SECOND

PSYCHOSYNTHESIS MEETING

Saturday, November 23, 1963--Manhattan College, New York

The tragic death of President Kennedy the day before and the exceptionally bad weather was the cause of the absence of several who had notified us they would attend the meeting. However, seven of us, living in the immediate locality, decided to go ahead and had a profitable two hours discussion. Following the presentation of a case-history by Dr. Cooper we approached the difficult area of the will.

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Participants:

John Adkins, Ph.D.	Jerry Cashman, M.A.
Jack Cooper, M.D.	Ted Gilbart, M.A.
Frank Hilton, F.C.I.I.	Fabian Rouke, Ph.D.
Anthony Summo, Ph.D.	

Cashman and Gilbart were new participants; both are members of the Department of Psychology, Manhattan College, working for their doctorates.

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Chairman, Jack Cooper: We all have the copy of Dr. Assagioli's comments on the transcript of the last meeting. Dr. Assagioli did a good job of helping us out in regard to this question of dis-identification...but as Frank Hilton indicated he didn't quite tell us what we were asking so a letter has gone to him to clear up some of the details. I wonder if any of you have any comments to make on that particular point. I'll classify this as old business.

Rouke: I thought that letter by Dr. Assagioli certainly showed a tremendous ability to just hit the point under discussion, and to draw up very concisely what had been to us at the time a seemingly long and somewhat disorganized discussion - he drew the meat right out of it!

Hilton: I wrote back to ask Roberto specifically about the change of title for the "Exercise of Dis-identification" - the point that you raised, Dr. Summo; and also Swartley's suggestion to change the final paragraph on page 43 of the explanation.

Summo: I think there was also the question of adding "I am not only" (FH: Yes, I asked him to give us a specific reply on that point too.)

Cooper: Any other comments on that particular item? Dr. Swartley will arrive a little later; he said he would bring a tape-recording of one of his patients.

A case presentation which I have here is one that is currently under therapy at the Regent Hospital. We'll just call her "Fran" because it will be easier to discuss it under this name. Her first admission to the hospital was Nov. 22, 1959 at the Institute of Living. She was a person of high IQ, a graduate from Smith College, married, has two children. Her main complaint at the time was that she was unable to function as a housewife and mother. The present illness

began approximately one year after the patient's marriage in 1953, at which time her husband was teaching in a private boys' school. She became suspicious, did not approve of other people knowing what sort of mail she received, she insisted the doors of their apartment be locked at all times, she didn't want to tell people that she was pregnant, she had difficulty in handling arrangements for guests for dinner; she had always been somewhat fearful and had frequent psychosomatic illnesses. In 1956 she complained of her breasts, a biopsy was done under local anethesia and she was discharged. On further examination she returned for a radical mastectomy. After the mastectomy she felt that the walls were closing in on her; she became pale, experienced sweating, refused to drive the car, or leave the home alone; and she was unable to keep any social contacts.

She entered psychoanalysis in 1958 and stayed in analysis for seven months, but quit when she felt that she was not getting anywhere. On several occasions she would have acute episodes of temper and would throw and break things. The husband received only a moderate income. The patient came from a high socio-economic family. The father is living, but was divorced from her mother when the child was about 9 or 10 years of age - in the 30s. The mother is 58 and is a neurotic alcoholic. This one sibling who is a graduate from college is considered to be unstable by this informant. The parents in the home were continually fighting, and the husband left home; a divorce occurred, and following this the children went to live with the grandparents and would see the mother on occasion. The mother lived in the New York social group and had numerous boyfriends. The father married into a fortune, and is now wealthy.

The patient herself is tall and somewhat slender; has had the right radical mastectomy. The physical examination is essentially normal other than for the absence of the right breast. She was admitted to an open ward at the Institute of Living but became disturbed and had to be placed in a closed division. She was tried on all kinds of medication and didn't seem to make much progress. She was discharged from the hospital in March 1961, and during the time there she received fairly intensive psychotherapeutic interviews. The diagnosis they made was schizophrenic reaction, chronic undifferentiated type.

She was discharged as improved, to be transferred to the Mercywood Sanatarium in Ann Arbor, Mich. At the time of admission she had phobias, hysterical conversions, neurasthenia, irritability and depression, and had feelings of depersonalization. She is an intelligent, introspective, dynamic, aggressive person who appears to be maintaining contact with reality only by very extreme efforts of control. During her periods of hospitalization the main stay of the therapeutic program has been psychotherapy, aided and abetted by the use of various tranquilizers. There has been an improvement in her ability to maintain behavioral controls in spite of intense underlying feelings of panic and anxiety. She still remains symptomatic in many areas as before and she was discharged on tranquilizers.

She was admitted July 29, 1962 to the Westchester division of N.Y. Hospital and the history was reviewed. She was noted to be of superior intelligence; the sexual adjustment in marriage had been exceedingly poor as she had never achieved orgasm, and she'd always felt that the husband was psychically weaker than she. She remained until August of 1962. When she was admitted she was tense, frightened, made frequent requests for medication to control her anxiety, and alternated with humorous clowning. She expressed loss of control, professed her inability to attend the therapy program at the hospital. She slept poorly, constantly demanded medication, talked under pressure, but did not display a

