The Collected Works

Milton H. Erickson

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Mind-Body Healing and Rehabilitation

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With a new editor’s preface, and nine new concluding chapters on the psychosocial genomics of mind-body healing.

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Chapter Seventeen

Hypnotically Oriented Psychotherapy in Organic Brain Damage

Milton H. Erickson

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Ordinarily brain damage with continued evidence of organic changes and destruction presents a seriously difficult problem for psychotherapy. In the following case history a rather detailed report is given of the use of a multitude of psychological measures, forms of instruction, direct and indirect hypnosis, and the manipulation of patterns of responsive behavior and reactions, all to effect therapeutic gains after a failure of conventional medical and surgical procedures. Considerable detail is given in presenting this case history instead of summarizing it by a simple statement of pertinent medical facts. An effort is made in this more detailed account to give the reader the “feel” of the psychological as well as the organic picture that confronted the author, both of which had a determining role in the therapy he devised.

On July 20th, 1955, this 38-year-old college-bred woman who had been a brilliant student and who had a master’s degree was returning with her husband and three children from a happy vacation trip. On the way she complained of a developing headache which rapidly grew worse and led to a state of coma.

She was hospitalized, and examination disclosed fresh blood in her spinal fluid, a right hemiparesis, a severe aphasia, and an aneurysm at the division of the left internal carotid artery just before its division into the middle and anterior cerebral arteries.

Treatment was conservative until August 2nd, when her symptoms became much worse and she developed severe hyperalgesia over her en-
tire right side, which was diagnosed as a “thalamic syndrome.” She was given numerous medications to control her pain, but since she appeared to receive no benefit, surgery was employed August 8th to clamp off the common carotid artery slowly and completely. This relieved her headache and some general symptoms but left some of her right-sided hemiparesis and hyperesthesia. A month later she developed extreme pain over her right side, which was diagnosed as “central in origin—the thalamic syndrome.”

She had regained her ability to walk fairly well although unsteadily, but her increased thalamic syndrome pain and the failure of analgesic medication and sedatives led in a few months to hospitalization in a well-known clinic in January, 1956.

General examination there confirmed the previous diagnosis of thalamic syndrome, disclosed numerous additional neurological findings concerning right-sided muscular and sensory dysfunction as well as the aphasia. The recommendation was offered that no further laboratory studies or general examinations were needed for diagnostic or other purposes. The previous failure of medications was noted, and the final recommendation was made that various untried experimental drugs might be considered. The prognosis offered was most unfavorable. This was rejected by the family, and in March, 1956, at her husband’s insistence and because of his wife’s completely vegetative course during her illness, she was admitted to another well-known neurological institute. The findings there confirmed the persistence of considerable hemiparesis, severe aphasia, and a continuance of the right-sided hyperalgesia. As in the previous neurological studies, she was found to have normal sensations and normal muscular functioning on the left side of her body. Her thalamic syndrome of generalized right-sided continuous pain and hypersensitivity was considered to have continued as possibly unchanged. No specific recommendations were made, and her prognosis was again stated as most unfavorable.

She entered a third neurological institute in June, 1956, and underwent neurosurgery for her thalamic syndrome. Report was made to her family physician that “we interrupted the spino-thalamic and quintothalamic tracts on the left side and succeeded in producing a definite hemihypalgesia without side effects. This diminished the dysesthesia that she experienced on stroking the skin, while the deep diffuse spontaneous pain is still preserved.” In further discussion of the patient mention was made of the frequent association of a vegetative state associated with thalamic pain, and the increase of the potentials for sensory disturbances following thalamic injury. Her prognosis was given as most unfavorable, and mention was made of a possible continued vegetative
Therefore, recommendation was made that the patient be discharged and subsequent treatment be instituted by X-ray irradiation of the hypothalamus in an area posterior and dorsal to the sella turcica as a possible means of decreasing her hyperalgesia and perhaps a lessening of the vegetative state.

Upon the patient's return home, it was found that she had not retained the benefit noted immediately after the operation, and the neurological institute was again queried.

Explanation was given further that such an operation as had been done was often unsuccessful; they again advised X-ray treatment, and in case of failure of that, they stated that they would consider re-operation. On July 3rd the institute, in response to further inquiries about increasing symptomatology in the patient, suggested the possibility of further attempts by new trial medications. They obviously were not interested in another operation and considered the situation as hopeless.

Her family physician then sent her to a general practitioner, who noted upon physical examination a remarkable anomaly not mentioned in all previous examinations—namely, an exact anatomical midline distribution from the scalp to the perineum of the hyperalgesia of the right side of her body and of the normal sensation on the left side, in addition to her vegetative state and the obvious numerous neurological evidences of brain damage. This peculiar anatomical midline demarcation of normal and abnormal sensations he regarded as a hysterical overlay, especially when the patient nodded her head affirmatively to the effect that the right side of her vagina and rectum were also both continuously painful.

As an outcome of his examination and recommendations the family and the family physician decided to refer the patient to the author for hypnotherapy since, in the 11 months that had already elapsed, there had occurred only a diminution of her hemiparesis and the development of a profoundly vegetative state from which the patient could be aroused only by unusual stimuli, and then only briefly, despite months of continued effort by her family and numerous friends.

The husband hopefully accepted the suggested referral, and the patient was brought to the author on July 14, 1956.

Her husband gave her history; communications sent by the family physician served to give summaries of the patient's four separate hospitalizations—the findings made, the services rendered, and the various respective recommendations suggested. He then proceeded to describe her progressive vegetative decline.

The patient entered the office somewhat unsteadily and haltingly,
slumped into the chair, but now and then nodded her head vigorously when her husband stated that she really wished to get well. She presented a most discouraging appearance. Her hair was just beginning to grow out after neurosurgery, the right side of her face drooped, all right-sided movements were awkward, and she gave good evidence by her behavior and manner that she seemed to be suffering severe pain throughout the entire right side of her body. Examination disclosed that gentle touches were less well tolerated than hard slaps or deep pressure on the right side.

It was also noted that she showed marked pain reactions to any stimulus of the right side of her body from the midline of her scalp, down the face and upper chest. Her entire right leg was painful, and she nodded her head toward the right when asked if her vagina and rectum were painful. When asked if she meant only the right side of those parts, she nodded affirmatively. Closing of her eyes during tests or testing the sensation of her back and scalp did not alter the rather remarkable exact anatomical midline division of left sided normal sensations and the hyperalgesia of the right side. A brief test also disclosed a severe alexia which had not been noted in any of the previous examinations. The history, the appearance, and the obvious physical handicaps, including her aphasia and alexia, left no doubt as to the organic nature of her illness and of actual brain damage, despite the seeming “hysterical” character of her sensory disturbances, which did not allow for the normal interdigititation of sensory nerves from one side of the body to the other.

Inquiry about her clinical course was described by the husband as characterized by brief definite interest on the part of his wife whenever discussion of the possibility of further medical study was mentioned and a hopeful attitude at each clinic, only to be followed by tears, despondency, and apparently profound disappointment each time she returned home unimproved. For several months she had endeavored laboriously to talk to her husband and children and to participate somewhat in the home life. Sometimes it would take her 15 minutes to say haltingly “I can’t talk” or “it hurts,” referring to the right side of her body. Repeatedly she tried to take an interest in the visits of numerous friends, especially those of her family physician who was also a close family friend, but she seemed to find this impossible. While her paralysis had lessened greatly, she experienced much difficulty ascending or descending stairs or in stepping backward. The patient indicated that in using stairways she had to use the banister because her eyes did not seem to measure the steps correctly, and that stepping backward was a slow, laborious “thinking” process since her feet would lag behind the backward movement of her body, with a fall resulting.
Coldness and increased humidity also increased her physical distress, and her right-sided hyperalgesia as well as increasing the right-sided muscular dysfunction, sometimes severely, depending upon the degrees of cold and the humidity.

