity and value, but it's not really all that important when it comes to me sitting down with a client.

Q. Very interesting point you raised. In that case, do you feel that there is a common denominator in both substance addiction such as nicotine, drugs and alcohol, and non-substance addiction such as sexual and gambling?

A. Well, I see everybody as an individual. I have never seen anybody who is an addict as part of a group of addicts. I just see individuals. Yes, if you take somebody who is abusing alcohol and compare them with other alcohol abusers, there are going to be some common characteristics about which one can generalize, and the same would hold true with heroin users and smokers. Of all the so-called addictions (I dislike even using the word because it is so broadly applied) tobacco is the one with which I have the greatest familiarity. What I have found is that there is a fair amount of variation in terms of people's experiences of tobacco use, although there are some generalities that one could usefully consider. We can get into that if you want. Most of the generalities have to do with attitudes and beliefs that smokers share about nicotine, and at some point as we go along I will talk about how I differentiate nicotine from the other substances.

In terms of carbohydrate, food addictions, sex, gambling, these things cannot be true addictions - not by the disease model anyway. What you've got are people who may have chemical balances that cause them to have predispositions towards certain kinds of compulsive behaviors. I don't think of chemistry in these cases as primary. I think of the chemical imbalances as secondary, as a result of the way their mind is processing things. For purposes of hypnosis, that is a good way to think of it. Just reverse the normal thinking process for the medical and psychological establishment and see what happens. Maybe it's useful, maybe not. One thing that you could say is a common denominator is people engaging in behaviors that they believe, or others believe to be destructive to them and to other people, is that these folks have a difficult time stopping the behaviors, and that they feel compulsions and strong urges to engage in those activities whether it is using a substance or whether it is gambling or sex. That is the reason why they have all been called addictions. They have been lumped together because of that quality of compulsion that goes along with the activity.

Q. Do you feel, then, that compulsion is that one basic component that is present in all so-called addictions, both substance and non substance?

A. Yes. I would agree with that. Compulsions - a sense of being unable to stop or having a great deal of difficulty stopping the behavior. Those with compulsions and strong cravings for a drug or behavior, are similar to a lot of people with eating issues. It's fascinating to me that some of my weigh control clients say they are "carbohydrate addicted" and then proceed to tell me it is only certain kinds of sweets that they want. Peanut brittle is not good, but M&Ms are greatly compelling. "How about if I give you a pound of rice?" "I don't want any rice." So, you have got "carbohydrate addicts" who will sit around with a pound of cooked rice and not eat that because it doesn't taste all that good to them, but who will insist that they are addicted to carbs, and if one put them next to M&Ms they would be gobbling them up without any kind of control. It all sounds peculiar to me because I pretend I am a Martian, and then I look, and listen, and say to myself, "Wow, that's really weird. How can this be so?" as a part of understanding the individual and the dynamics of the individual's behavior. I have gotten a little far afield.

The question is the common denominator between substance and non-substance addiction. It is basically psychological - the psychological experience of the so-called "addictive" behavior. Let me make another comment about that. I am differentiating because when I work with smokers, in particular, most of them tell me that they are addicted. Well, we don't know that for sure because they haven't been diagnosed as medically addicted by proper authorities. As I understand it, about two-thirds of smokers statistically are going to be addicted, and I may have a skewed population. I am getting a population of smokers who consult with hypnotherapists. At any rate, some of them must be addicted, by the technical definition. What I say to them is, "I don't like the word addiction when it is applied to heroin and nicotine equally. There are enough differences between heroin and nicotine

addiction that they ought to have their own different categories. For example, if you take a heroin addict and lock him in a room for 12 hours, what's going to happen? He is going to go into withdrawal. He is going to get sick. He is going to be pretty damn miserable. If you take the smoker and stick him in an empty room, they are going to get bored. They might want a cigarette but they are not going to get sick. They are not going through withdrawal with the kind of intensity that a heroin addict does. They won't get sick. They might get annoyed or bored. Maybe angry, who knows? It depends on the personality of the individual, and there are some other things to consider as well. For example, smokers sleep all night. Heroin addicts will not sleep through withdrawal. They will wake up and go get something to stop their cravings.

Q. Interesting point there. What about those with so-called sexual addictions and gambling addictions as far as obviously in the middle of the night they might not get up and go out seek out a sexual liaison or go to a gambling table but do you feel there are some common factors involved there as well as with heroin addiction?