manic distractability or flight of ideas. She was excessively preoccupied with this fear of loss of control. The psychological report indicated that she has been on the brink of an overt schizophrenic illness for quite some time. Neurotic mechanisms are no longer adequate to handle the impaired self-image following the radical mastectomy. At this time some ego impairment of a schizophrenic nature was indicated on the projective test. She had conflict at three levels: most overtly she is concerned with her immaturity and dependency, preconsciously and at times even consciously she is concerned with her lack of feminine identification, due to the inability to identify with her negatively perceived mother. However, most basic is her fear of not having any identity. Certainly her early environment and parental relationship was such as to be inducive of schizophrenic illness. Although she is in good contact some of her thought processes and, at times, inappropriate affect are childish, almost ~~au~~tistic, and her fantasy suggested schizophrenic psychosis. Further, her personal relationships, probably because of the strong hostile urges and basic feelings of inadequacy, are tenuous. The test suggests that further withdrawal would probably occur; because of the neurotic overlay and pan-anxiety and pana-phobia a diagnostic impression of schizophrenic reaction, chronic undifferentiated type was made. Her motivations and fair ego strength and intelligence should be considered positive prognostic signs although the chronicity of her emotional difficulty may make her complete recovery somewhat dubious. Anyway, on admission she insulted a couple of nurses and required transfer to the disturbed division in spite of large amounts of medication. She showed some withdrawal symptoms, began to have some seizures and was placed on Dilantin. She had about ten electro-shock treatments and gradually she began to improve and was discharged on 6/25/1963. The discharge conference stated that the decision was taken that the patient should have another course of EST because of the failure to break through her phobic reactions. She appeared to benefit from these treatments so that it was possible to move her back to a convalescent hall. The staff recognized that she was not well at the time of discharge but the husband insisted ~~upon~~ that she be discharged. It was the desire of the patient and her husband that she be allowed to try it on the outside.

June 9, 1963 she came to the Regent Hospital and at that time the diagnosis was made as psychoneurosis mixed (anxiety tension and phobic state). She was seen for short periods of time in psychotherapy; was somewhat willfull and defiant, and stated she was a rebel. At the present time she is on various types of tranquilizers and mild sedations. The first time I saw her in interviews she was quite phobic, and could not leave the hospital. She developed crushes on male patients and would not spend any time with her husband or make any efforts to go out of the hospital at all. In the Initiated Symbol Projection techniques she could visualize very rapidly, accurately and could sit down and write reams of material on her visualizations. In going into the forest she would see the little old man and have a philosophical discussion about material of a theological nature. Then we began to work with the will aspect. She recognized that she'd lived on just the <u>determination</u> aspect of will; she was <u>determined</u> that she was going to rebel against society and in spite of the fact that she was an honor student in her school, she would dance to all hours, get drunk, and rebel openly against society. Her marriage was a rebellion against her family. She was <u>determined</u> that she was going to be a housewife and a mother of two children. We talked about the other aspects of will, such as being able to work out a <u>willingness to do</u>. She started with simple exercises such as taking out matches out of a box and then putting them back in, with some sense of contentment. She developed a phrase: "I am <u>willing</u> to do this; I am <u>willing</u> to do that; I am <u>willing</u> to spend some time with my children." She was using more of the volitional aspect of will. She began to improve, began to go out to the

nightclubs and into the community; she could move as far as 42nd street. She attended a special class where they are teaching her certain aspects of charm; she has shown an interest in religion, and she can spend longer times with her children than she had been able to before. Her present main conflict is living with her husband.

President Kennedy's assassination yesterday, created a crisis in her life and she identified strongly with his death. Her statements were something like this: "I see now what is important, and what isn't important"; "these things that I have been doing - such as going out on dates and drinking - that's not important, but the important thing is to work along with what President Kennedy was doing!" She began to understand the necessity of using her drive and her capacity for visualization. She actually seemed to have a religious conversion - with new thoughts and feelings.

Adkins: When she came to Regent Hospital, did she come as a full time patient?

Cooper: Yes, she is living in the hospital; she goes out whenever she wants to. The administrators of the hospital decided that she should come in at 10 o'clock at night, and up to that time she had been staying in the hospital practically all the time. As soon as they put the curfew at 10 o'clock - she hasn't been in at 10 o'clock since! She comes in at 4 or 5 a.m.. She has acted out a considerable amount of her rebelliousness and is now minimal.

Summo: The initial diagnosis made was that of chronic undifferentiated schizophrenia; at Regent Hospital it was a psychoneurotic reaction - is it that she has ceased to be schizophrenic or was the official diagnosis psychoneurosis? What I am concerned with is that you <u>do</u> handle - therapeutically - different types differently!

Cooper: Well, she had been treated as a schizophrenic patient, with poor response. She was given so much medication at one time that she became addicted to it; she showed withdrawal symptoms and there was no change in the schizophrenic pattern, if there was one at the beginning. When a patient doesn't respond to therapeutic regimes, the tendency is always to label it "schizophrenia." We can't do that any more, because now with tranquilizers there are schizophrenics who are responding to treatment. So I question the first diagnosis; I think the Regent diagnosis, which I didn't make, is more accurate.

Summo: So it would seem - on the basis of the way she was able to project and to utilize the volitional aspects of will.

Cooper: The fact that she could use the volitional aspects of will doesn't necessarily mean that schizophrenic patients who are on tranquilizers and under control, can utilize the volitional aspects of will and do much better. I can't see that we can use it as a diagnostic tool, because I think it's an unexplored and an untapped aspect of treatment.

Adkins: Is it possible to look at the patient as capable of using the schizophrenic method of coping with life or the neurotic method of coping with life? That is, instead of thinking of it as a fixed category, one <u>is</u> either schizophrenic, or neurotic, or "normal"? We have these tendencies in all of us actually, the question of diagnosis then might be considered to be the balance, i.e., which of these coping devices is the patient using preponderantly? And your patient is not now using - in these terms is not now using - the schizophrenic coping devices preponderantly.

Cooper: What she is using now is a tool that's new to her and she is using it in a normal way. As long as she was working on the determination aspect of will her defenses and her philosophy wouldn't support her over what she was doing. Now, there is a sensation of virility and strength. We might say that we are strengthening her ego. The diagnosis of schizophrenia, as far as I am concerned as a psychiatrist, consists of the psychosis; i.e., a person reaches a point where they are out of touch. They hear voices or see visions, and this seems to be more of a healing process of the psyche than a pathological condition. They withdraw, and then gather their forces or their thinking, and if they are given the chance to withdraw they come out of it, later on. We sometimes see a spontaneous remission of a schizophrenic psychosis. Most of them shouldn't last over a year and a half to two years. We are able now to speed the healing process with medication. So I think of schizophrenia as a psychosis. When you are thinking in terms of schizophrenic thinking or ideas then we have to look at it a little bit differently.