The patient's reaction to her condition at first was one of severe fright and concern. Her first hospitalization was marked by cooperation and an attitude of full confidence in her physicians and the future. The exacerbation of her symptoms that led to her second hospitalization at a nationally famous clinic was accompanied by a reaction of complete hopefulness and certainty. The recommendation there of trial medications and new drugs and the implied hopelessness of her condition resulted in a feeling of despair and, at the same time, a desperate determination to do everything possible to help herself. She did succeed in improving so far as her hemiparesis was concerned, but ascending and descending stairways, her difficulty in stepping backward, the cold winter weather in her home state, and her aphasia and alexia constituted serious obstacles. Codeine and empirin and barbiturates were progressively less effective.

She would struggle vainly and laboriously to talk to her children and husband, but her aphasia gave her so helpless a feeling that she despaired each time. Also, she did not recognize what her alexia really was. She merely felt it to be a peculiar visual impairment of blurring, although objects in general seemed to be clearly outlined.

She made numerous but futile efforts to respond to the almost daily visits of friends, but often found her attention severely distracted from them by surges of pain. There resulted a progressive withdrawal from everything. She would sleep until 10:30 A.M., then arise and take a shower despite the severe pain it caused her. (Her explanation later was that, aside from personal cleanliness, she hoped such a procedure might help her to get accustomed to her constant right-sided hyperesthesia and hyperalgesia.) She would then eat a combination breakfast and lunch, lie down on the couch, stare at the ceiling, and smoke. At 6:00 P.M. she would arise, eat dinner, return to the couch, stare at the ceiling, smoke and now and then, but with decreasing frequency, try to talk to her husband or to listen to her children, but with less and less success.

Her third hospitalization and the possibility that neurosurgery might be done aroused her intense interest and hope, which turned rapidly into despair. At the fourth hospitalization she had cooperated with new confidence and enthusiasm but was severely disappointed that only hemihypalgesia was secured. She looked forward to a return to the hospital for a second neurosurgical operation and further benefits, but with not too hopeful an attitude.
The transiency of the improvement resulted in black despair and a feeling of hopeless frustration, a feeling that had been present for many months but now seemed to dominate her completely. She passively agreed to see the general practitioner recommended by her family physician, but even his discussion of the anatomical midline division of normal and painful sensations as a hopeful evidence of benefit from hypnotherapy did not arouse much active interest. She passively accepted the referral to the author and, upon meeting him, handed him a slip of paper reading, “Help me,” very poorly, almost illegibly written.

This special, personally made plea despite the fact that her husband was with her, and the peculiar, seemingly hysterical character of her anatomical midline demarcation of her body sensations, impressed the author most favorably as hopeful indications that the patient would be cooperative in every effort at therapy, and they seemed to represent not hysterical reactions but an extensive somatic overcompensation. Such an explanation was made to her, to her husband, and written in a letter to her family physician. To give her some feeling of faith she was carefully told, with intense emphasis and much elaboration, that such a midline distribution of sensations could very well be interpreted not as hysterical but as an utterly intense compensatory effort by her body to improve and by itself to effect “normal” sensations. This rather specious explanation appeared to give her some faith and hope.

Nevertheless, the problem presented appeared far from hopeful to the author. The first hour’s interview exhausted her, and she seemed to have lost interest within 15 minutes, even though her husband did the talking. There was not question of the husband’s interest and intense desire to see his wife benefited, but all general understandings indicated that the question of any improvement, if at all possible, would be dependent upon the intensity and persistence of her efforts. Hence, before they left the office, a solemn vow was extracted from the patient to the effect that she would cooperate in every detail with the therapist, and she was warned that “good medicine often tastes bad” and that she would not always enjoy executing therapeutic instructions. She shrugged her shoulders and, after many futile halting attempts, finally managed to say, “I—I do——what——” and when finally asked if she meant that she would do what was asked of her, she nodded her head vigorously.

She was dismissed from the room, which she left rather unsteadily to the alarm of her husband, and certain arrangements were made with him since his business required prolonged frequent absences. These arrangements included the patient’s staying with a companion who would serve as an assistant in any way the author demanded. A relative who
had accompanied the patient volunteered, and the interview with her led to the conclusion that she would be an ideal person for any therapeutic plan developed.

Three days of intensive thinking of what to do with an obviously brain-damaged patient with definite residuals of a hemiparesis from a hemorrhage within the skull, a severe aphasia, an alexia, a thalamic syndrome for which the patient had undergone thalamic surgery without recognizable benefit, a history of nearly 11 months’ vegetative living in a state of frustration and despair, and an agreed-upon poor prognosis by outstanding neurological clinics led to a decision to investigate experimentally the possibilities of helping the patient by combining hypnosis, hypnotic techniques, the patient’s own well developed pattern of frustration, and the implications of Lashley’s work, which, within certain wide limits, demonstrated through experiments of cortical destruction upon rats and monkeys that the loss of learning was largely dependent upon the amount of cortical destruction, rather than the location, and that the learning is carried in the form of neural patterns that in some way preserve their identity in spite of variations in sensory, motor, and cortical elements.

The results the author began achieving led later to a modified adaptation of similar but much less complicated techniques for behavioral retraining under hypnotherapy of a 70-year-old woman previously diagnosed as suffering from a circumscribed irregular arteriosclerotic condition of the brain (Erickson, 1963). In the case now being reported the rationale of the author’s decision was that the patient had a well-developed pattern of frustration and despair which, properly employed, could be used constructively as a motivational force in eliciting responses with a strong and probably compelling emotional force and tone leading to actual new learnings of self-expression or possibly to a restoration of some learnings.

The plan devised was complex and involved; sometimes it varied not only from day to day but within the day itself, so that, outside of certain items, the patient never knew what to expect, and even what was done often did not seem to make much sense to her. As a result, the patient was kept in a striving, seeking, frustrated, struggling, and emotional state in which anger, bewilderment, disgust, impatience, and an intense, almost burning desire to take charge and do things in an orderly and sensible manner became overwhelming. (During the writing of this paper the patient was interested in what was being included and pointed out that many times, “I hated you horribly, you made me so furious, and the madder I got, the more I tried.”)

Since the problem was clinical in nature and no conventional therapy
was known, therapy had to be experimental, but since it was the patient’s welfare at stake, there was no way nor attempt at evaluation of the actual usefulness and validity of any single one of the procedures employed. Recognition can only be given to the agreement of competent outstanding clinics in their evaluation of the patient’s prognosis as decidedly poor—in fact, hopeless—and the actual eventual outcome of the therapy devised.

Fortunately, the patient’s first companion was a highly intelligent, deeply interested, wholly cooperative person with an amazing flow of language and fluency of speech. This was seized upon as the first therapeutic approach, but without acquainting the patient with essential details or purposes.

At the first session the patient was told by the author with painful exactitude and emphasis that she was to extend herself to the very fullest extent of her physical and mental ability to listen carefully to each question the author asked her and to make every effort to reply, however arduous she found the task to be. She nodded her head vigorously, and she was asked her husband’s full name. Before she could complete the first partial efforts to frame his name with her lips, the companion, as previously instructed, replied with great rapidity with his name, age, and birthplace, all of which was gravely recorded by the author as if furnished by the patient.

Equally carefully and slowly, the patient was asked her full name, including her maiden name. Again the companion, while the patient was struggling with her mouth, gave the name, age, street address, etc. On and on this went, the author gravely and earnestly asking the patient questions, recording as if they were the patient’s replies each of the companion’s answers, some of which were purposely approximations or even wrong.

Slowly the patient’s early wonderment turned to obvious anger and infuriation, especially at the erroneous answers and misinformation.

At the end of the hour the author remarked casually to the patient, “You’re as mad as a wet hen, aren’t you?” in response to which the companion verbosely reassured the author that the patient was not in the least angry. The author continued, “And you really don’t want to come back either, do you?” Again the companion solicitously reassured the author, while the patient, apparently in an utter fury, with trembling lips, stammered, “I prom—prom—prom—[ised]” and stalked out of the room much more steadily and easily than she had entered.