A. The reason those behavioral difficulties have called it addiction is because of the behavioral similarities that they have with those addicted to substances. They have been labeled as addicts. Consider this: there were no sex addicts in 1912. There was no such thing because no one had invented the label. There were philanderers. There were people who were overindulging in sex, and they were looked down upon as morally depraved and that kind of thing. Or maybe they were thought of as rich, and they could get away with it. At any rate, spiritually or morally they were considered off track at best. And, along comes the notion of addictions, which is first applied to alcohol - or the disease model of addiction - first alcohol and then other drugs. Then people say "Well, these people are compulsively having sex. It is like an addiction." All of a sudden, they dropped "It's like..." and said "It is an addiction." And it was the same with gambling.

I have not worked with these people very much, if at all, so I can't make really any generalizations about the so-called sexually addicted and the gamblers - at least, not from personal experience. My uninformed guess is that if you set these people down in front of me and they talked with me about what is going on with them that there would be any number of psychological dynamics that would be similar to some of the substance addictions. However, if you take a sex addict and you lock him in a room for 12 hours, are they are going to get sick? No. The same is true with the gambler. They are not going to get sick from physical withdrawal from gambling. That's not true with heroin, and that is not true with cocaine, Valium, amphetamines, Prozac and some of the other addicting drugs. It's not even necessarily true with alcoholics depending on again which end of the spectrum of consumption volume that they fit into. An interesting thought for you - I don't know if it is true now but it used to be that in Japan there were no alcoholics. Nobody was considered an alcoholic. They just said "He likes Sake." If they knew people were drinking who sometimes woke up in the gutter the next morning covered with their own vomit, it was "He likes Sake." And there was no negative social consequence to being a drunk who fell down in the gutter and woke up there the next morning.

Q. You have raised an interesting question too - one that I would love to explore more and that is what about the role of compulsion vs. choice or does it have to be "versus choice" in addiction? Is addiction strictly a compulsion? Does the person have some choice in the matter?

A. First of all, compulsions are psychological phenomena. Typically, what happens in a compulsion in my model is the person is dissociated to some extent and has an unconscious set of imperatives, which are actually causing them to behave in certain ways, and they consciously feel like they have no choice. The reason they consciously feel they have no choice is that they have dissociated themselves from the

activity so their conscious mind is going “This is really dumb. This is bad, and I really ought to be stopping it.” Meanwhile they are engaging in the behavior. I certainly have heard that type of thing from smokers and people with eating issues quite a bit. They will be saying, “This is really dumb. Why am I doing this?””, while they are engaging in the behavior and so what is happened is that their unconscious mind has actually hypnotized them - they are acting out of a post-hypnotic suggestion. They are conscious of the behavior and yet they don’t know why they continue doing it. They may even be fighting against themselves, and unhappy that they are doing it. However, the real key is that it is dissociation. If they fully associated into the moment, they would have choice. Full conscious awareness and volition in an action gives someone choice. Milton Erickson demonstrated that with a young man who was about 16 years old who came to see him because he had a tic on one side of his face. Milton said to him, “Can you do it on the other side?” The young man practiced for hours in a mirror so he could make a tic on the other side identical to the one on the first side. What that did is that gave him conscious control of the tic. When he was able to consciously control the second side, he had control of both sides. That is the metaphor that I use for explaining how we gain full choice by making an activity fully conscious.

Typically what I will do with clients who feel conflicted yet helpless while actually doing the unwanted behavior is an anchor collapse, which is an NLP technique. An anchor is a stimulus response association. Pavlov’s dogs are an example. Ring a bell; the dog would salivate because there was a conditioned response to the tone with the presentation of meat when they were hungry. So, I’ll take somebody and get them fully associated into “I am just going to eat it. I don’t give a damn” or “I’m just going to smoke. I don’t care.”

I anchor that state. I usually use a touch anchor on one knee. Then I anchor them into “I just want to quit. I’m tired of it. I just want to be done” into the other knee. Typically what happens is these two things will be dissociated in time. So they will be engaging in the behavior at one time, and then later they will be just wishing they could quit. The two don’t ever mix. So to make it easier to affect the offending behavior usually both will be need to be associated in time, that is, made simultaneous rather than sequential. Once I have an anchor for each of them, I will then fire both anchors simultaneously. What happens is the person will for the first time experience both “I want to” and “I don’t want to”, “yes” and “no” simultaneously. And one will see a shifting on both sides of their faces, because they do not normally experience those feelings simultaneously. Once I have done that, I will go back and check it and say, “What do you think about smoking?” They will say “Yeah, I can remember it” and they will feel conflicted versus either fully congruent with “I’ll smoke” or fully congruent with “I want to quit.” They will be conflicted both ways. There will be a mix. At which point, it is a lot easier for me to work with them. This technique is very powerful, particularly with substance abuse.