Adkins: You think of psychosis as itself a method of trying to heal oneself?

Cooper: I think of it as a healing process, as in tuberculosis - the healing process is the fever and the encapsulation of the organism. In this healing process tuberculosis patients become restless and they will move around a lot more than they should. You see the same thing in the prodromal symptoms of polio. There will actually be a "drivenness." I interviewed two pediatricians who had in the prodromal states of polio mowed their lawns. They were both in iron lungs and they both admitted that they were foolish. They had taught the mothers of their children that whenever they had a cold or sore throat to go to bed and rest; but this drivenness - which was a part of the polio - pushed them into doing these things against their better judgment. Likewise a tuberculosis patient will be impelled to move. Some studies of TB patients call them schizophrenics. Some of the early polio cases will be schizophrenic, as part of a healing process; and Selye in Montreal is studying this from a hormonal standpoint. Schizophrenia to me is the healing response in the body. With the tranquilizers we have now, we have accelerated this healing. Now they are functioning but are back in the same situation and we need to give them help. That's why I think the psychosynthesis techniques will be of more assistance than the analytic.

I was interested in presenting this patient because of the previous analytic therapy. If Dr. Padula joins our group today he will tell us of patients that he has had who have had intensive analytic therapy, and with short terms in psychosynthesis they were able to get enough ego strength to go ahead and carry on and function as more adequate persons.

Summo: To go back to this "determination versus the volitional"; you said that she developed an attitude of "I am willing." (JC: Yes, from determination); now was this a transition that was fostered by you as a therapist or? (JC: No, no, this was her idea). Then actually what we are getting is a change from a more rigid approach to a more flexible approach, for to be able to will indicates flexibility - to be able to move toward or away from.

Cooper: Yes, able to move toward or away. She recognized that when she was saying "I am willing to sit here," that she was using the determination aspect of will. This realization came upon her, with an intensive emotional reaction. "What I am doing is not using the volitional aspect but the determination, not doing it because I am willing to do it, pleasantly, but actually because it's a matter of determination!" With this change in attitude she began to function and move out into the community.

Hilton: To relate this to what was discussed at the last meeting on the "self," in your discussion with her, did you or she, see the will as an attribute of the self?

Cooper: She not only has been able to see it as an attribute of the self but she has had the first real self-realization, a self-actualizing experience. I have shown her the Assagioli description of the self. She had read Maslow's "Toward a Psychology of Being"; she had been working with the dis-identification technique and none of them seemed to help until all of a sudden she had an emotional experience, stating: "I see it's a matter of being willing - and not determination; of just relaxing and letting go and letting things be." "I understand now what the problems are, I feel now that I will be able to work them out, I have been going at it in the wrong way. I feel that I have been trying to solve these problems with determination and that is wrong."

Rouke: At what stage in the situation did she and her husband separate? (JC: She physically separated from her husband in 1959). When she first had this mastectomy?

Cooper: Yes, after the mastectomy - breast removal. she had a cancer and she has now a six or seven year cure on the cancer. (J.A.: was it actual cancer?) Yes, it was malignant, just on the borderline.

Adkins: What reaction did she have to that operation?

Cooper: The operation just set off the whole business. Up until the surgery she was doing all right; she could maintain a kind of balance at home. It was tenuous but she was holding all right until the mastectomy. After the biopsy, she was sent home; then she was brought back into hospital for the mastectomy. She was an excellent patient as far as the mastectomy was concerned. Due to the loss of muscle in the arm - most of the ladies have problems with weakness and swelling - she worked well with the therapist and with the other patients. She would demonstrate to them that this is what could be done. (Summo: the determination!) Yes, determination you see.

Adkins: Did she have any psychiatric care at the time of the mastectomy? Do you know anything about the surgeon or the physician attending; were they people with empathy? There is a great deal of difference in physicians; some have rapport with the patient, others are very matter of fact.

Cooper: It was this difference in physicians that got me into psychiatry! As a medical student I was not biassed as my father was a garage mechanic. When I studied medicine, I looked at all the X rays and the tests, and I could see the patients still complaining - they still had their pains; despite giving them thousands of dollars worth of medical examinations they were still sick people. My first thought was what they needed was a hamburger, or some kind of food; later on I felt that maybe what they needed was money; until I saw a psychiatrist at work one day, and then I saw the emotional conflict. Later on I saw the difference in physicians. The more scientific techniques, the more trouble! There were all kind of tools and the atmosphere was tense. The doctor who loved emergencies had many emergencies! Another doctor would wash his hands and would take a sip of alcohol. He'd go through the routine but his patients never had difficulties; if they did, they seemed to solve themselves. I asked him one day "What do you do to your patients? Your patients are different!" "Tell me what it is!" He laughed and said "I just talk to them!" - and from that day on my interest was in that kind of doctor. It was my sad discovery to find that doctors were trained

to be a kind of skilled technician, rather than trained to develop the art of medicine. In medical school we found one third of the students had this capacity of empathy; one third of them were on the borderline; and one third of them were just technicians. The medical school technique of training emphasized the technical aspect, so that by the time they graduated they were not interested in psychiatry. (Adkins: and even some of those who had it were trained out of it!) Yes, and then maybe five years after they had been in practice they would become susceptible to psychiatric understanding. But it takes five years in practice to get over medical training. When Fran went into Westchester hospital - in a locked psychiatric division - she fought. In my experience as a police psychiatrist I found the kind of person that gave them the most trouble was the normal man who was locked in - not the criminal type. The normal fellow who was put in for 100 days for driving without lights or speeding reacted by fighting, and he was usually placed in solitary confinement. The police thought that he was the worst customer. Next to him the hardy criminal would turn his clothes inside out, sit down and wait his time out; he would be placed as a "trusty" and very quickly would begin bringing in wine, whiskey and drugs; while the normal man would be residing in solitary confinement because his hostility would be acted out. Fran reacted in this way when she was confined, with a release of all of her hostility - and then she was given shock treatments.

Adkins: And so they took this as one of their cues for diagnosing her shizophrenia perhaps.