The next day, as soon as the patient, Anne, was seated, she was asked for her entire history. Immediately, the companion Jane, began a rapid-fire summary of Anne’s purported personal history such as date
and place of birth, schooling, teachers’ names, years of attendance at college, and much family data, many of which were merely approximations or often in actual error. Anne glared at Jane in increasing anger and also at the author, who was hastily making notes and behaving as if it were Anne who was speaking. All of the time Anne’s lips and mouth were struggling to reply, to make corrections, and when the hour was concluded by the author’s announcement of the hour for the next appointment, Anne stalked out of the office even more steadily than she had before, only to be called back and told gravely that a daily schedule of activities had been arranged for her and that the companion’s responsibility was to keep a chart on Anne’s cooperativeness. Anne nodded her head vigorously and angrily, turned quickly with a single backward step, and left, still angry. She was called back, and with great intensity, after fixating her gaze rigidly upon the author’s face, she was told slowly, repetitiously, that she was to be fully and completely obedient in relation to the schedule. She was then allowed to leave the office, departing at first slowly as if in a trance state and then gradually more briskly. As she turned to leave the office her appearance and manner indicated that she was in a trance. No effort was made to test her for hypnosis. The reasons for this are no more than the author’s clinical experience in securing hypnotic responses from subjects without letting them know at first, lest the conscious awareness lead a patient to try to be overhelpful in the therapeutic procedures.

Much later Anne remarked to the author, “I was sent to you for hypnosis, but you never even seemed to try to use hypnosis. When I look back, though, I’m sure you must have had me in a trance many times when I didn’t know it. When I get mad at people, I stay mad—maybe for years. But it was different with you. I’d get mad, really mad, but the next day when I was still mad, something in me made me want to come back.

.Maybe that just means you were getting through to my subconscious mind, and that was why. Did you have me in a trance a lot of times?” To this question, since she had not made all the progress the author felt to be possible, his standard evasive reply was given:

“I like to help patients, but I often don’t try to explain what I’m doing. The answer to your question is, you can guess any way you want to, and either way is all right with me.”

Such a reply closes the question without answering it, yet leaves the author free to elicit trance states or selected or isolated hypnotic phenomena without the patient’s awareness of what is really occurring. Much more readily do patients look upon them as their own conscious intentional effort rather than a passive responsive act elicited by the
operator.

Leading the patient to “See what I [the patient] can do,” is much more effective than letting the patient see what things the therapist can do with or to the patient.

Jane showed Anne a typewritten schedule, but Anne actually could not read it because of her alexia. After many vain struggles by Anne to read it, Jane read it to her several times, but with specified and different errors. Anne listened intently, and her facial expressions indicated that she recognized some of the variously read items and was annoyed. It included bedtime, shower time, meal times, swimming hours, medical appointments, etc., and, most emphatically, the declaration that whatever Jane said or did was to be obeyed scrupulously regardless of what Anne thought, understood, knew, or wanted. There were to be no exceptions of any sort.

This schedule was intended only as another means of stimulating the patient without letting her realize what was happening. Thus, in spite of the clock in full sight and the radio announcing the time as 9:00 o’clock, Jane declared it to be 10:00 P.M. and “bedtime.” Anne sputtered inarticulately, and Jane read from the schedule the author’s emphatic declaration that Anne was not to dispute or disobey Jane’s instructions, all of which were listed on the schedule furnished Jane by the author.

At breakfast time Anne was awakened early and asked if she wanted scrambled eggs, toast, and coffee. Anne nodded her head affirmatively, then noticed that the clock indicated she was being awakened 1½ hours too soon, and pointed at the clock. It was later learned that she recognized the time of day by the position of the hands, not the clock face numerals. Jane cheerfully remarked that it was a lovely morning, and Anne furiously dressed, came angrily into the breakfast room, and was dumbfounded to find oatmeal and a lettuce salad for her, while Jane had fruit, dry cereal and coffee.

Immediately after the breakfast, which Anne ate with resentment while Jane cheerfully commented on every topic that came to mind—including the author’s absolute order that Anne should always clean up her plate—Jane abjectly apologized for not having told Anne to take her shower before breakfast. Cheerfully and with much light chatter she took Anne back to the bedroom and saw to it that Anne took a shower, completely ignoring all of Anne’s efforts to tell Jane by sign language that she had showered, that the shower floor was wet, that the towels proved that she had showered, etc. Jane merely chatted fluently on a wealth of topics. Jane’s sense of humor and zest in following this type of instruction was extremely helpful, and she easily used her own ready ingenuity to execute the author’s wishes.
At a later session Anne attempted to communicate effectively by writing a note with her left hand, which she did poorly, and handed it to the author who vainly attempted to read it upside-down and gravely handed it to Jane, who followed suit. Shrugging of shoulders and helpless looks led Anne to say “turn, turn, turn.” Obediently the author and Jane turned back toward Anne with further shoulder shrugging. Anne burst into tears and said, “Turn paper round.”

This was done, and the request was read “Can she take me dinner out?” It was obviously slowly, painfully, and laboriously written.

Immediately consent was given, and Anne unhesitatingly but stupidly asked, “Breakfast lunch too.” Ready consent was given, and Anne looked happy and triumphant. Jane had really enjoyed frustrating Anne at every meal by such measures as presenting her with a carrot instead of a banana while Jane cheerfully ate a banana herself. More and more at meals now and then Anne would explosively utter some article of food she wanted, and she was always properly rewarded in an entirely casual matter while Jane chattered endlessly on minor casual topics, always interspersing unimportant minor errors, to Anne’s obvious annoyance. Thus a birthday present would be suggested for Anne’s oldest child when it was the youngest child’s birthday. (Incidentally, Anne was greatly underweight, but she rapidly gained weight in being obedient about cleaning up her plate.)

The request to go out for meals gave new opportunities for Anne’s frustration since Jane drove the automobile. It did not take Anne long to discover the need to start to say “Right,” meaning “Turn right” a block or so in advance, and shortly to say “Right” at the intersection, since Jane invariably turned the wrong direction or continued straight ahead if not instructed at the proper time.

The menus at the restaurant were another source of instruction and frustration. Since Anne could not read, Jane would order foods that she knew Anne did not like, and always the author inquired if she cleaned up her plate regularly.

Anne attempted to point out to the waitress the items she wished, but Jane stopped that by telling the waitress “Doctor’s orders” and reaching for the menu. Shortly Anne began pointing out specific times on the menus, but unless she named it, Jane ordered wrongly.

This led shortly to pointing and naming and the getting of some of the foods she wished. Her reading ability soon reached the point where she could read but not always name the item completely. This Jane handled by such a measure as ordering “potato salad” when Anne had pointed to “baked potato” but said only “potato.” It was not long before Anne could say “steak me medium” or otherwise make her wishes clear.
Almost from the beginning the author had taught Anne and Jane the rhyme of “Pease porridge hot, pease porridge cold” and the accompanying hand and arm movements. This game was played regularly with the patient a dozen or two times a day, with Jane reciting the rhyme at first slowly, then with increasing speed. This was done at varying times during the day, sometimes in the middle of a meal or even during a shower bath.

Gradually Jane began to make the wrong movements, eliciting corrections from Anne who would spontaneously correct her by saying irritably “no, no,” “this this” or “no, this way.” Without comment Jane would make the correction, only to make other errors later. Also Jane began reciting the rhyme with variations in tempo. This occasioned considerable annoyance to Anne, who soon began to mouth partially the various words of the rhyme. As Jane noted this, she would make deliberate errors in the words, and frequently Anne would explosively utter the correct words. Often this game was made a part of the therapeutic session with the author so that her progress could be noted and further instructions could be given to Jane about errors to be made.

Direct hypnosis seemed to the author to be impossible; therefore Anne was told impressively within the first two sessions that it would not be employed. (Many months later Anne explained, “You really fooled me when you said ‘no hypnosis,’ that I couldn’t be hypnotized. Remember, I asked you before and you just talked and didn’t really answer”).

Instead, Anne was told in a most painstaking, laborious way, holding her attention in a most rigid, fixed fashion, “As Jane says that rhyme [“Pease Porridge Hot” was not the only one employed; there were many others], listen carefully, hear every syllable. Give it your full attention, notice each sound, all vowels and consonants. Remember each word. Think each word. Remember each word. Think each word. Remember carefully when you were a little girl, when you first learned those rhymes. Where were you sitting or standing? Who taught you? Remember how hard, when you were a little girl, it was to get the words just right. Remember who taught you, where you stood or sat and how, when you learned the onesies and twosies, how happy you were.”