I once used this technique with a cocaine addict, and he had an incredible response to the anchor collapse. I wish I had a video of it. His wife was in the room with us, because she wanted to sit in on the sessions. I anchored on one knee his desire to use the cocaine. I had him think about cocaine and touched his knee as he got this little grin on his face, and his face lit up. Then I had him go to a neutral space and then I asked him about wanting to quit. He was very serious. He wanted to get off the cocaine. So then I anchored that state on the other knee. Then I had him to go back to a neutral state. Next I fired both of anchors simultaneously. As I fired both anchors simultaneously, he physically tried to pull away from my touch. That response is generated because they have such a strong feeling of wanting the substance, and a such a strong desire to quit that there is a huge gap between the two states. Those two states together feel really strange. I just held on to him two or three minutes, which is long enough for the integration to begin. Then I said “What do you think about doing some cocaine now?” He had the facial expression of wanting to quit. He didn’t grin anymore. He didn’t light up again. I

said, “Do you notice the difference?” He said, “No.” His wife on the other hand said “Yeah, I can really see it.”

Q. My next question was going to be “Can you describe your approach to the treatment of addiction?” It sounds as if this is possibly your basic approach and that the underlying assumption is that the addict must be associated in order to realize that they have a choice?

A. It is one piece of my approach, and there are people with whom I don’t need to do the anchor collapse. With regard to my general protocol, let’s talk about smokers because that is probably the thing that I do the most that could be considered working with “addiction.”

The first thing that I do is to find out what their beliefs are. I go through a list of common beliefs that smokers have: “Cigarettes are my friend, etc.” People will say that kind of thing, and will be really serious. So what I will do is reframe it. I say “Boy, how would you like to take one out and have a conversation with it. Just pull it out and just talk to it, and pour your heart out. Put them on your pillow at night, and say goodnight to them, and wake up and say good morning. I’ll tell you what, I will introduce you to somebody who is always going to be there for you, the best friend you ever had. Eventually, we don’t know when, he is either going to kill you or hurt you real bad. You want to meet him?” They all kind of laugh and look a little sheepish and say “No.” And what that does is break the association. It blows out the metaphor that “cigarettes are my friend.”

Another belief is that they are addicted. I go through my song and dance about differentiating heroin from nicotine, and I go through a number of steps with belief so I can at least loosen the notion. The reason being, that as long as they have noxious beliefs about being “addicted” in the same way that heroin addicts are, they are going to have a harder time quitting.

I will address any fears they might have about gaining weight, about going through withdrawal symptoms, or about quitting being unpleasant. I will check to see if there is an element of defiance. For smokers in particular, many have been nagged a lot about quitting, and so they get a “(expletive) you, don’t bother me” kind of an attitude. I have even had a few say, “Cigarettes are something no one can take away from me.” They will be very, very strong on that. Usually what I will do with that is talk about the value of defiance. Defiance is actually about us standing up for ourselves, and proclaiming who we are. Somebody can’t make us be somebody else. Of course, they are asking me to help them quit smoking, and they want to be a nonsmoker, so it doesn’t make sense to be defiant by saying “I am going to keep smoking no matter what.” That isn’t who they want to be. I also point out that as an adult they have a lot more choices than they did as a child because most of the people who start smoking are 18 years old or younger. I have had a few that started in their twenties but I have had any number of them that started at 14, 15, 16 years old. One person started smoking when he was 5. His parents gave him cigarettes. They thought it would be cool. So off and on from 5 to 8, 9 years old, here and there he would smoke a cigarette. As an adult people have a lot more choices. They could just punch somebody in the nose. They could call an annoying person a name. They don’t have to associate with them anymore. They could file a lawsuit. All those things are things that adults in our society have as choices. A lot of times just reminding smokers of all those things will be enough. One woman was so precious, I wish I had a videotape of her. She used to smoke to annoy her husband, because she would work 12-hour days and when she would come home in the evening she wanted 30 minutes or so to decompress. She didn’t want to be around anybody. He hadn’t seen her all day, so he wants to visit. She would smoke because it would drive him away. I looked at her and told her “You are an adult, and you are a woman. You have so many other ways of torturing this poor guy.” She said, “Yeah!”, and the look on her face was so delighted. These are what some people call secondary gains,

irrelevant things that became associated with her smoking.