Cooper: I think this does happen when we lock patients in. The same thing occurred in the Institute of Living; when the doors were locked she (Fran) acted out her hostility. Many of our patients when placed in a locked division will act in this way.

Adkins: No matter where she was she had the habit of thinking that she was enclosed, probably visualizing, conceiving in her mind that authorities were telling her that she must not do, or must do, something; but when <u>you</u> spoke to her, in some way she was able to consider what <u>she</u> wanted to do and was <u>willing</u> to do. Now when she began to realize that she was not encapsulated in this invisible army or authorities...

Cooper: This was upsetting to her - when she made the discovery. She said "No longer is the outside hemming me in; I am just doing it myself." And with this realization, that <u>she</u> was hemming <u>herself</u> in, she was able to mix. This was an insight that she was able to develop. Any further comments?

Summo: How often do you see her? (Cooper: I have seen her an hour a day, sometimes an hour and a half, and then in between times, since August the 15th - five hours a week.) Did you use the psychosynthesis approach every time?

Cooper: No. I used the psychosynthesis approach, but utilizing anything that might come up - wherever she wanted to start there we would start, and generally we would wind up with some aspect of will; and she gains the insights as we go along. A very intelligent girl, has an IQ in the region of 165 and strictly verbal, very little performance...

Rouke: Very little performance, verbal and explosive aggression? (Cooper: Yes, explosive aggression) That is just what we have found with disturbed adolescents and the rebels. It goes along with the high-spiked electro-encephalograph.

Cooper: Her EEC shows dysrhythmic changes.

Summo: Dr. Rouke just came back from Europe where he presented a paper on studies we had done with pre-delinquent and delinquent students; and we were able to pick this out fairly consistently.

Rouke: So it was with great significance that some of the sub-test relationships in the Wexler showed (?) this particular business of high verbal and low performance; and it was almost all this temporal parietal - usually as the result of a birth injury or a high fever in early childhood.

Cooper: Well this spiking, etc., came on after the electro-shock (referring back to the case of Fran), but prior to the mastectomy she functioned fairly well. (Summo: Was an EEC done before the shock?) No, the EEC after the shock. This, to me, would be important, the same as to you; but it was done on the second hospitalization in Westchester.

Rouke: Was any shock given before these explosive reactions?

Cooper: The explosive reactions occurred after the shock treatment. Adkins: Where was the shock treatment given? Cooper: At Westchester. Adkins: Was that for a long period? Cooper: She had about 12 or 13. Summo: What happened there was that somehow she lost the inhibitory factor due to the shock and I feel that the spiking was probably present before. (several voices: You can't tell!)

Rouke: Was she tested before the shock, for the IQ?

Cooper: Yes, she was tested before shock treatment and showed this high IQ and slow performance. Now whether or not there was this spiking before we do not know. We can guess at it and say that it probably was there.

Hilton: How far will this technique of the will - the one that you have been experimenting with - operate with these delinquent adolescents?

Summo: It works excellently with adolescents; it is a terrific tool because they have a beautiful fantasy life that they can throw themselves into.

Cooper: Yes, they can live it. Rouke: Yes, they can become "Superman." Summo: Yes, the "I am in control of myself" kind of thing. Cooper: That is right.

Summo: Just the other day I was talking to one of them. I put her into an amusing ly simple projection; and the week before (in I.S.P.) she had somehow managed to wander down on to a beach, and there she had found a shoe and a cross. They were hers, but she didn't quite know how they had gotten there; and then she said "I do not want to do this anymore!" So I said, "All right, let's terminate it"; and then the following week I said, "Well last week we got you down to the beach, so what do you want to do?" She said, "I want to lie on a blanket"; which she did. I asked her "What are you thinking of?" "Nothing!" "Would you like to dream?" Then she went ahead and projected a dream; but finally, when it was over - and I guess this was my lack of experience in operating with this particular kind of thing - I said: "All right, well come on back and let's talk." But after we had been talking a while she said, "Listen, do you mind if we go back, so that I can get out of the sun - I am going to get an awful sunburn!" So I said, "Close your eyes, go back and come right out of the sun!"

Cooper: It is very important that you get them to a safe place before you quit. This we have learned; and it is necessary. They will usually come out themselves, but it is exceedingly important to wind up properly - I always like to come back to the meadow, wind up in the meadow before we end the session. But any time

we leave them in the 'midst of the mud' there's trouble. (Summo: Yes, she - my patient - would have been cooked - baked patients!) I had a 64 year old lady patient the other day who has received a tremendous amount of electro-shock and she was sent to me for further shock therapy. She is limited in intelligence, she cannot read or write to any great extent and yet she has a special visual capacity - and with two sessions with this I.S.P. business she is better. This is how Frankl lived for four years in prison camp; and my patient, Fran, says "This is the real world isn't it? This is the world that we should really live in." She says, "I have this gift of visualization and I haven't been using it!"

Summo: I wonder if we couldn't develop an approach - something like this - with children, who have this beautiful ability to carry themselves beyond the office, so to speak. Of course, I think it would probably require an almost completely different technology to be able to work it with youngsters.

Rouke: To use their fantasy, sure!

Cooper: Frank, in your latest Newsletter weren't you talking about creative thinking, creative expression in education handled in the Montessori schools? Personality expression through movement is basic and the so-called eurhythmics in the Steiner schools; and then Prof. Bonomo worked on in this field. Here is one of the techniques she uses: "In the classroom, after some moments of silence, she gives the beginning of a story and asks each pupil in turn to add a little to it, visualizing the scene he or she contributes. For instance, she says, "Let's imagine ourselves at the bottom of the ocean. What do we see?" or "A ray of sunshine is advancing. What does it illumine?" Each pupil then adds its own contribution. This group creativity greatly interests the children and gives them a sense of co-authorship, of collective action, etc. The results have been very gratifying: release of pent-up energies, joy, improved behavior, self-discipline, cooperation - with the older children sometimes spontaneously helping the younger - and the discovery of artistic gifts. Some of the pupils have later become designers, decorators, architects.