The preceding is a brief but representative example of the indirect method of fixating the patient’s attention, regressing her in her thinking and remembering to earlier times and situations, and literally inducing through attention-fixation a trance state and possibly some hypnotic age regression through careful use of her actual past history obtained through extensive inquiries of the husband or Jane.

Also, very early in therapy an attempt had been made to capitalize upon infantile utterances such as “goo,” “da,” “ma” as a measure of
teaching the patient to talk. This, however, hurt her feelings and served only to emphasize her infantile helplessness in speaking. This was apparently too threatening a measure, though Anne later told of doing it when alone because she had “promised” to do as told. Also, the author was the only person who seemed to have a genuine hope for her, and she wished not only to please but also to get “even with him for his silly tricks.” Thus, a peculiar state of ambivalence, of mixed dislike and liking, existed in the patient, along with a compelling, highly emotional motivation to learn.

Each such session appeared to be followed by improved performance, and Jane’s enthusiasm waxed anew each time she made her report preceding each session with Anne.

Rhymes were paraphrased and were fitted into the situation to personalize them to fit Anne’s past experience. Thus, mention was made in a session of a certain street address, and at a signal from the author Jane obligingly in a singsong fashion recited “Annie and Willy sitting in a tree, k-i-s-s-i-n-g.” The flush on Anne’s face disclosed Anne’s full remembrance of that specific childhood experience, and the situation was immediately seized upon again to fixate Anne’s attention, to emphasize the time, the place, the difficulties in learning childhood rhymes, and the need always to listen to every word and sound. Numerous other little, more-or-less embarrassing experiences of Anne’s past were used similarly.

One morning, when Jane had prepared an atrocious breakfast for Anne, Anne pushed Jane aside and, as she walked into the office first, said, “I’m mad—at you—at her too—she helping—can’t help get mad—sorry—much sorry.”

Anne’s facial expression indicated that she was angry, that she regretted it, that she sensed some legitimate purpose on the part of the author and wished for some kind of reassurance.

In reply, with Jane joining in at once, the following rhyme was chanted to her: “Anne is mad and we are glad and we know how to please her; A bottle of wine to make her shine and (husband’s name) to squeeze her.” Anne’s reaction was a joyous response “He’s coming, he’s coming.” By coincidence, her husband was coming into town that weekend, a fact known to the author, and the session was spent planning a pleasant weekend for Anne and her husband with an occasional spontaneous word or phrase from Anne suggesting other possibilities.

She was also complimented on the adequacy of her remarks and speech and told amusedly that however angry or mad she got, the worst was yet to come. Her surprising answer came unhesitatingly, “I’m game.” She was beginning to realize her improvement.
Jane was then thoroughly drilled in saying the “Pease Porridge” rhyme in a halting, hesitant, and stuttering fashion.

She learned this in a phenomenally fast manner, and then Anne, who knew nothing of this special measure, was asked to recite with Jane the Pease Porridge rhyme, however hesitantly she had to do it.

Slowly the two began, Anne slowly, while Jane began to increase the tempo and then to stutter the words in a painfully annoying fashion. Anne glanced at the author, was sternly instructed to listen to Jane and to continue the joint recitation. Anne turned to Jane and her lips and face showed the ideomotor, therefore involuntary and uncontrollable, efforts on Anne's part to correct Jane's stutter. On and on, over and over, Jane continued, with Anne's lips twitching, and finally Anne was haltingly prompting Jane throughout the whole rhyme. This particular session lasted about two hours, and Anne's speech became increasingly better. The same measure was employed with other rhymes, and Anne was obviously pleased and confident though often immensely annoyed.

At the next session Anne made the pitiful plea, “Now Jane is my best——friend——I——like her——much, very much. She——she——she does everything—you tell her. I don't want to hate her. Do——do——do——do——something else.”

The author told her sternly, after fixating her attention rigidly by his manner, that he was conducting the therapy, that he would please or displease her as he felt best, but that her obvious improvement warranted a change. She was thereupon instructed to take Jane out to dinner and to put in the order for both of them, asking Jane each item she wished, and doing the ordering and she was assured that Jane would eat it, but she was warned to speak slowly, carefully, or that the situation would be reversed. Several evenings later Jane ate a dinner that was a mess, to Anne's intense merriment and the waitress's bewilderment, since both women were obviously amused and sober (e.g., mustard on lemon meringue pie!).

Interspersed with all of the above therapy was another variety of therapeutic endeavor.

This was the beating of time to music, at first to slow music and then to rapid, lilting melodies, although Anne preferred either classical or dance music such as “The Blue Danube.” This beating of time followed various patterns: right hand and left hand separately at intervals, then together, then alternately at every other beat; right and left hand separately at intervals, then together, then alternately at every other beat; right and left feet separately at intervals, then together, then left and right feet at alternate beats; left hand and left foot together, then alternate beats for the hand and foot similarly; then left hand and right foot
jointly, then separately at alternate beats, then both hands and feet together, separately and alternately and then alternation of left hand, right foot, with right hand, left foot.

Jane was an excellent taskmaster and arbitrarily interrupted meals, showers, television and radio programs at will to ensure “enough practice to satisfy the doctor.”

The final step of this measure was to have Anne beat time with the right hand on the left knee, the left hand on the right knee, each time alternating the position of the arms so that first the right arm would be in front of the left, and then vice versa.

As Anne progressed in variously beating time to music, she was instructed to hum. Jane would join in, softly singing out-of-time and off-key, to Anne’s annoyance, and then, as Anne began singing the tune, Jane dropped out. In fact, Anne’s only protection from Jane being out-of-time or off-key was to hum or sing the tune herself.

Family duties took Jane away, and in her place was put a shy, young, timid girl, extremely sweet and lovable, unwilling to offend and yet obviously afraid not to do exactly as instructed, and easily flustered by sharp criticism.

Anne’s reaction was excellent. She liked the girl immediately, adopted at once a protective maternal role, and was constantly springing verbally to the girl’s defense at the slightest threat of the author’s displeasure directed to the girl.

The excellent progress Anne had made under Jane’s care was not only maintained but enhanced by Anne’s protective attitude toward the young girl, who was exceedingly conscientious despite her timidity and gentleness, and actually just as competent a taskmaster as was Jane. More and more improvement occurred; Anne was taught to “relax” as a means of resting from the summer heat of Phoenix, and the girl, an excellent hypnotic subject, would posthypnotically relax with her and in rapport with Anne. Thus, Anne was exposed over and over to the hypnotic situation without ever needing to know she had been hypnotized. She was left no opportunity to wonder and to question and perhaps to doubt her own capacity to improve. Instead she had to attribute her responses and changes not to passive responses to the author and the task he assigned, but to her own efforts explained in part above.

Remembering Jane’s conduct at the table, Anne was most careful to spare the young girl the distress Anne felt certain that the girl would experience in obeying the author’s instructions if she patted her slice of bread to indicate she wanted the butter and being handed a stalk of celery. Also Anne soon learned that the girl, with obvious distress would reply to a patting of a slice of bread and say haltingly, “But—but—
—"would elicit the verbal response of, “Ask me not but’s and I will tell
you no lies,” or when Anne asked for water by saying “wat—wat—wat”
as she lifted her water glass would elicit from the girl a flush of embar-
rassment and the simple utterance, “What, when, where, and why are
parts of speech.” Thereby Anne readily realized the competence of Jane’s
reports, the author’s own careful observations during therapeutic ses-
sions, and the thoroughness of the instructions to this girl who aroused
so strongly her protective maternal urges. (Incidentally, the young girl,
now a mother of several children, and Anne are still the warmest of
friends.)