Typically also I will ask people how old they were when they started. They will say 14 years old. I will say “Would you let a 14 year old make that kind of decision about your health now?” “No.” “Well, isn’t that what you have done up until today? You’ve let a 14 year old’s decision make that kind of impact on your health?” They will typically respond “Gee, I never thought of it that way.”

You can see what I am doing here. I am bringing these beliefs into their awareness, and reframing them. I will also find out what times they typically smoked: after meals, stress, boredom, various other sundry times. Some are habitual triggers like, “It’s 3:00 p.m. Time to stick a tube of paper filled with some dried up poisonous weeds in it in my mouth, light it on fire, then suck on it and inhale the toxic fumes.” When I say these things they laugh. That is another way of messing with their mental representation of a cigarettes and smoking. What’s going on is a loosening of the structure of beliefs, and habits that they have associated smoking that had kept the behavior in place. When their beliefs change, their behaviors and amount of smoking they do will change. I have actually not finished doing all that I wanted to with clients, although I had started with some of the reframes I just mentioned, and I “

Another thing is that smokers tell me that they have compulsions, so I grab my arm with my holding fingers like I have a cigarette between them, and I look at it and go “No, please don’t make me smoke you. Noooooo!” Of course, they laugh. I say “Oh, yeah, those sneaky desires for a cigarette are like jaguars. They hang out in trees and just drop down on you when you are not looking.” I really get them laughing, and make it absurd. They are saying absurd things very seriously. “Well, you know, cigarette just came - the feeling just came and I couldn’t go on without smoking.”

Usually I’ll ask them something like, “How did you know you were craving a cigarette instead of a bath?” I make them think about their thinking. Our behaviors all have a mental structure to them. For us to get up in the morning, we have to do something in our mind that initiates the sequence of arising from the bed. The same thing is true for a smoker, the same thing is true for somebody who looks at an M&M and just *has* to have it. If you, first of all, bring the structure to the consciousness using what in NLP is called the meta-model, you can get all the specific details of their strategy, and it starts to deform the pattern. They are used just to doing it. They are not used to knowing how they do it, and they are not used to breaking it down into a lot of little pieces.

Another thing I have done with smokers who say they like smoking, is ask them what they like about it, and nine times out of ten they will tell me that they don’t know. I say, “How peculiar. If I go to a restaurant, I could tell you what I liked about the restaurant. If I had a great meal, I could tell you what I liked about the meal. If I went to a movie I could give you some idea about what it is I liked about the movie, and why I enjoyed it. You have done this smoking thing something like 200,000 times in your life, and you say you like it, but I don’t know what it is about it that you like.” Of course, by this point, they are going “Well, that’s kind of weird.” And I will press them for more details and what happens, again, is that they start to say, “Well, maybe I don’t really like it that much.”

Another thing is, “you could just give yourself the responses you wanted from the inside”, because it wasn’t the cigarette that they wanted. It was their response to it. Often I’ll say, “First of all, you can either go into the desired response directly, or you can think “it’s time”, have a desire, then have to look around and find cigarettes, find the lighter, pick them up, take the package of cigarettes” and describe the activity in exquisitely boring detail. The lifting it all the way up, noticing which hand do you use, which fingers, etc. and I’ll have them go through all this detail, and make them tell me everything. By that point it is starting again to deform, and break apart the habitual pattern by which they had automated the responses and the behavior. There is a lot of stuff that I can do with this. I mess with their patterns, their strategies, and with their choices.

One woman had the defiant “Nobody can take cigarettes away from me” attitude, and I only found one thing that worked with her. She wasn’t buying this “You are an adult. You have other choices” thing. She liked smoking. She was only quitting for health reasons, and she did *not* want to quit. She was doing it because she thought it was in her best interest. She had the beginnings of emphysema, and her doctor told her if she quit smoking she could probably get the emphysema to reverse. She was around 63, her great granddaughter was on the way, and she said she wanted to live long enough to see her great granddaughter. But, she had that defiant “No one can make me quit” attitude in full strength. I had to think about how to approach that for a while. What I finally said to her was “So, some people have beliefs they are willing to die for. Is this one that *you* would be willing to die for?” She said, “No” in kind of like a nonchalant voice. I said again, “No, would you really be willing to die for this belief?” And she said “*No!*” She got scared. And, when she got scared, I touched her on her knee. Then every time I mentioned cigarettes after that I touched her on the same spot on her knee, associating fear of death with smoking. And it worked. She quit.