I have another patient at the moment who has remarkable music ability. He can hear whole symphonies just as Mantovani does. He has been trained as an athlete and he has spent six years in mental hospitals. His present music teacher is not using the standard methods of teaching, nor is she interested in using it therapeutically, but she is merely trying to bring out this auditory quality. He has had five lessons on the piano now; you can't imagine the difference in this boy; he is putting into expression what he hears. He is spending his time practicing the piano, and has given up much of his delinquent behavior.

Rouke: I think that I will try using it with children in a one-and-one setting. Also I have new patients (just starting) with whom I will use these techniques. Both are patients who have been in analysis previously - not that it was unsuccessful but it was several years back and for a different problem; and it was successful at the time. One has an alcohol problem; the other an overweight problem; both came in the other day "looking for magic," expecting I was going to hypnotize them and eliminate the problem; they found I work differently. I have only seen them once so I have a nice opening to try this with them because they are both quite intelligent women, about 35 to 40.

Cooper: The thing that is gratifying to me is their applicability in every situation - you can find appropriate techniques in the Manual. For instance there are techniques to use with schizophrenics. Dr. Padula had a patient who was

schizophrenic, had a voice that came right from the top of her head, it was controlling her thoughts. I suggested that rather than use any of the symbol projection material that we move in the other direction, of focussing attention on the environment. So we started the procedure given in the beginning of the Manual, of taking a picture and looking at it for a minute and describing the details of it; or going to a shop window and describing the details in it; or of actually learning to play an instrument. The instrument she selected was a harmonica. But as she began to do these things and kept a diary of it, and as she began to pay attention to the things around her, the voices gradually diminished, disappeared; she began to dress better; she began to function better and work at a different level. (Summo: You were pulling the attention out...) Yes, pulling it out instead of turning it in. (Hilton: The reverse of visualization!) Right.

Rouke: When you get somebody who is reacting too intently - with emotion - to environment, then you need to move them inwards, and when you get soneone who is too intent inwardly, then you move them outward. (Cooper: Right.) We tried a little experiment this week and unfortunately due to the tragedy yesterday we didn't get to complete it. It wasn't a formally planned thing but Jerry and I share a class - I have it on Wednesday afternoon, he has it on Friday afternoon - of about 112, mostly engineers. This is a class in fundamental dynamics and behavior, and we had just begun the section in the text we are using, which is McCurdy's "Personal World," on the self concept and the meaning of "I." I felt that instead of lecturing I would use some of these techniques, to get them feeling what "I" means. So I explained to them what I was going to do and asked them to sit comfortably, close their eyes and just concentrate on the things that I would mention. I went through the verbalizations of "I have a body but I am not only my body," etc.; then I let them wait a while, and amazingly in about 2 or 3 minutes, that room was as quiet as could be. There were one or two rebels who did not want to do it - but out of 100 you are going to have a few. So then we went into the second part, of visualizing themselves performing a task that required a lot of patience, like untying a knot; and then visualizing themselves building something beautiful from a wreck, using the creative potential for beauty that was in them. Finally I had them walk up the hill to the light, and enter it. When I finished they all just sat there; it was very similar to the experience I have had with people who are in a light trance state. I feel that a lot of them - when they started this concentration - almost went into an auto-hypnotic state at a light level. So, to be very sure, I used the usual technique for bringing them out of hypnosis - the "one, two, three, and now you are wide awake"; and, of course, they felt a little embarrassed and had to shuffle around and laugh a bit. They said,"What did you do, hypnotize us?" I said, "No, but I want to congratulate you, because many of you seemed to have achieved auto-hypnosis without any previous training." (These are intelligent, senior engineers, and they have had lectures on hypnosis.) Some of them doubted this, so I said, "Well, can any of you remember when nobody in this room moved a muscle for 35 minutes before?" Then the reaction was quite amazing - "35 minutes?!"; the time apparently had been completely condensed for them. What we had hoped for was that when Jerry met them yesterday, (Friday) he would get their further reactions; because one of them had said to me, "I could hear everything you were saying, but it seemed that I was beginning to move away and then come back, and then move away and then come back - should this have happened?" I told him that was a perfectly normal reaction; and another one said, "Was it right that I should feel as if I were floating?" Now these were very good responses. These were some of the students who have been more interested in hypnosis but they all were quite - I think I can use the word - fascinated with what they were able to achieve. (Cooper: I think the term "fascination" is

right too, in the sense of what's happening.) Yes, so I don't know what we can do to further this. Cooper: You've made a good start.) We'll meet them individually on Monday, and then I will have them again Wednesday. There is this whole section in the Manual - we've dealt with a few chapters in the development of self-concept.

Adkins: After we had our last meeting I attended the workshop of the Society of Clinical and Experimental Hypnosis....I hadn't had any experience in hypnosis at all - actual so-called hypnosis; but I found out that I have been doing a lot of the things that they discussed. I have been using a technique in therapy which is helping people focus on various different things - and this is somewhat similar. I had been prejudiced against hypnosis, I guess Freud hypnotized all of us against it in a way - or his disciples - and I thought well I'd like to know what it is, because it may be a matter of <u>focussing</u>, or something like that. I was amazed at the scholarship of these people who gave the papers, these men were men of first caliber and they've done amazingly fine clinical and experimental work. But this sort of thing that you are doing - I am trying to get an understanding of what it really is. What is it? It's something that's very important for us - it's certainly a window into what is.

Cooper: It is a usual phenomenon; it's a thing that's been referred to as idedic imagery; it is the capacity to <u>see</u>. To test it, you usually ask the patients to see if they can visualize a blackboard, and then on it write a figure; you give them an arbitrary figure 2; if they can write it as if they were writing it in chalk, then have them place another one beside it, and then see how many figures they can write before the first one disappears. See what happens to them.

Summo: Yes; many of my pupils are fairly bright, with a very good attention span and I have found that I can "shortcut" - instead of having them start with a number, and keep writing in the normal direction, I have them alternate left to right; it breaks down more quickly.