When the author felt that Anne had gained as much as was possible
from this protective maternal situation with the girl, a third companion
was then secured, after a careful survey of possibilities with Anne’s hus-
band concerning friends and relatives who might be willing to serve.
The woman selected by the author was oversolicitous, worried, mistrust-
ful, very eager, in fact too earnestly eager to execute whatever instruc-
tions she had been given about Anne’s daily program, though she did
not like them or even understand them. These instructions were care-
fully limited to what Anne could do either easily or with some little ef-
fort. For example, the woman was instructed, “When Anne starts to but-
ter a slice of bread, watch carefully, and when it is half buttered, you
butter the other half, or if you see Anne reaching for her glass of water
(or coffee cup or glass of iced tea) nearly empty, you are to jump up and
tell Anne, ‘You don’t need to say a thing, I’ll fill it,’ or tell Anne to cut
her meat or to put lemon in her iced tea, etc.” The husband had most
emphatically told this companion to obey the author’s instructions, how-
ever nonsensical they might seem, such as making Anne take a dozen
shower baths in a single day or at 2 A.M. or to put the right shoe on the
left foot. (This had been done repeatedly by Jane more than once just
before bringing Anne to the office.) The first time this happened, Anne
angrily extended her feet and pointed at her shoes. The author compli-
mented the appearance of the style of the shoes and the low heels. She
shook her head angrily, and the author very rapidly recited the well-
known jingle of “goats eat oats, mares eat oats, does eat oats, and little
lambs eat ivy.”

After a few moments of confusion both women recognized the jingle,
but Anne unwittingly went through a mental process of sorting out
words and identifying them and differentiating them from the auditory
impression given by the rapid utterance.

Later, when Anne was beginning to correct somewhat her alexia, the
same measure was employed somewhat differently. Slowly she was
taught to recognize the words of similar jingles such as “Nation mice
lender ver says knot” (Nay, shun my slender verses not) and then later to be told or to discover the words. This served not only to interest and amuse both women but to effect for Anne possibly a new ordering of her attitude toward words both written and spoken.

This companion’s oversolicitude, overeagerness, and overhelpfulness aggravated Anne intensely, and she did every possible thing to prevent being helped. Also, Anne learned to retaliate. Anne herself sought from the author a number of such jingles written out with which to annoy this companion, who seemed to lack much of a sense of humor. Yet, Anne was a sweet personality, and the general relationship between the two women was good. The companion did recognize that in some inexplicable way the author was accomplishing therapy. This companion thus aided greatly in literally compelling more effort on Anne’s part in order to escape the oversolicitous aid that served to motivate her to still greater effort. Also this companion could not comprehend what the author was attempting, and was worried and mistrustful of the author. Anne’s favorable rapport with the author literally compelled her to demonstrate to this companion that the author’s methods, however incomprehensible, were good and most helpful.

However, Anne tired of this companion, and earnestly told the author one day. “She good—do right [obeys author’s orders]—not happy job—she have go.” This was an exhausting effort at communication because it distressed Anne for two reasons: the discharge of the companion and distress at seeming to oppose the author. Her request was acceded to only after an extensive review over several hours of all the learning she had which had been frustrated by this woman, and then the author made clear to Anne some of his reasons for considering that frustration as desirable, and also why it was not previously explained to her. Additionally, many amused comments were made by the author over the woman’s lack of a sense of humor, of Anne’s half-resentful, half-amused plaguing of the woman with jingles and in other ways, and he pointed out that the woman always evened the score in some way. Anne did not realize how closely the author checked the daily course of events with that woman and gave instructions to her to help keep the score even and not to disturb the ties of a distant relationship that existed.

Accordingly, both women were much pleased by the author’s termination of her employment, since a new venture in motivating and learning processes seemed in order.

A fourth companion was then secured after intensive questioning of the husband. She was a young girl, obedient but on the whole not too interested or impressed by the various procedures and the monotonous reports and activities at the office. Anne was frequently displeased and
disgruntled with her, could find no direct fault with her except her lack of enthusiastic, intelligent interest. She did repeatedly tell the author that she would be glad when she was sufficiently improved to get rid of “that girl with her mind elsewhere.”

There was no question of where Anne’s “mind was.” Anne’s interest was in her improvement, and she did not like to have anybody, however conscientiously obedient, disinterested. Thus Anne was forced into a position of validating her improvement by being irked, even angered, by her companion’s lack of interest and meaningless (to the companion) obedience.

A fifth companion was then secured. This was an older woman, rather absorbed in her own interests, rather “slack about doing things” as Anne complained, and who obviously regarded the author’s whole procedure as bizarre, purposeless, and without meaning—even silly and ridiculous. However, care was taken to make sure that she executed her duties, and Anne particularly enjoyed the author’s assignment of special bizarre tasks.

She also enjoyed the older woman’s general dislike of the situation and duties and took particular pride in improving even more extensively just to demonstrate to that woman that the author, whom Anne had now come to like greatly, was correct in his methods and that the companion was wrong (Anne’s opinion and emotional reaction to this companion were probably more vital than the author’s procedures, which were to intensify Anne’s own motivation).

One particular item thought of by Anne at this time was that when she could not say a word, she would “walk around it.” The author agreed and pointed out that she could count and stop at the right number when she could not give her son’s age. But Anne herself devised the method, when blocked on a word—for example, butter—of getting up from the table and elaborately walking around in a tortuous path about the furniture in the room, sitting down and saying, “Pass the yellow stuff there,” pointing to it. What Anne did not realize was that, when blocked in saying a word and then walking a tortuous path in and out and around the furniture, she was indirectly and unwittingly adding to her vocabulary and lengthening her sentences. Thus, blocked on saying butter, she had, in the procedure she devised, to say to herself mentally, without realizing it, “I must get up and first walk around that chair and then over the end table and past the davenport and open and close the refrigerator door and then go back to the table and say, Please pass that yellow stuff.” That this is what actually did occur is not known, nor was any inquiry made. She had suffered brain damage and she was improving by nonconventional methods. Experimentally, it would have been scientific
However, a number of normal subjects were deliberately asked to do as Anne and her companion had described as the walking about the room in a random, tortuous path. This done, they were asked to relate the thinking they had done as they did so. Naturally they prefaced their explanation with, “I couldn’t help wondering what your purpose was, but I decided to walk around the coffee table, and then over to the book case, and then around the throw rug and then past the radio.” Anne’s aphasia was a motor aphasia. Presumably her thinking processes were like those of the normal subjects. At all events, she would return to the table with some remark such as, “Pass that yellow stuff there,” instead of limiting her utterances to “Butter, pass,” or “yellow stuff, pass.”

This particular companion was always bored by the sessions in the office, did not try to conceal the fact, and the author took advantage of Anne’s half-resentful half-amused attitude toward the companion, to delight in having them go through the various “exercises” that had been assigned. Particularly did Anne enjoy the author’s discounting of her inability to talk originally by the bald assertion, which the companion resented, that any little baby could say “goo” and “ga” and “da,” and so could Anne. These particular exercises Anne had resented at first. They had been used sparingly in the office, though it was later learned that they had been done secretly by Anne in her apartment. But Anne enjoyed going through them with this companion, even enlarging them from meaningless syllables to baby talk, a measure Anne did deliberately and without prompting to irritate the companion for her criticisms of the author. An excellent, constructive example is, “en—ee—bah—dee,” and this intentionally transformed into “anybody.”

One other step that seemed to the author of importance was the institution of a measure to correct, if possible, the alexia. This the patient was almost irrationally certain could not be corrected despite the considerable progress with menus and jingles, and hence a completely indirect measure was taken. She was furnished pencils and paper and told to sign her name. It was reasoned that, since aphasia involved motor elements and visual word memory and that the alexia was a matter of visual perception, a motor skill might be employed, one that was not related as such to ability to read which is naturally followed or accompanied by reading.

She signed her name in an almost illegible fashion. She could spell her name verbally but could not identify the letters when only one letter at a time was exposed to her. She could recognize her name and her husband’s nickname. She could not recognize her last name or even such a
simple word as cat.

She was instructed to take a pencil in each hand and, holding the pencils in the correct writing fashion, simultaneously to write with both hands her own name. She spontaneously noted that her left hand wrote backward and was spontaneously interested in figuring out the probable individual letters in both writings, since the right and left hand writings compared fairly well because of the poor writing caused by the residuals of the hemiparesis of the right arm.