Q. Again, I think these are brilliant treatment approaches. What about in cases of relapse? Are there any different or additional factors you would use for relapse in the areas of smoking, food addictions, any types of addictions?

A. Typically, what I am looking for under those circumstances is that either they are going through major stress, which means they have found their new choices are insufficient. So, I'll typically reframe the relapse this way: It is an unconscious signal to their conscious mind that they need some more help. That what they have done up until now has been insufficient and they need something else to do, more choices.

Secondly, I remind them that anybody can make a mistake. When you notice a mistake, what do you do? You correct it. Recently I had this funny thing happen with a client who said, "Well, you know, I smoked one so I decided what the hell, I'll just keep going." So, I said, "Oh. So you took your hammer, whacked yourself on your thumb, and it hurt really bad! 'Well, damn, I already hit myself once. Might as well do it again'. (Whack) 'Damn!'" He starts to laugh. By this point, he's not thinking that one cigarette has blown the program anymore.

Another thing I will look for is undiscovered, undisclosed secondary gains. I go through a lot of checking for secondary gains, and handle them in a variety of ways. Another thing that I do a lot with smokers, which can go into our list of primary techniques, is the visual squash. I know that you are familiar with the technique. Essentially what we've got is a part that wants to quit, a part that wants to smoke and then I do a negotiation between the two of them so they can cooperate and work together.

Q. Would you give just a very basic outline of that for the reader that may not be familiar with it?

A. Basically what we do is we have the person imagine the part of themselves that smokes on one hand. "If that part were to come out on one of your hands, which hand would it pick? The right hand? Okay, good. Okay, so the part of you that most wants to quit will come out on your left hand.." Then I will have them objectify the parts, which causes them to dissociate from each of those parts. "What does it look like, what color, what shape, which is heavier, which is bigger, if the smoking part were making a sound what sound would it make, if the "I want to quit" part were making a sound what kind of sound would it make?" Then what I will do is ask each part what its positive intention is for the person. "The smoking part wants to relax." Okay, so once she gets relaxation, we'll go higher and higher and higher in the hierarchy of values. "Once you relax what does that do? What is the positive intention of relaxation?" 'Comfort.' "What is the positive intention and value of comfort?" 'Good health.' So you might actually have someone smoking to be healthier. Ironic, to say the least.

On the other hand we have the part of them that wants to quit. So we ask what the positive intention is, and the response is "I want them to be healthy." 'What's the positive intention of good health?' "Have a happy life." So eventually we get to the point that both will have the same intention or a complementary intention. Then I will say to the part that smokes "So, have you noticed when you look at the other part's intention, that it is positive?" 'Yes.' Then I will do the same with the other part. Then I will use a little piece of hypnotic language, and have the person ask the parts if they would be interested in having a way of cooperating that would get them more of what they wanted for you and be more satisfying. I didn't ask them if they would cooperate, I asked would they be interested in cooperating under those circumstances, and usually they respond with a "yes". When I get a yes, I say "Okay, hold your hands up facing palm to palm, maybe a foot apart", and then another piece of hypnotic language, "and your hands will only come together with an honest unconscious movement at

the same rate at which these two parts pull together, and form a new cooperative arrangement.” So we watch for that honest unconscious movement. First, they will go into a trance. They don’t think they are. Their eyes will be open and they will be talking, but their hands are moving by themselves. And, then I will have them, once the hands come together signifying the completion of the process, bring the newly formed part, or newly cooperating parts back into themselves and re-integrate them. That ends the internal conflict, and I expect them to have quit by that point. The other thing that I use frequently that I have not mentioned so far, is metaphor. I will just tell people stories. I am sure you are familiar with Ericksonian metaphor to some extent, Ashley. Basically what I do is if we reach a sticking point with a particular belief, or they are holding onto something really strongly, I might just tell them a story or two or three or six and somehow or other that seems to help.

Q. Dr. Anderson, you have so beautifully answered my questions and given me a wonderful overview of your treatment approach. I want to thank you for your time and I appreciate every effort that you have made to conclude this interview.

A. My pleasure, Ashley.