Cooper: Then you bring color into it by having them visualize a red square - or whatever color you suggest. If they can do this then you can go on with your standard number - there are twelve standard situations that you can put them in. (Adkins: This is hypnotic?) It isn't necessarily hypnotic. It's good to have them relaxed; and during the process some of them can see better if their eyes are closed and some have the visual phenomena with the eyes open. (Adkins: Is this described in here--the Manual--?) Yes it's in the Techniques under initiated symbol projection.

Adkins: It is very similar then to the techniques that these men (Society of Clinical Hypnosis) are developing; and all of them are turning away from any use of hypnosis in a dramatic or sensational way, to a therapeutic way. (Summo: Good) I think the most amazing thing to me was that they brought out, time and time again that it is not a <u>weakness</u>; you know, that the folklore about hypnosis is that you are weak if you can be hypnotized. And then they also emphasized self-hypnosis, such as you mentioned. That's really what they are aiming at, to help the person to direct himself and to use this ability.

Cooper: Would it not be interesting to go back and read some of Mesmer's original work?!

Rouke: Yes, we may have some very interesting material; when we were in Vienna we had a chance to meet Prof. Deutsch(?) who had been a musicologist and for 14 years Professor at Cambridge, and had lectured at Harvard, Yale, Princeton,

Columbia, Chicago, Calif. He is one of the top men in the world in this field. We had an introduction to him...and Walter Bromberg(?) was there - who wrote "The Mind of Men" and several other books. In that he has some wonderful material on Mesmer and some of the early healers, like Valentine Greggs (?) and Zieless (?) the Austrian. The Prof. told us how he started out as a historian, and studying the history of art he became interested in music, then he became a musicologist. When he started to study Mozart, he got interested in Mesmer; and he has accumulated material on Mesmer that has never been published. He is going to send it to us.

Cooper: When you get it, let's go over it, because he may have hit on much of what we are talking about now; and he may have shown us the way.

Hilton: Do you, Dr. Rouke, see this as related to hypnosis - this may be a question of semantics - this "moving to and away" that your students mentioned. Isn't it more of a question of leading into the realms of thoughts and feelings while still maintaining your self-identity, not losing yourself in the subjective world?

Summo: Frank, yesterday I was telling Dr. Rouke about this, when I was telling him about a patient. The word that I use - but how accurate it is I don't know - to me it looks almost like a "waking hypnosis."

Cooper: "Réve éveillé" is what it is, the waking dream.

Rouke: You see, I think, the phenomena - whatever we call it - that the patient experiences are similar; now they are not necessarily identical, and certainly this is not identical with a deep trance where somebody is somnambulistic, but in the light level trance the patient is maintaining contact with the world around him, where he is aware verbally and tactually of all of the immediate sensations. I think this is the type of thing we have, and I don't know how we should define it, I don't think it makes too much difference, I don't think we should be afraid if it is called "hypnosis" because I don't think this is anything wrong.

Hilton: Provided we remember the point that Swartley stressed, and you (Dr. Cooper) stressed too - which brings me back to the point I was trying to make - of them maintaining their self-identity when you take them through this. They always have "choice," and they should maintain "choice"; even in their initiated symbol projection.

Rouke: Well one of the things I insist on in therapy with a patient with whom I use hypnosis, is that "This is not something I am going to do to you, <u>you</u> are going to do this. All I can be is the road sign or map, <u>you</u> are driving the car!"

Adkins: Yes, they emphasized that over and over again in the workshop. The patient is still conscious; he is doing it, but he is <u>willing</u> to do it. Now of course a very dependent person is willing to do it because he trusts the person and the person is going to love him or something, but when he gets over more into the realm of self-hypnosis then he is doing it because <u>he</u> wants to do it. So it fulfills your question. I didn't understand this before but I am beginning to understand it a little bit now.

Cooper: One factor is that we have a person who is there to guide and to help them out of trouble. Then we have them recognizing that <u>they</u> [illegible] the walking; you are just the guide, to assist them; and at this stage [illegible]en they can

become, shall we say, daring or more exploratory - as soon as we lose our fear of the visual phenomena, because it's ingrained in us, we are trained that hallucinations are dangerous and signs of mental illness; and this we have to get out of our thinking.

Rouke: Sure; because after all, if we stop to think, the creative vision of any of us is similar to this hallucinatory experience, except that he knows that it is not real out there, he knows that this is originating in his own mind, the fear of the difference.

Cooper: This fear comes from the stage presentation of hypnosis, that the person is being made a fool of, (Summo: Yes) and is being duped in some way. But in my talking with patients about hypnosis - I try to get them to feel a little bit more at ease with anything that resembles it - I point out to them that when they sit in front of a TV set they are hypnotized, they are not only hypnotized but are living atrocious things. To test it with a friend, while he is sitting there ask him to lift his hand, and he'll move it without thinking; and you'll see that he is under a state of hypnosis. We smoke Camels becaus "Doctors smoke Camels," and all that sort of business. So suggestion is used by the Madison Ave. boys all the time.

Rouke: The other element here is that when you help them to achieve physical relaxation they lose much of their anxiety; because, after all, anxiety is a total reaction - physical as well as emotional or mental. And when they lose the physical side of it they lose something else. Then they have a sense of confidence, of "if this can happen, then I can do a lot of other things!" And I usually try to get them to consider the power of their own mind and their own self: "It was your own mind that made you as sick as you are; if it can use that power against you, just think what power it can use for you!" And then I try to get them to concentrate on the reality of their "self." I think this technique on the "I", is going to enable me to lift them to a higher plane. Get them to concentrate on the use of this technique, to help rather than to hinder. Because patients have the evidence right in their own illness, that it is powerful - because it has messed them up.

Summo: We have the fact here, too, that the person wants to. I think we are right back to the first case that Jack Cooper talked about. The volitional aspect of this thing. (Cooper: That's right - the volitional aspect of will.)

Rouke: It's when you get to the creative motivation; they want to get better!