This was one special exercise the author devised which the patient delightedly modified to confound the author while still abiding by instructions. The assignments were her name, those of her family, her birthplace, and then, knowing that she was an ardent baseball fan, she was instructed to write simultaneously with both hands numerous pages filled with the statement that she hoped her favorite team would lose each game. This she did reluctantly—in fact, resentfully. Then one day she entered the office with a broad, triumphant smile with a whole handful of sheets of paper covered with remarkably improved script. Apprised by Anne’s facial expression, the author accepted the sheets most carefully, with only a casual careless look. At first then disappointment, then fury showed in Anne’s face, whereupon she demanded imperiously of the author, “You read them.” The reply was given that the author had trouble enough reading his own script without attempting someone else’s. Since her secret plan was so easily defeated, Anne furiously snatched the papers back and read freely, “I hope the X team wins. I hope other teams lose.” in all, she had written and read aloud easily a dozen different statements negating the author’s original demand that her team lose, etc.

She was most elated over this, and the author promptly expressed his demand that she write various uncomplimentary things in relation to persons or objects she liked. She took much pleasure in defiance of this by simultaneously writing right- and left-handedly complimentary remarks, and, with less and less halting speech, reading them. She enjoyed this defiance greatly as well as taking much pride in her improved handwriting and ability to identify individual letters and words.

A newspaper was shown her, and she was asked to read an account of her favorite baseball team. She futilely attempted to do so, whereupon the author read it aloud to her, actually paraphrasing it into a most derogatory account. She snatched the paper from the author and haltingly and imperfectly reread the article aloud correctly, half amused, half angry at the author. This measure served to convince her that she could read “if you make me real mad.”

There were, of course, numerous other measures essentially varia-
tions of those already described, that were employed to prevent boredom or slackness and to keep the patient continuously alert and yet annoyed, frustrated, and at the same time hopeful and pleased by recognizable yet often not immediately realized progress.

By November 1956 she was sent home for two months, returning for further therapy in January and February. She had lost considerable ground, which she attributed to the coldness of her home state. Improvement was rapid and quickly surpassed the previous gains.

She returned home again, and her friends noted no aphasia, although the family physician noted occasional evidences. The alexia persisted, although considerably decreased.

Weekly letters from her were demanded, a laborious task often written with many errors.

Some of these were arbitrarily sent back with peremptory demands for corrections without the errors being marked. She resented this disdainful handling of her correspondence but invariably found the errors, corrected them, and would append the statement, “This makes this week’s letter.” (One man-upmanship is a potent therapeutic force.)

Very slowly she began to read short stories to her youngest child. Currently her alexia is far from being corrected, but she can and does read some of the newspaper.

She has been exhibited to a considerable number of physicians as a former patient and has joined the author in challenging them to guess her original diagnosis. Almost all have noted that her right leg is slightly edematous and have offered a diagnosis of thrombophlebitis. On one such occasion she laughingly replied, “You’re right, only you are wrong. Just listen to me try to say that word and you will know.” She then attempted to say “thrombophlebitis” and laughed at the guess of “speech defect,” saying, “No, aphasia,” even adding “from a hemorrhage.”

She still is very slightly awkward from hemiparesis residuals, experiences considerable hypersensitivity and some deep pain of the right side; and cold weather and high humidity greatly increase the deep spontaneous pain and her hemiparesis residuals. She is still taking a minimum dosage of codeine and emerin and an occasional sedative. It was she who persuaded her husband to move to Arizona, but to Tucson, not Phoenix, where the author lives. Thus she is too far away for an emergency call, but she does see the author for occasional visits at irregular intervals of one to four months. For a family physician she was referred to an internist in Tucson, for whom she developed an immediate respect and liking.

She follows a good general daily program except on unusually chilly
winter days. That period of the year she is most likely to want to see the author once a month, as “insurance that I am staying all right and it is just the cold that makes things more difficult.” She entertains freely, drives the family car, picnics in the mountains with her family, does the family shopping, but has a housekeeper do routine household tasks.

The specific difficulty in stepping backward had been corrected by having her learn to dance, something she had always enjoyed, and which the first two companions had enjoyed doing with her, the first companion with considerable difficulty, the second with ease, while no trouble was later experienced by the patient in dancing with her husband.

Posthypnotic suggestions to the second companion ensured certain awkwardness that Anne helpfully corrected.

Her stair climbing and descending difficulty persists, but the move away from her home state permitted living in a one-level house. However, a climb of two, three, and even four or five steps is easily managed by the measure of carefully noting the number and height of the steps. A larger number necessitates actual assistance.

Cold, if intense, and high humidity, besides increasing the symptoms of her thalamic syndrome and the paralytic residuals, have the peculiar effect of decreasing her sense of taste. This was confirmed by her over- and underseasoning of foods, an item of fact discovered by her family, since she is an excellent cook. At such times she carefully loads her plate and “cleans it up” so that she will not lose weight because of definite lack of appetite.

**DISCUSSION**

To discuss the therapy employed and its rationale is difficult. The patient had been rendered suddenly and distressingly helpless at a most happy period of her life but without any loss of her intellectual capacities. The helplessness of her situation, the frequent surges of hope occasioned by trips to nationally famous clinics, the black and hopeless despair that followed, the meaningless, well-intentioned, obviously false and uninformed assurances by all of her friends, associates, and her relatives that “everything is coming along fine,” left her more hopeless and despairing than ever, to say nothing of her actual pain and physical difficulties. She recognized her vegetative state, felt helpless to do anything about it, and found herself facing a completely wretched future for which she could see no remedy nor any way to hope for one.

She knew that the diagnosis of “hysterical reaction of her partial hemiparesis” was wrong because she knew she did have pain explained
to her as “thalamic syndrome,” but she did recognize that the general practitioner actually had made a finding he could recognize as new and different from any made by all the other physicians and that he was obviously positive that it signified hope. This had encouraged her briefly, but then all of her hopes had been dashed on previous occasions of optimism.

She had consented to see the author, was again encouraged by his interest in the peculiar midline sensory demarcation and his prompt discovery of her alexia, which he seemed to recognize understandably, although none of the famous clinics had seemed to pay any attention to it (nor do their reports make any mention of it). Next she was, as she later explained, “fearfully and powerfully” affected by the author’s frank and open statement in her presence that she was a totally hopeless case unless she wanted, really wanted, to get well, that every possible opportunity would be given to her, that no effort would be made to spare her feelings at the sacrifice of her welfare, and that the case would be accepted only under an absolute promise of full cooperation despite the fact that therapy would not seem reasonable, nor even sensible nor considerate; that all reasonable, conventional things had been done to no avail for an intelligent adult now reduced to a state bordering on infantile incapacity. Therefore, she would be handled and treated accordingly without regard for her intelligence, her master’s degree, or her social background.

Therapy would be oriented about her helpless condition, and use would be made of every possible pattern of reaction and response that she had retained without regard for banal social conventions, and a demand was made that she give her solemn promise to abide by whatever therapeutic measures the author might propose. It was pointed out simply and emphatically that to date all conventional therapies had failed, that there would be no loss entailed by new measures, and that a therapy devised to meet the actual reality she represented instead of the lost realities of the past might conceivably serve a useful purpose. (Later the patient stated that this frank, nonreassuring offer to give help, but a 20 refusal to promise it, influenced her to take hope and to give and to keep her promise of cooperation despite the anger, frustration, and displeasure the author’s methods occasioned. As she explained later, “It didn’t make sense most of the time, but I couldn’t help noticing that I was doing better. But you did make me just awful mad, and after awhile I discovered it [being angry] helped. Then I didn’t mind how mad you got me. But it was awful at first.”

Although it cannot be positively stated as factual, one may speculate that the treatment accomplished gains for the patient according to the following utilization of procedures:
1. Her vegetative state was corrected not by sympathetic care and attention nor by patient instruction, but was rendered intolerable by cheerful and obvious stupidity intentionally executed that refuted every intellectual understanding she possessed, and stimulated an actual desire to understand and to learn—but what to learn she did not know. Only a strong and compelling motivation was there, compelling her to seize upon anything offered. It intensified her need to avoid such unmistakably given misunderstandings of her needs, which then led to a frustration state quite different in character from the frustration of incapacity to which she had become so well accustomed. Instead, it was a frustration that compelled her to take action to avoid it by one means or another, and there was no fixed, set, or rigid pathway, nor any opportunity for passive withdrawal, by which she could escape. Each new measure employed by the author placed slightly new and different demands upon her, most of which frustrated her in some new and different way and in a fashion which was intended to lead to effort rather than to a vegetative state.

   In fact, “cleaning up her plate” when served weird combinations of good, nutritious foods often served to give expression to her innermost emotions of resentment, “which somehow made me feel better.”

   The emotions accompanying each new demand upon her were something more meaningful than useless despondency and the desperation of the past. There was a desire to retaliate, to do something, to change things, and for varied reasons—anger, amusement, bewilderment, confusion, disgust, etc. There was no one dominant emotional state causing a generalized rejection of things or a withdrawal as had derived from her despair and despondency and depression over her incapacities.

2. General knowledge indicates that verbal learning is based upon a variety of experiential processes. Consider children learning to count. They can learn by rote repetition to count to 10 accurately. Given a good sample of children and various methods employed to teach them to count by verbal instruction and, at the same time, having them touch the instructor’s fingers on the nails one by one in proper sequence from one little finger to the next makes the task easier. Hearing, seeing, tactile experience and verbalization combine to facilitate the process of verbal learning. Transfer to a task of counting the fingers without touching them is then easily
accomplished. Then the child can be given the task of counting the fingers with the hands turned palms up and counting in sequence from one thumb to the next but without touching the fingers. The task suddenly is more difficult for the child unless he is allowed to touch the fingers. Then the hands can be held up, the palm of one, the back of the other, facing the child, and he counts readily without touching the fingers.

Transfer of this learning to the counting of 10 marbles in sequence is then easy. Then place one large marble anywhere, but usually best at the end of a row of marbles, and ask the child to count them visually. The answer too frequently is “nine little marbles and a big one,” not the simple reply of 10. Then have that child count the marbles by touching each as he looks at them and counts; the answer is “10, but one is big.” Also, how does one learn to read without moving the lips? And the rhythmic person (as the author knows by personal experience and inquiries of similar persons) has intense difficulty in counting the rapid, rhythmical drumming on a table but can count more rapidly and more accurately when a few marbles are dropped from the hand to a tabletop in as rapid but nonrhythmic fashion.

Throughout therapy innumerable items and speculative ideas were kept in mind and revised at each session to fit any immediate changes in the patient’s situation and to add new or to arouse old associations to all relearnings and any new learnings.

The Pease Porridge rhyme was ideal for this: it demanded attentiveness, an anticipatory span of attention, coordination of hand, arm, and eye movements, auditory attention, an active motor set and participation; too, presumably, it would arouse some ideomotor and ideosensory and hence involuntary speech movements, possibly, perhaps undoubtedly, including subliminal speech.

Certainly the painful stuttering so deliberately and well-thought Laboriously-done by her companion would serve to, and almost be sure to, elicit ideomotor and ideosensory speech experiences. (Consider the overwhelming natural tendency to say words for a stutterer). These would include quite possibly, even probably, subliminal speech and affectively reinforced speech memories, particularly associated motor memories. Also, it would serve to elicit strong self-protection tendencies, a desire to get away from something unpleasing to the self—even as her speech problem was unpleasing to her and it demonstrated that there is an escape from a speech problem—an item of vital general significance.
3. The rhythmic beating of time to music and listening while beating time to lilting songs would lead to ideomotor and ideosensory speech experience, and the peculiar and complex combinations of right- and left-sided beating of time and the constant shifting of the beating pattern from left to right and vice versa were deemed to aid in the development of new alternative neurological pathways of response to auditory stimuli. Additionally, the tendency to hum, to anticipate the next words of the song already heard many times, the tendency to join in the singing, and the frustration by the companion’s out-of-time humming and off-key singing appeared to offer a most compelling eagerness and motivation to use her vocal cords out of sheer self-protection, since she did have an excellent ear for music.

4. The patient’s markedly underweight state and the authoritative demand that “she clean up her plate” served not only to correct her weight, an item she could sense and appreciate as a visible proof of her improvement, but put her into an eager state of mind of wanting to have her choice of food instead of the nutritious but unwanted selections by her companion. Her appetite, her long-established tastes in food, and her need to protect them served to motivate her desire to speak and also to read the menu so that she could be certain of having her wishes met.

5. The alexia, a distinct problem in itself, is nevertheless related closely to speech. (Watch little children’s lips, even those of some adults, as they try to read silently.) Thus, the restaurant menu served the dual purpose of compelling not only speech but reading also. (As reported by Anne later, the first restaurant meal ordered for her, taking advantage of her hopeless speech condition and alexia, aroused not only her anger, but a tremendous desire for doing a turnaround on Jane, something she planned for weeks before the opportunity arose. And such a plan had to be based on actual and inclusive expectations).

Thus the diet frustration, despite her gain in weight, filled her not only with a wealth of mixed emotions but literally forced her into a position anticipative of the correction, but not so recognized, of both the alexia and the aphasia as a means to an end rather than an end in itself.

6. The selection of the first companion was a fortunate act of fate, but it suggested the use of different companions, each to call forth pro-
gressively and more assertively the various natural patterns of response that characterized Anne. The first companion by her quickness in seizing upon situations and taking advantage of them while obeying orders forced Anne from a state of frustration and black despair into a state of intense desire to frustrate the companion—hence to do and not to yield hopelessly.

The second companion was picked as a measure of evoking Anne’s own deep maternal urges. She missed her family greatly, seized upon the second companion as a substitute, and to the very extent of her ability attempted to do things to prevent the author from rebuking this girl. Also, the girl was a good hypnotic subject and could be given posthypnotic suggestions creative of special situations such as the radiating joy at every success of Anne’s and her eyes brimming with tears whenever she mistook Anne’s helpless pointing at something instead of naming it and therefore proferring something wrong, which Anne’s vigorous negative shake of her head disclosed it not to be wanted.

Thus, by virtue of the girl’s excellent posthypnotic amnesias, she and Anne would attribute events to situational developments which could not appear in any way to have stemmed from the author’s instructions. Also Anne, in her maternalism, would have another type of aversion toward her difficulty, an aversion having its origin in its distress not to her but to someone else. Thus, a set of circumstances could be created in which Anne could take charge spontaneously and not feel that it had been arranged by the author. Anne knew full well that Jane and the author worked hand in hand, but with this girl Anne was inspired to take charge herself. Additionally, the afternoon siesta which posthypnotic suggestion made so easy for the girl served to set an almost irresistible example leading to “joint relaxation,” and Anne delighted in following the example set with the development of an intensely warm interpersonal situation in which Anne was the dominant personality, which was not hitherto the case with Anne’s friends during her illness at home nor with Jane. And she is definitely a strong character.

7. The third companion served the significant purpose of compelling Anne to reject emphatically any effort at over solicitude and to compel a determination to be as self-reliant as possible. This continued unrecognized work initiated by the previous girl and compelled Anne to strengthen it.
8. The fourth girl, by virtue of her feeling of boredom and disinterest, served a most important role of compelling Anne to recognize that much was yet to be done, that much had already been accomplished, and that she herself would have to undertake the responsibility to do all that was requested and even more.

9. The fifth and last companion, absorbed in her own thoughts and troubles, with her tendency to scorn and belittle the author, was actually exceedingly helpful. She powerfully reinforced Anne’s assumption of self-responsibility, placed Anne in the position of appraising and recognizing the extent of her improvement, and aroused intense emotional desires to protect the author from criticism of his methods. Thereby Anne unwittingly placed herself in the position of not only justifying and validating the methods, but the forcing of recognition by this companion that the methods were right and that she was continuing to improve.