Cooper: It's willing, it's more than wanting. The simplest illustration I can give you is that I have been practicing it myself - this didactic thing. I had occasion the other day to wait for my bus; now I didn't know the period was going to be 45 minutes, but I knew it was going to be some little period of wait. I had a choice: I could take a taxi, I could take another bus, etc., but this offered me an opportunity to stand on a bus stop, however long it took, to wait for a bus with some form of contentment, not standing there cursing or anything of that nature, but standing there working on this aspect of the will. I wish I could give it a name, and so for 45 minutes in spite of the fact that a gentleman came up and was puffing on a pipe, a seedy looking old man and talking about how bad the bus service was, he still didn't distract me. When I finished this 45 minutes and I got on this bus I felt like I had accomplished something, I was feeling like "a big man." (Adkins: Yes, and you felt refreshed!) Yes, I felt refreshed and I felt virile, I felt like I had accomplished something, actually standing there for 45 minutes with some sense of pleasure.

Rouke: You know, there are some cab drivers who achieve that. I have noticed a difference when riding crosstown in a traffic jam. Some cab drivers are all het up and angry and talking, and the others just sit calmly. I have asked each of them, and each has come up with an answer similar to this: "So I can't change it; so I might as well accept it, and live with myself!" I have tried it myself in driving in traffic - when you are stopped and you know that you cannot move, you can just sit there; it works!

Cooper: So we are own case-histories! I have been practicing it myself, and I think I can see value in it; and now rather than take the train in the morning I take the subway just for practice in this same kind of thing. I feel like I am on top of the world when I wait for 45 minutes for a bus without blowing my top. And the old gentleman next to me - foul words were coming out, smoking furiously, telling about how rotten the bus service was and how it was going to get worse. My first thought - which I squelched- was, "What are you doing about the smog problem ?". I saw the hostility was coming out so I leaned back against the post...(Jumbled voices, then Summo:...it heightens.

Cooper: Yes, it heightens so you are so aware of everything around you, you are no longer dulled; the thing that dulls you is this resentment and hostility. As soon as the old man started puffing smoke next to me...and my hostility toward him began to show up, even a little bit, I lost the feeling entirely. It took me a few minutes to get back into the proper frame of mind...the moon was sitting up there, it was beautiful...the comfort of leaning up against that pole I was unaware of any physical discomfort.

Gilbart: It seems that at one time you were concentrating on not attending to your environment, and one of the results was that you interpreted it more satisfactorily.

Cooper: The women were prettier...and the place took on a sheen yet it is in the ugliest part of New York, but for some reason or other it became comfortable. (Summo: It's very paradoxical.) Yes, very.

Adkins: Ted Gilbart spoke of "attending", and when we think of that a little more it was you who were attending, wasn't it? So that you were there, somehow in the 'citadel', and when you thought "He's adding to smog!" you noticed that, and when you attended to that you got certain results that you didn't want; so you decided to attend to something else, which would give you different results. But you were the captain. (Cooper: Right, I could decide.) The problem we are thinking of all the time in relation to all this is the self - isn't it? And what is this thing we call "I"? Well, you spoke of the taxi drivers who learned this technique. Well, then we go along with that technique, but I wonder if the self is then dormant; you are doing the good technique and are getting the good results; but it's when you decide to change from one technique to another that the self becomes more evident.

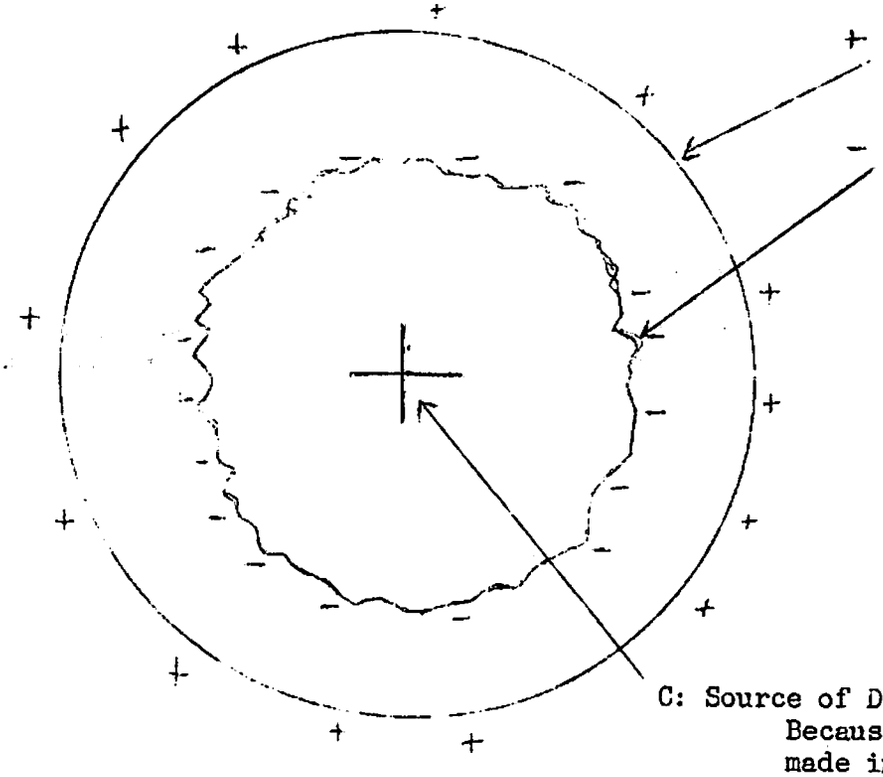
Cooper: Here is what Maslow has to say: "My feeling is that the concept of creativity and the concept of the healthy self-actualizing fully human person seem to be coming closer and closer together and may perhaps turn out to be the same thing." Creativeness, you see, and in my situation I was using this aspect of will which was (Adkins: You were creative, you were creatively attending as Ted said.) Yes, at the same time it seems to be the healthy attitude as witnessed by our taxi drivers who are able to achieve it.