10. The handwriting exercise in itself was an added special measure of peculiar complexity. Anne knew that she could write only illegibly, and the simultaneous right and left-handed writing intrigued her curiosity and interest.

   At first her left hand wrote more legibly than her right. This pleased her, but although she did not realize it, it also forced her unwittingly into taking a reading attitude toward her handwriting. Then having her write derogatory things about her baseball team gave her the golden opportunity to retaliate with much amusement against the author for all the things he had done directly or indirectly against her. By such amused execution of an assigned task, abiding by the essence of the task and yet seemingly defying the author, there was established an easy, comfortable, interpersonal give-and-take relationship between two adults rather than an impersonal physician-invalid relationship. Thus there could be a sense by the patient of sharing significantly and pleasurably in both a joint and a separate accomplishment conducive to her welfare.

   As she continued the writing, she realized progressively her capacity to read more and more, and this was assumed by her to be her own spontaneous development. Thus, her faith in herself was greatly strengthened. The impersonally critical treatment of her weekly letters compelled her not only to read while writing them but to read them with searching care to correct errors. She enjoyed receiving letters, but cold impersonal criticism of errors
noted but not marked in an otherwise friendly newsy letter, coupled with a peremptory demand reminiscent of her original promise to the author, compelled her not only to read while writing them but to read with searching care to prevent errors.

Thus, the return of her letter with a peremptory demand for corrections not indicated for her gave her a golden opportunity to retaliate by searching out the errors and then returning the corrected letter with the triumphant statement that it was the letter for the current week. And one or two occasions in which she missed errors she had made taught her to ensure her triumphant escape from a letter every week because a letter twice returned for correction was accorded no value. Moreover, Anne was strongly competitive, and her need to win was of utmost value in this manner of dealing with her letters. (She now dictates letters by tape recorder—it is more convenient since there are residuals of hemiparesis in her right arm and her alexia is far from corrected so far as writing is concerned.)

11. The recitation of childhood rhymes, little experiences from her childhood, embarrassing or semi-embarrassing incidents, served not only to awaken past memories but to reinforce all associated mechanisms of behavior and learning responses.

12. It is true that the patient’s progress might be attributed simply to the increased individual attention she received. However, it is also true that she had received an immense amount of individual attention from numerous relatives, friends, and her family, all of which did not prevent the development of a vegetative state. Also, she received extensive and highly skilled nursing and medical care and attention, all to no avail. But all such care and attention had been based upon concern, sympathy, fear, worry, helpful protective attitudes and a despairing concept of her as helplessly and hopelessly invalided, despite the diminution of her hemiparesis. Such attention was always accompanied by sympathetic and encouraging assurances in the face of obvious and unmistakable disability and therefore was patently false and expressive only of the wishes of others and an unintentional emphasis upon her invalidism. The patient’s own retained intellectual capacities permitted her recognition of the falsity of the assurances and the significance of the sympathetic concern as actual expectation of a continuance of her invalidism. As was mentioned early in her medical history, she had a master’s degree and possessed excellent intelligence.
The therapeutic attention devised for her and described in this report was of another character entirely. There was no fear, concern, anxiety, or sympathy offered. Instead, there was literally a peremptory demand for cooperation and the exacting of such a promise. Instead of gentleness and sympathetic consideration, there was the annoying assignment of seemingly meaningless tasks and the deliberate devising of situations which would lead to feelings of frustration accompanied by intense emotions of a motivating character rather than of hopeless despair. She was not encouraged to talk, but a situation was created that could lead to involuntary ideomotor efforts of speech and quite possibly to subliminal speech. Frustration was used deliberately to prevent despair by compelling the patient, in self-protection, to strive to secure some satisfaction of ordinary, reasonable, and legitimate desires. For example, being handed a carrot instead of a banana not only infuriated her but tremendously intensified her desire to talk and a need to reject her helplessness so that she might retaliate in kind, as indeed she later did.

Yet she had not been asked to talk, which she knew she could not do. Instead, a situation was created which, through the intensity and welter of her emotions, would impel her to seek some measure or means of meeting her wishes and needs. Neither was she asked to learn to step backward without falling. Instead, her maternal urge to protect the second companion from the author’s seeming displeasure about the companion’s inability to dance well was used. (A posthypnotic suggestion to the companion ensured a certain awkwardness.) Hence, stepping backward easily and readily was only an incidental and unrecognized part of her emotional relationship to that young girl.

Likewise, the simultaneous writing with her right and left hands, especially of statements offensive to her personal loyalties, could not be recognized by the patient as a form of speech corrective of alexia. To her it was a motor task, repetitious and monotonous, that inspired her to confound and defy the author finally by angrily reading aloud the exact opposite of what he had deliberately misread.

So it was with all of the other individual attentions she received. They were all deliberately and intentionally controlled and directed toward the evoking of whatever capacities for all kinds of responses which she might have or could develop, without regard for courtesies or social niceties but only for whatever responsive behavior might be conducive to restoration of previous patterns of
normal behavior. However, the nature of her specific reactions was not and could not always be anticipated. Her welfare was the governing purpose of the therapy devised—not sympathy, consideration, or even common courtesy. Perhaps the best example to illustrate this was the occasion on which Anne had laboriously, slowly and with apparent distress crossed her legs in an effort to relieve her deep spontaneous pain. When she had completed this difficult task, the author amusingly chanted the old childhood rhyme, “I see London, I see France, I see somebody’s underpants.” The celerity and ease with which Anne embarrassedly uncrossed her legs with no apparent recognition of painful feelings was a startling revelation both to herself and to her companion. Later Anne recalled this incident by saying haltingly, “member—underpants—move—move leg fast—no hurt.”

Numerous other little incidents like this, conducive to strong emotions and automatic responses, unquestionably served to restore and to reinforce normal responsive patterns of behavior and to compel a confident realization of her own recovery of latent capacities of response awaiting adequate stimulation.

13. Hypnosis and hypnotic techniques, usually indirectly and unexpectedly, were frequently employed to arrest and to fixate her attention rigidly upon therapeutic ideas and understandings. By so using hypnosis, her attention was directed and controlled and possible demands for conventionally “sensible” instructions were forealled. The liking she had developed for the author, the slow but continuing progress which she could see and sense, served with the hypnosis to prevent an intermingling in her conscious daily thinking of conscious doubts, fears, anxieties, and uncertainties with the authors’ carefully given helpful ideas. Instead, she became the author’s ally, and any questioning doubts were left to the companions.

Even now, seven years later, she feels “different” in the office, and much of her behavior is highly suggestive of a hypnotic state. (For therapeutic reasons no effort is made to test her.) However, this seemingly hypnotic behavior is absent in the waiting room, and she socializes easily and well with the author and others. Another comment in this connection is warranted. About a year ago she met the author at the Tucson airport and took him to her home for some additional therapy. However, she first acted as a hostess, displaying her home and her garden and making inquiries of a purely social character for about an hour. Then when the author
remarked, “I believe you have some questions to ask me,” there
developed a fixed, rigid attentiveness and a seemingly unwariness
of her surroundings similar to that of her behavior in the office.

14. In brief, the therapy developed to meet Anne’s manifold problems
may be best summarized as: (a) The devising of measures to ne-
gate her passive withdrawal and her vegetative state dominated
by a sense of hopeless, helpless frustration; (b) Employment of
measures, sometimes directly, sometimes indirectly, capitalizing
upon her frustration and despair by employing measures which
might conceivably make use of resulting strong emotional drives
as a basis of evoking a great variety of response patterns and of
motivating learning; (c) Arousal of motivational forces and memo-
ries that had played a part in her development from infancy to
normal adulthood; and (d) Inducing and compelling an open-
mindedness or mental receptiveness to new, inexplicable, curiosity
evoking ideas in settings causing the patient to look forward with
hopeful anticipation and not to expend her energies in despondent
despair over the past. Always and ever-changing challenging ac-
tivities of the present and the future occupied her mind, and thus
there existed a mental frame of reference conducive to recovery of
lost learnings and the development of new learnings, possibly by
new and alternative associative neural pathways.