Adkins: What about those people who - let's say - had parents who trained them

in this from their beginning, so that now they go along in this way easily, without any effort at all. Now couldn't we say they are drifting along, and their self is not so evident? (Cooper: until it becomes absent) Well it can go along in free wheel, as it were; but now, if they wanted to, they no doubt could exercise the self in attending to something else like the patient you spoke of. They could go into other spheres - it would be the movement, wouldn't it, that would evidence the self, it would be not their drifting along in even a benign habit?

Cooper: I have a patient who exemplifies this very thing. Now under treatment she was able to get back to this 'self', this healthy one you were talking about; she was drifting along and then became depressed, despondent. The depression then was the absence of this 'self'. And one day suddenly she said: "I feel like my old self!" "Well", I said, "fine, this is a spiritual idea, this is a healthy idea." But she said,"you are wrong, that's just me; that's just my old me, that was how I was before I became sick!"

Rouke: I have a way of presenting this in class, developed maybe 10 or 12 years ago in teaching the development of personality and self, and it works so well that I use it pretty much in therapy. (Here Dr. Rouke showed the following Diagram):



After you meet the new patient and have the first initial period of enthusiasm, they then meet resistance and discouragement and start to slump. When that happens I revert to the role of teacher for a while; and although I know they are not going to grasp it completely at this stage of therapy I spend maybe most of an hour discussing it, and then later on they'll come to it. I talk about their feelings of inadequacy and the things that they are feeling very uncomfortable about, and illustrate to them that their concept of themselves is a

totally negative one because of criticism in childhood, because of parents that they could not please, because of any one of a number of reasons; and so to defend against this - which they can't live with - they throw up the defense wall (A on diagram). And this, of course, appears to be positive, deceiving themselves and deceiving others. Then I let them know that this (A) is positive, but it's phony; this (B on diagram) is negative but it's inaccurate. I say, "When we started to break down the defenses you were faced with this situation (B) and nobody can live with it, it's uncomfortable; but we are not going to stop here, we are going to break this down and get through to the middle (÷ on diagram) to something that you haven't recognized for a long time, and that is the essential worth of you, because you are a human being, because you are a human person, the finest thing in creation!" Then I talk about what it means to be a human person; that it is the pinnacle of creation, and this is going to give the patient a very solid sense of dignity - that will not be conceit because there are three million others that have exactly the same thing, in the eyes of God. The sense of this equality of man and the sense of the dependence on the Infinite gives dignity and humility, and with these twin cornerstones we can build anything.

Cooper: I amplify this just a little bit more: to point out to them that in addition, "you have a job to do which nobody else can do." Now putting this into their frame of consciousness, early, I think is an important step, because Assagioli points out that the unconscious is like an undeveloped film; the images we put into it may not come up until latter, but it is exceedingly important what kind of images we put in, just exactly as you are saying.

Adkins: I do essentially the same kind of thing, but that (Dr. Rouke's diagram) is a very nice way of helping a person visualize.

Cooper: Those images are exceedingly important, and should be planted early and should be repeated frequently while you are working with the patient.

Rouke: Usually I give the diagram to the patient, and I tell them, "Now, think this over during the week and see what you think about it; when you come back next week we'll discuss it." And depending upon the person's religious orientation you can go stronger in one direction or in another; but it works even for someone who claims he has no religious orientations.

Adkins: Well I suppose you do as I do; you take not only this whole general presentation, but you take each one of these in detail. For instance, the "phony positive," and you help them analyze and listen to themselves, because under that phony positive they hear - if they are careful they can hear - the negative. Then you help them to see through that negative, see through the invalidness of that negative. You are not helping them to correct a propaganda by a counter-propaganda, you are helping them to see the invalidity of this propaganda, and the reason why it is invalid is because of this.

Rouke: Yes, it doesn't compare with truth; and of course I usuallly bring this in when their outer ring of defense has began to crumble, when they go into this first resistance and discouragement.

Adkins: You take them in detail? I take them one by one. (Rouke: Not necessarily, no!) (Cooper: You just give them a concept that they hold and repeat.) The thought that I have, is that you have to deal with the negativistic belief,, otherwise you are in danger of superimposing a positive belief, and the negativistic belief which is more whole-heartedly believed will sabotage the other. But if you help them to see through the negativistic belief - for instance, the

belief that they are no good - you help them to see that it is not true.

Rouke: That's it, that's the one I use - more than the one that you are talking about.

Cooper: We use Assagioli's idea of repetition and I may repeat five or six times during the interviews while working with the patient. We try as much as possible to give them the understanding; keep putting in, keep feeding - repetition is something that Assagioli keeps talking about - keep repeating it, inside.

Rouke: The way that I follow up this negative thought concept is not to stress the negative aspect but just to ask the patient, "Well now how do you think that this developed?" As children, they developed their sense of their own worth, and sooner or later they come to the point where they say, "Well it is what my people thought about me!" And then you have got them; because then it is a very easy progression (Adkins: Yes, they only "took it on"); then they can see that this is an accretion, something that was learned of the emotional problems of their parents; and you can then stress that no problem starts in this generation. (Adkins: It has been learned so it can be unlearned.) Yes. (Adkins: Yes, that is essentially my own idea.)

Cooper: Very well then, shall we close now, and talk about the possibility of our next meeting...the psychiatrists who are interested apparently cannot make Saturdays - office hours and things of that nature.

Summo: But will they not run into the same trouble during the week - probably more so.

Hilton: How many of them have said that Saturday is a bad day for them?

Cooper: Dr. Holt did - Saturday afternoon is his busiest time (followed discussic of dates of next meeting and <u>Saturday, January the 18th at 2 P.M.</u> was decided upon).

Adkins: I think that this is the most convenient time you could choose, i.e., Saturday afternoon...and I think this place (Manhattan College) is excellent.

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At the close of the formal meeting, informal discussions continued for half an hour or so over coffee in the College Cafeteria. These touched on the need for more research into the area of the will. Dr. Cooper mentioned that Dr. Swartley had an unusual tape-recording of a session with one of his patients which could be heard and discussed at our next meeting. Ted Gilbart mentioned the possibility of writing his doctoral thesis around the subject of our discussions and was warmly encouraged by those present.

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